APA-4

CERTIFICATION OF EMERGENCY RULES
FILED WITH LEGISLATIVE SERVICES AGENCY
OTHNI LATHRAM, DIRECTOR

Pursuant to Code of Alabama 1975, §§41-22-5 (b) and 41-22-6 (c) (2) a. and b.

I certify that the attached emergency rule is a correct copy as promulgated and adopted on the 18th day of March, 2020.

AGENCY NAME: Alabama Medicaid Agency

RULE NO. AND TITLE: 560-X-06-.13ER Covered Services: Details on Selected Services

EFFECTIVE DATE OF RULE: March 18, 2020

EXPIRATION DATE (If less than 120 days): _____

NATURE OF EMERGENCY: The above-referenced rule is being amended to allow certain services in accordance with the time prescribed by the governor as a State of Emergency due to the COVID-19 (Coronavirus) pandemic.

STATUTORY AUTHORITY: Title XIX, Social Security Act; 42 CFR, §§ 405.310(k), 440.50, et seq.; State Plan.

SUBJECT OF RULE TO BE ADOPTED ON PERMANENT BASIS __YES _X_ NO

NAME, ADDRESS, AND TELEPHONE NUMBER OF PERSON TO CONTACT FOR COPY OF RULE:

Administrative Secretary
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, Alabama 36103
(334) 242-5833

Stephanie McGee Azar
Commissioner

REC'D & FILED

MAR 18 2020

LEGISLATIVE SVC AGENCY

Rule No. 560-X-6-.13ER Covered Services: Details on Selected Services

(1) Acupuncture: Not covered.

(2) Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure which is a covered service under the Alabama Medicaid Program. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered. For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. In order to bill for medical supervision, the anesthesiologist must be physically present and available within the operating suite. "Physically present and available" means the anesthesiologist would not be available to render direct anesthesia services to other patients. However, addressing an emergency of short duration or rendering the requisite CRNA or AA supervision activities (listed below in a. through g.) within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist's personal continuing involvement in a particular case, medical supervision ceases to be available in all other cases. In order for the anesthesiologist to be reimbursed for medical supervision activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities:

(a) performs a pre-anesthesia examination and evaluation;
(b) prescribes the anesthesia plan;
(c) personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies;
(d) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
(e) monitors the course of anesthesia administration at frequent intervals;
(f) remains physically present and available for immediate diagnosis and treatment of emergencies; and
(g) provides indicated post-anesthesia care.

Administration of anesthesia by a self-employed Certified Registered Nurse Anesthetist (CRNA) is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll and receive a provider number to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units. No Physical Status Modifiers can be billed.

Administration of anesthesia by a qualified Anesthesiology Assistant (AA) is a covered service when the AA has met the qualifications and standards set forth in the Alabama Board of Medical Examiners Administrative Code. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist.

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure. Anesthesia services include all customary preoperative and postoperative visits, the anesthesia care during the procedure, the administration of any fluids deemed necessary by the attending physician, and any usual monitoring procedures. Therefore, additional claims for such services should not be submitted.

(h) Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Thus, additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e. pudendal block or paracervical block) is considered part of the obstetrical coverage. Thus, additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

(i) When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

(j) When a medical procedure is a noncovered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a noncovered service.

(3) Artificial Eyes: Must be prescribed by a physician.

(4) Autopsies: Not covered.

(5) Biofeedback: Not covered.

(6) Blood Tests: Not covered for marriage licenses.

(7) CAT Scans, CTA's, MRI's, MRA's and PET scans: See Chapter 34 of this code for specific details.

(8) Chiropractors: Not covered, except for QMB recipients and for services referred directly as a result of an EPSDT screening.

(9) Chromosomal Studies: Chromosomal studies (amniocentesis) on unborn children being considered for adoption are not covered. Medicaid can pay for these studies in the case of prospective mothers in an effort to identify conditions that could result in the birth of an abnormal child.

(10) Circumcision: Circumcision of newborns is a covered service. If medically necessary, non-newborn circumcision is covered.

(11) Diet Instruction: Diet instruction performed by a physician is considered part of a routine visit.

(12) Drugs:

(a) Non-injectable drugs: See Chapter 16 of this Code.

(b) Injectable drugs: Physicians who administer injectable drugs to their patients may bill Medicaid for the cost of the drug by using the procedure code designated by Medicaid for this purpose. The injectable administration code may be used only when an office visit or nursing home visit is not billed.

(13) Examinations: Office visits for examinations are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this limit.

(a) Annual routine physical examinations are not covered.

(b) Medical examinations for such reasons as insurance policy qualifications are not covered.

(c) Physical examinations for establishment of total and permanent disability status if considered medically necessary are covered.

(d) Medicaid requires a physician's visit once each 60 days for patients in a nursing home. Patients in intermediate care facilities for the mentally retarded will receive a complete physical examination at least annually.

(e) Physical examination, including x-ray and laboratory work, will be payable for recipients eligible through the EPSDT Program if the physician has signed an agreement with Medicaid to participate in the screening program.

(14) Experimental Treatment and/or Surgery: Not covered.

(15) Eyecare:

(a) Eye examinations by physicians are a Medicaid covered service.

(b) Office visits for eyecare disease are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(16) Filing Fees: Not covered.

(17) Foot Devices: See Chapter 13 (Supplies, Appliances, and Durable Equipment) for specific details.

(18) Hearing Aids: See Hearing Aids Chapter in this Code.

(19) Hypnosis: Not covered.

(20) Immunizations: Payment for immunizations against communicable diseases will be made if the physician normally charges his patients for this service.

(a) The Department of Public Health provides vaccines at no charge to Medicaid physicians enrolled in the Vaccines For Children (VFC) Program and as recommended by the Advisory Committee on Immunization.

(b) Effective October 1, 1994, the Alabama Medicaid Agency will begin reimbursement of administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program.

(c) Medicaid tracks usage of the vaccine through billing of the administration fee using the appropriate CPT codes.

(d) The Omnibus Budget Reconciliation Act of 1993 mandated that Medicaid can no longer cover a single antigen vaccine if a combined antigen vaccine is medically appropriate. This change will become effective January 1, 1994. The single antigen vaccines may still be billed only if prior approved before given and a medical justification is given. These vaccines are diphtheria, measles, mumps, and rubella. In order to request the prior approval for these vaccines, providers should contact the Alabama Medicaid Agency fiscal agent.

(21) Infant Resuscitation: Newborn resuscitation (procedure code 99465) is a covered service when the baby's condition is life threatening and immediate resuscitation is necessary to restore and maintain life functions. Intubation, endotracheal, emergency procedure (procedure code 31500) cannot be billed in conjunction with newborn resuscitation.

(22) Intestinal Bypass: Not covered for obesity.

(23) Laetrile Therapy: Not covered.

(24) Newborn Claims: The five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital that may be filed under the mother's name and number or the baby's name and number are routine newborn care and discharge codes, circumcision, newborn resuscitation, standby services following a caesarean section or a high-risk vaginal delivery, and attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. When filing claims for these five kinds of care, CPT codes shall be utilized. All other newborn care (any care other than routine newborn care for a well-baby), before and after the mother leaves the hospital, must be billed under the child's name and number.

(25) Obstetrical Services and Related Services: Office visits for obstetrical care are counted as part of each recipient's annual office visit limit under certain conditions. See Rule No. 560-X-6-.14 for details about this quota.

(a) Family Planning: See the Family Planning Chapter in this Code.

(b) Abortions: See Rule No. 560-X-6-.09 (1).

(c) Hysterectomy: See Rule No. 560-X-6-.09.

(d) Maternity Care and Delivery: The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total

obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered. When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician shall use a "global" obstetrical code in billing. If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of annual office visits. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

1. Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

(i) To justify billing for global antepartum care services, physicians must utilize the CPT antepartum care global codes (either 4-6 visits, or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's annual office visit limit. Physicians who provide less than four (4) visits for antepartum care must utilize CPT codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's annual office visit limit.

(ii) Billing for antepartum care services in addition to "global" care is not permissible; however, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's annual office visit limit.

2. Delivery and postpartum care: Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

3. Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within sixty-two (62) days post delivery. Additional claims for routine visits during this time should not be filed.

4. Delivery only: If the physician performs the delivery only, he must utilize the appropriate CPT delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

5. All obstetrical ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure. Generally, ultrasounds are conducted to detect gestational age, multiple pregnancies, major malformations, detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

(e) Sterilization: See the Family Planning Chapter in this Code.

(26) Medical Materials and Supplies: Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

(27) Oxygen and Compressed Gas: A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to the Alabama Medicaid Administrative Code, Rule No. 560-X-13-.15 and the Alabama Medicaid Billing Manual Chapter 14, DME, for more information.

(28) Podiatrist Service: Covered for QMB or EPSDT referred services only.

(29) Post Surgical Visits:

(a) Hospital Visits: Post-surgical hospital visits for conditions directly related to the surgical procedures are covered by the surgical fee and cannot be billed separately the day of, or up to 90 days post surgery.

(b) Office Visits: Post-surgical office visits for procedures directly related to the surgical procedure are covered by the surgical fee and are not separately covered the day of, or up to 90 days post surgery, and cannot be billed separately, e.g. suture removal.

(c) Visits by Assistant Surgeon or Surgeons: Not covered.

(30) Preventive Medicine: The Medicaid program does not cover preventive medicine other than EPSDT screening.

(31) Prosthetic Devices: External prosthetic devices are not a covered benefit under the Physician's Program. Internal prosthetic devices (i.e., Smith Peterson Nail, pacemaker, vagus nerve stimulator, etc.) are a covered benefit only when implanted during an inpatient

hospitalization. The cost of the device is reimbursed through the payment of the inpatient hospital per diem rate and is not separately reimbursable.

(32) Psychiatric Services: Office visits for psychiatric services are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Psychiatric Evaluation or Testing: Are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations shall be limited to one per calendar year, per provider, per recipient.

(b) Psychotherapy Visits: Shall be included in the annual office visit limit. Office visits shall not be covered when billed in conjunction with psychotherapy codes.

(c) Psychiatric Services: Under the Physicians' Program shall be confined to use with psychiatricICD-9-CM diagnosis codes (dates of service prior and up to September 30, 2015) (range 290 – 319) or ICD-10-CM diagnosis codes (dates of service October 1, 2015 and forward) (range F01.50 – F99) and must be performed by a physician.

(d) Hospital Visits: Are not covered when billed in conjunction with psychiatric therapy on the same day.

(e) Services Rendered by Psychologist: See Chapter 11 (EPSDT) for specific information.

(f) Psychiatric Day Care: Not a covered benefit under the Physicians' Program.

(33) Second Opinions: Office visits for second opinions are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Payment is made in accordance with the provider's reasonable charge profile allowance for an initial office visit for the appropriate level of service.

(b) Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.

(34) Self-Inflicted Injury: Covered.

(35) Surgery

(a) Cosmetic: Covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member.

(b) Elective: Covered when medically necessary.

(c) Multiple:

1. When multiple and/or bilateral surgical procedures, which add significant time or complexity are performed at the same operative session, payment may be made for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure code that is not considered to be an integral part of the covered service. This also applies to laser surgical procedures. See Medicaid National Correct Coding Initiatives at www.medicaid.gov. Exceptions are noted in Rule No. 560-X-6-.14, Limitations on Services.

2. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g. excision

of previous scar or puncture of ovarian cyst) are performed during the same operative session, the reimbursement will be included in that of the major procedure only.

3. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated surgical procedure.

4. CPT defined Add On codes are considered for coverage only when billed with the appropriate primary procedure code.

5. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. For Medicaid approved modifiers, refer to the Alabama Medicaid Provider Manual.

(36) Telephone Consultations: Not covered, except that during the time prescribed by the governor as a State of Emergency due to the COVID-19 (Coronavirus) pandemic, telephone use may be covered for telehealth/telemedicine as described in Chapter 28 of the Alabama Medicaid Agency's Provider Billing Manual, but only in strict accordance with the March 18th, 2020 Provider Alert with subject line "Alabama Medicaid Extends Temporary Telemedicine Coverage" and any subsequent Alert or amendment thereto.

(37) Therapy: Office visits for therapy are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Occupational and Recreational Therapies: Not covered.

(b) Physical Therapy: Is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. See Rule No. 560-X-7-.12 for further requirements of coverage.

(c) Group Therapy: Shall be a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally.

1. Group Therapy is included in the annual office visit limit.

2. Group Therapy is not covered when performed by a case worker, social services worker, mental health worker, or any counseling professional other than a physician.

(d) Speech Therapy: The patient must have a speech related diagnosis, such as stroke (CVA) or partial laryngectomy. To be a covered benefit speech therapy must be prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician.

(e) Family Therapy: Shall be a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation which justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is included in the annual office visit limit. Family Therapy is not covered when performed by a case worker, social service worker, mental health worker, or any counseling professional other than a physician.

(38) Transplants: See Rule No. 560-X-1-.27 for transplant coverage.

(39) Ventilation Study: Covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record should contain all of the following:

(a) Graphic record;
(b) Total and timed vital capacity;
(c) Maximum breathing capacity;
(d) Always indicate if the studies were performed with or without a bronchodilator.

(40) Well-Baby Coverage: Covered only on the initial visit, which must be provided within eight (8) weeks of the birth.

(41) Work Incentive: A claim stating physical examination for a child to be put into a day-care center for mother to work is a covered procedure. (Must state "Work Incentive Program.")

Author: Elizabeth Huckabee, Associate Director, Physician and EPSDT Unit
Statutory Authority: Title XIX, Social Security Act; 42 CFR, §§ 405.310(k), 440.50, et seq.; State Plan.
History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983; June 5, 1983; July 8, 1983; November 10, 1983; April 12, 1984; June 8, 1984; October 9, 1984; January 8, 1985; May 8, 1985; June 8, 1985; July 9, 1985; September 9, 1985; **Emergency rule** effective January 22, 1986. **Amended:** effective April 11, 1986. **Emergency rule** effective December 1, 1986. **Amended:** effective March 12, 1987. **Emergency rule** effective March 4, 1987. **Amended:** effective June 10, 1987; June 10, 1988; October 12, 1988; July 13, 1989; May 15, 1990; June 14, 1990; October 13, 1990; April 17, 1991. **Emergency rule** effective July 1, 1991. **Amended:** effective October 12, 1991. Emergency rule effective January 1, 1992. **Amended:** effective April 14, 1992; March 15, 1994; January 12, 1995; January 14, 1997, and October 11, 2000; June 14, 2002; May 16, 2003; April 16, 2004; November 16, 2004; March 17, 2005. **Amended:** Filed May 11, 2012; effective June 15, 2012. **Amended:** Filed January 11, 2016; effective February 25, 2016. **Amended:** Filed July 12, 2018; effective August 27, 2018. **Amended:** Filed December 12, 2019; effective February 14, 2020. **Emergency Rule:** effective March 18, 2020.

Rule No. 560-X-6-.13ER Covered Services: Details on Selected Services

(1) Acupuncture: Not covered.

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(a) performs a pre-anesthesia examination and evaluation;
(b) prescribes the anesthesia plan;
(c) personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies;
(d) ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
(e) monitors the course of anesthesia administration at frequent intervals;
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Administration of anesthesia by a self-employed Certified Registered Nurse Anesthetist (CRNA) is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll and receive a provider number to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units. No Physical Status Modifiers can be billed.

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Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure. Anesthesia services include all customary preoperative and postoperative visits, the anesthesia care during the procedure, the administration of any fluids deemed necessary by the attending physician, and any usual monitoring procedures. Therefore, additional claims for such services should not be submitted.

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(b) Effective October 1, 1994, the Alabama Medicaid Agency will begin reimbursement of administration fees for vaccines provided free of charge through the Vaccines For Children (VFC) Program.

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(d) The Omnibus Budget Reconciliation Act of 1993 mandated that Medicaid can no longer cover a single antigen vaccine if a combined antigen vaccine is medically appropriate. This change will become effective January 1, 1994. The single antigen vaccines may still be billed only if prior approved before given and a medical justification is given. These vaccines are diphtheria, measles, mumps, and rubella. In order to request the prior approval for these vaccines, providers should contact the Alabama Medicaid Agency fiscal agent.

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(22) Intestinal Bypass: Not covered for obesity.

(23) Laetrile Therapy: Not covered.

(24) Newborn Claims: The five kinds of newborn care performed by physicians in the days after the child's birth when the mother is still in the hospital that may be filed under the mother's name and number or the baby's name and number are routine newborn care and discharge codes, circumcision, newborn resuscitation, standby services following a caesarean section or a high-risk vaginal delivery, and attendance at delivery (when requested by delivering physician) and initial stabilization of newborn. Standby services (procedure code 99360) are covered only when the pediatrician, family practitioner, neonatologist, general practitioner, or OB/GYN is on standby in the operating or delivery room during a cesarean section or a high-risk vaginal delivery. Attendance of the standby physician in the hospital operating or delivery room must be documented in the operating or delivery report. When filing claims for these five kinds of care, CPT codes shall be utilized. All other newborn care (any care other than routine newborn care for a well-baby), before and after the mother leaves the hospital, must be billed under the child's name and number.

(25) Obstetrical Services and Related Services: Office visits for obstetrical care are counted as part of each recipient's annual office visit limit under certain conditions. See Rule No. 560-X-6-.14 for details about this quota.

(a) Family Planning: See the Family Planning Chapter in this Code.

(b) Abortions: See Rule No. 560-X-6-.09 (1).

(c) Hysterectomy: See Rule No. 560-X-6-.09.

(d) Maternity Care and Delivery: The services normally provided in maternity cases include antepartum care, delivery, and postpartum care. When a physician provides total

obstetrical care, the procedure code which shall be filed on the claim form is the code for all-inclusive "global" care. The indicated date of service on "global" claims should be the date of delivery. If a woman is pregnant at the time she becomes eligible for Medicaid benefits, only those services provided during the time she is eligible will be covered. When a physician provides eight (8) or more prenatal visits, performs the delivery, and provides the postpartum care, the physician shall use a "global" obstetrical code in billing. If a physician submits a "global" fee for maternity care and delivery, the visits covered by these codes are not counted against the recipient's limit of annual office visits. For purposes of "global" obstetrical billing, services rendered by members of a group practice are to be considered as services rendered by a single provider.

1. Antepartum care includes all usual prenatal services such as initial office visit at which time pregnancy is diagnosed, initial and subsequent histories, physical examinations, blood pressure recordings, fetal heart tones, maternity counseling, etc.; therefore, additional claims for routine services should not be filed. Antepartum care also includes routine lab work (e.g., hemoglobin, hematocrit, chemical urinalysis, etc.); therefore, additional claims for routine lab work should not be filed.

(i) To justify billing for global antepartum care services, physicians must utilize the CPT antepartum care global codes (either 4-6 visits, or 7 or more visits), as appropriate. Claims for antepartum care filed in this manner do not count against the recipient's annual office visit limit. Physicians who provide less than four (4) visits for antepartum care must utilize CPT codes under office medical services when billing for these services. These office visit codes will be counted against the recipient's annual office visit limit.

(ii) Billing for antepartum care services in addition to "global" care is not permissible; however, in cases of pregnancy complicated by toxemia, cardiac problems, diabetes, neurological problems or other conditions requiring additional or unusual services or hospitalization, claims for additional services may be filed. If the physician bills fragmented services in any case other than high-risk or complicated pregnancy and then bills a "global" code, the fragmented codes shall be recouped. Claims for such services involved in complicated or high risk pregnancies may be filed utilizing CPT codes for Office Medical Services. Claims for services involving complicated or high risk pregnancies must indicate a diagnosis other than normal pregnancy and must be for services provided outside of scheduled antepartum visits. These claims for services shall be applied against the recipient's annual office visit limit.

2. Delivery and postpartum care: Delivery shall include vaginal delivery (with or without episiotomy) or cesarean section delivery and all in-hospital postpartum care. More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery or a claim for "global" care.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

3. Postpartum care includes office visits following vaginal or cesarean section delivery for routine postpartum care within sixty-two (62) days post delivery. Additional claims for routine visits during this time should not be filed.

4. Delivery only: If the physician performs the delivery only, he must utilize the appropriate CPT delivery only code (vaginal delivery only or C-section delivery only). More than one delivery fee may not be billed for a multiple birth (twins, triplets, etc.) delivery, regardless of the delivery method(s). Delivery fees include all professional services related to the hospitalization and delivery which are provided by the physician; therefore, additional claims for physician's services in the hospital such as hospital admission, may not be filed in addition to a claim for delivery only.

EXCEPTION: When a physician's first and only encounter with the recipient is for delivery ("walk-in" patient) he may bill for a hospital admission (history and physical) in addition to delivery charges.

5. All obstetrical ultrasounds must be medically necessary with medical diagnosis documented supporting the benefit of the ultrasound procedure. Generally, ultrasounds are conducted to detect gestational age, multiple pregnancies, major malformations, detect fetal growth disorders (intrauterine growth retardation, macrosomia) and anomalies that would appear later or may have been unrecognizable in the earlier scan.

(e) Sterilization: See the Family Planning Chapter in this Code.

(26) Medical Materials and Supplies: Costs for medical materials and supplies normally utilized during office visits or surgical procedures are to be considered part of the total fee for procedures performed by the physician and therefore are not generally a separately billable service.

(27) Oxygen and Compressed Gas: A physician's fee for administering oxygen or other compressed gas is a covered service under the Medicaid program. Oxygen therapy is a covered service based on medical necessity and requires prior authorization. Please refer to the Alabama Medicaid Administrative Code, Rule No. 560-X-13-.15 and the Alabama Medicaid Billing Manual Chapter 14, DME, for more information.

(28) Podiatrist Service: Covered for QMB or EPSDT referred services only.

(29) Post Surgical Visits:

(a) Hospital Visits: Post-surgical hospital visits for conditions directly related to the surgical procedures are covered by the surgical fee and cannot be billed separately the day of, or up to 90 days post surgery.

(b) Office Visits: Post-surgical office visits for procedures directly related to the surgical procedure are covered by the surgical fee and are not separately covered the day of, or up to 90 days post surgery, and cannot be billed separately, e.g. suture removal.

(c) Visits by Assistant Surgeon or Surgeons: Not covered.

(30) Preventive Medicine: The Medicaid program does not cover preventive medicine other than EPSDT screening.

(31) Prosthetic Devices: External prosthetic devices are not a covered benefit under the Physician's Program. Internal prosthetic devices (i.e., Smith Peterson Nail, pacemaker, vagus nerve stimulator, etc.) are a covered benefit only when implanted during an inpatient

hospitalization. The cost of the device is reimbursed through the payment of the inpatient hospital per diem rate and is not separately reimbursable.

(32) Psychiatric Services: Office visits for psychiatric services are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Psychiatric Evaluation or Testing: Are covered services under the Physicians' Program if services are rendered by a physician in person and are medically necessary. Psychiatric evaluations shall be limited to one per calendar year, per provider, per recipient.

(b) Psychotherapy Visits: Shall be included in the annual office visit limit. Office visits shall not be covered when billed in conjunction with psychotherapy codes.

(c) Psychiatric Services: Under the Physicians' Program shall be confined to use with psychiatricICD-9-CM diagnosis codes (dates of service prior and up to September 30, 2015) (range 290 – 319) or ICD-10-CM diagnosis codes (dates of service October 1, 2015 and forward) (range F01.50 – F99) and must be performed by a physician.

(d) Hospital Visits: Are not covered when billed in conjunction with psychiatric therapy on the same day.

(e) Services Rendered by Psychologist: See Chapter 11 (EPSDT) for specific information.

(f) Psychiatric Day Care: Not a covered benefit under the Physicians' Program.

(33) Second Opinions: Office visits for second opinions are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Optional Surgery: Second opinions (regarding non-emergency surgery) are highly recommended in the Medicaid program when the recipients request them. Payment is made in accordance with the provider's reasonable charge profile allowance for an initial office visit for the appropriate level of service.

(b) Diagnostic Services: Payment may be made for covered diagnostic services deemed necessary by the second physician.

(34) Self-Inflicted Injury: Covered.

(35) Surgery

(a) Cosmetic: Covered only when prior approved for medical necessity. Examples of medical necessity include prompt repair of accidental injuries or improvement of the functioning of a malformed body member.

(b) Elective: Covered when medically necessary.

(c) Multiple:

1. When multiple and/or bilateral surgical procedures, which add significant time or complexity are performed at the same operative session, payment may be made for the procedure with the highest allowed amount and half of the allowed amount for each subsequent procedure code that is not considered to be an integral part of the covered service. This also applies to laser surgical procedures. See Medicaid National Correct Coding Initiatives at www.medicaid.gov. Exceptions are noted in Rule No. 560-X-6-.14, Limitations on Services.

2. Certain procedures are commonly carried out as integral parts of a total service and as such do not warrant a separate charge. When incidental procedures (e.g. excision

of previous scar or puncture of ovarian cyst) are performed during the same operative session, the reimbursement will be included in that of the major procedure only.

3. Laparotomy is covered when it is the only surgical procedure performed during the operative session or when performed with an unrelated surgical procedure.

4. CPT defined Add On codes are considered for coverage only when billed with the appropriate primary procedure code.

5. Appropriate use of CPT and HCPCs modifiers is required to differentiate between sites and procedures. For Medicaid approved modifiers, refer to the Alabama Medicaid Provider Manual.

(36) Telephone Consultations: Not covered, except that during the time prescribed by the governor as a State of Emergency due to the COVID-19 (Coronavirus) pandemic, telephone use may be covered for telehealth/telemedicine as described in Chapter 28 of the Alabama Medicaid Agency's Provider Billing Manual, but only in strict accordance with the March 18th, 2020 Provider Alert with subject line "Alabama Medicaid Extends Temporary Telemedicine Coverage" and any subsequent Alert or amendment thereto.

(37) Therapy: Office visits for therapy are counted as part of each recipient's annual office visit limit. See Rule No. 560-X-6-.14 for details about this quota.

(a) Occupational and Recreational Therapies: Not covered.

(b) Physical Therapy: Is not covered when provided in a physician's office. Physical therapy is covered only when prescribed by a physician and provided in a hospital setting. See Rule No. 560-X-7-.12 for further requirements of coverage.

(c) Group Therapy: Shall be a covered service when a psychiatric diagnosis is present and the therapy is prescribed, performed, and billed by the physician personally.

1. Group Therapy is included in the annual office visit limit.

2. Group Therapy is not covered when performed by a case worker, social services worker, mental health worker, or any counseling professional other than a physician.

(d) Speech Therapy: The patient must have a speech related diagnosis, such as stroke (CVA) or partial laryngectomy. To be a covered benefit speech therapy must be prescribed by and performed by a physician in his office. Speech therapy performed in an inpatient or outpatient hospital setting, or in a nursing home is a covered benefit, but is considered covered as part of the reimbursement made to the facility and should not be billed by the physician.

(e) Family Therapy: Shall be a covered service when a psychiatric diagnosis is present and the physician providing the service supplies documentation which justifies the medical necessity of the therapy for each family member. Family therapy is not covered unless the patient is present. Family Therapy is included in the annual office visit limit. Family Therapy is not covered when performed by a case worker, social service worker, mental health worker, or any counseling professional other than a physician.

(38) Transplants: See Rule No. 560-X-1-.27 for transplant coverage.

(39) Ventilation Study: Covered if done in physician's office by the physician or under the physician's direct supervision. Documentation in the medical record should contain all of the following:

(a) Graphic record;
(b) Total and timed vital capacity;
(c) Maximum breathing capacity;
(d) Always indicate if the studies were performed with or without a bronchodilator.

(40) Well-Baby Coverage: Covered only on the initial visit, which must be provided within eight (8) weeks of the birth.

(41) Work Incentive: A claim stating physical examination for a child to be put into a day-care center for mother to work is a covered procedure. (Must state "Work Incentive Program.")

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Statutory Authority: Title XIX, Social Security Act; 42 CFR, §§ 405.310(k), 440.50, et seq.; State Plan.
History: Rule effective October 1, 1982. **Amended:** effective April 15, 1983; June 5, 1983; July 8, 1983; November 10, 1983; April 12, 1984; June 8, 1984; October 9, 1984; January 8, 1985; May 8, 1985; June 8, 1985; July 9, 1985; September 9, 1985; **Emergency rule** effective January 22, 1986. **Amended:** effective April 11, 1986. **Emergency rule** effective December 1, 1986. **Amended:** effective March 12, 1987. **Emergency rule** effective March 4, 1987. **Amended:** effective June 10, 1987; June 10, 1988; October 12, 1988; July 13, 1989; May 15, 1990; June 14, 1990; October 13, 1990; April 17, 1991. **Emergency rule** effective July 1, 1991. **Amended:** effective October 12, 1991. Emergency rule effective January 1, 1992. **Amended:** effective April 14, 1992; March 15, 1994; January 12, 1995; January 14, 1997, and October 11, 2000; June 14, 2002; May 16, 2003; April 16, 2004; November 16, 2004; March 17, 2005. **Amended:** Filed May 11, 2012; effective June 15, 2012. **Amended:** Filed January 11, 2016; effective February 25, 2016. **Amended:** Filed July 12, 2018; effective August 27, 2018. **Amended:** Filed December 12, 2019; effective February 14, 2020. **Emergency Rule:** effective March 18, 2020.