

Provider Insider

Alabama Medicaid Bulletin

April 2015

HEALTH HOME EXPANSION TO HELP PATIENTS WITH CHRONIC HEALTH CONDITIONS

More than 220,000 Medicaid recipients with chronic health conditions will soon have access to enhanced care coordination and other services to improve their overall health when the Alabama Medicaid Agency expands its Health Home program on April 1, 2015.

Six probationary Regional Care Organizations (RCOs) have signed contracts to operate Health Home programs. The groups include: Region A: Alabama Community Care – Region A and My Care Alabama; Region B: Alabama Care Plan; Region C: Alabama Community Care – Region C; Region D: Care Network of Alabama; and Region E: Gulf Coast Regional Care Organization.

Region	Probationary RCOs	Contact Name	Phone #
A	• Alabama Community Care – Region A	• Dean Griffin	• (256) 265 - 8823
	• My Care Alabama	• Rachel Muro	• (205) 220 - 1400
B	• Alabama Care Plan	• Anna Velasco	• (205) 558 - 7641
C	• Alabama Community Care – Region C	• Joe Campbell	• (256) 265 - 2432
D	• Care Network of Alabama	• Robin Nutter	• (334) 528 - 1815
E	• Gulf Coast Regional Care Organization	• Danny Rickert	• (251) 767 - 0530



The program, which has operated since 2012 as Patient Care Networks in 21 counties of the state, is expanding statewide as an interim step toward implementation of full-risk Regional Care Organization. RCOs are locally-led managed care systems that will ultimately provide healthcare services to Medicaid enrollees at an established cost under the supervision and approval of the Alabama Medicaid Agency.

In contrast, the Health Home program is defined by the federal government as an optional Medicaid program that integrates and coordinates care for patients with certain chronic conditions to achieve improved health outcomes. In Alabama, the Health Home program is set up to add an additional level of support to Patient 1st Primary Medical Providers (PMPs) by intensively coordinating the care of patients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease and hepatitis C.

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Pass It On!

Everyone needs to know the latest about Medicaid.
Be sure to route this to:

- Office Manager
- Billing Dept.
- Medical/Clinical Professionals
- Other _____

The information contained within is subject to change.
Please review your Provider Manual and all Provider Alerts for the most up to date information.

(Continued from page 1)

Care management, or coordinated care, in the Health Home program is done by connecting patients with needed resources, teaching self-management skills, providing transitional care and bridging medical and behavioral services, among other efforts.

The Health Home program will operate alongside the Patient 1st program until October 1, 2016, when the Health Home program will be incorporated into the full risk RCOs' operations. The Agency will continue to operate its current fee-for-service program until full-risk RCOs are implemented in October of 2016.

For more information on the Health Home Program, go to the Alabama Medicaid Agency website at www.medicaid.alabama.gov and click on "Regional Care Organizations" on the lower left hand corner of the page.

OUTPATIENT CLAIMS WITH TPL

System changes have been made to allow providers to submit the other insurance payer amounts at the header or detail level. Outpatient claims will capture Third Party Liability patient responsibility amounts at the header level or detail level. Providers should submit to Medicaid the "other payer" amount fields as processed by the other insurance payer – at the header or detail level.

System editing and payment methodology will take place as stated in the Alert published on October 31, 2014:

In order for claims with TPL to be considered for payment, the patient responsibility must be greater than zero. Patient responsibility is calculated by adding together any co-payments, co-insurance and deductible. Claims that do not contain a patient responsibility will deny with error status code 631 (TPL Patient Responsibility is Zero for Payer).

When calculating payment methodology for claims with TPL primary, Medicaid will pay the lesser of patient responsibility or Medicaid allowed amount minus TPL paid amount for outpatient claims.

If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

ICD-10 TELECONFERENCE TRAINING INFORMATION

ICD-10 Teleconference Sessions		
Class	Date	Time
ICD-10 General Overview	April 14, 2015	10:00 - 11:00 AM
ICD-10 Testing	April 29, 2015	10:00 - 11:00 AM
ICD-10 General Overview	May 13, 2015	10:00 - 11:00 AM
ICD-10 Testing	May 19, 2015	10:00 - 11:00 AM
ICD-10 General Overview	June 3, 2015	10:00 - 11:00 AM
ICD-10 Testing	June 23, 2015	10:00 - 11:00 AM

In order to prepare providers and vendors for the upcoming changes that will be implemented as a result of ICD-10, Alabama Medicaid is conducting virtual teleconferences. Virtual training lets you take advantage of training from the convenience of your own office - all you need is a computer and telephone. There will be two ICD-10 classes offered as described below:

ICD-10 GENERAL OVERVIEW - Discuss the changes being made by Alabama Medicaid for ICD-10. Topics to be covered during the session include: Alabama Medicaid website overview, affected /unaffected transactions, provider web portal and PES software changes, claim form changes, and new and modified EOBs. Time will be available for questions and answers.

ICD-10 TESTING - Provide information on how the changes being made by Alabama Medicaid will affect you and the transactions you submit, as well as the types of testing that should be completed prior to the CMS ICD-10 implementation date. Specific topics to be covered include: test data set-up, tips for testing, testing contact information, ICD-10 testing dates, and testing strategies. **Beginning April 2015, the Collaborative Testing (CollabT) tool will be discussed. Even if you have previously attended an ICD-10 Testing teleconference, we encourage you to attend to receive the updated information. Time will be available for questions and answers.**

To register for a class, follow the instructions provided below. If you have a suggestion on a topic to be covered during the teleconference or need additional information, contact the HP ICD-10 team via email at alabamaictesting@hp.com.

REGISTER TO ATTEND ICD-10 TELECONFERENCE TRAINING

Registration is required in order to attend an ICD-10 teleconference session. You may register for one or multiple sessions. To register, access the ICD-10 Teleconference Training Information page of the Alabama Medicaid website at:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx.

Select the registration link associated with the session, date, and time you wish to attend. We encourage you to register today. Once your registration has been received, a confirmation e-mail will be sent along with both conference line and Virtual Room link instructions. We encourage testing your connectivity prior to the start of the session to confirm that you are able to successfully connect. **Please check the Alabama Medicaid website for future updates.**

MEDICARE COPAYMENT

Effective February 9, 2015, Alabama Medicaid has updated the system (paper, web, batch) to accept copayment on Medical Crossover and Institutional Crossover Claims. Providers may resubmit their claims to Alabama Medicaid.

On paper claims the copayment can be submitted in the shaded area (top line) in the deductible section (k) for Medical Crossover claims and for Institutional Crossover claims the new value code A7 is used for copayment. Web-portal has added a new field in the Medicare section to submit the copayment amount.

If you have any questions, please contact the Provider Assistance Center at 1-800-688-7989.

MEDICARE CROSSOVER CLAIMS AND RAILROAD RETIREES

Claims billed to and paid by Medicare for Railroad Retirees will be denied by Medicaid with denial code 2808 when the claim is crossed over from Medicare. The error message provided with denial code 2808 states “COBA – MEDICARE ID NOT ON FILE”. Medicaid’s claim system is unable to match the Medicare ID submitted on the claim by the provider to the Medicare ID provided by CMS on its Medicare enrollment database as CMS converts Railroad Retiree Medicare IDs into a different format than what is listed on a recipient’s ID card. If you receive a denial code of 2808 on a COBA crossover claim and the recipient is a Railroad Retiree you should resubmit the crossover claim through the Provider web portal using the crossover claim form and the recipient’s Medicaid ID number. Please contact Wanda Wright at 334-242-5257 for any questions.

NEW SUBSETS OF MODIFIER 59

CMS has established four new HCPCS modifiers to define subsets of the modifier 59, a modifier used to define a distinct procedural service. CPT instructions state modifier 59 should not be used when a more descriptive modifier is available. Medicaid began recognizing these four new modifiers effective for dates of services January 1, 2015 and thereafter.

The subsets are as follows:

- XE** - Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XP** - Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XS** - Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XU** - Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

At this time, Medicaid will accept either a 59 modifier or a more selective - X{EPSU} modifier as correct coding. However, providers are encouraged to use the more selective modifiers when applicable.

RADIOPHARMACEUTICAL DRUGS (INVOICE PRICED)

A provider who administers a Radiopharmaceutical drug not priced on the cahabagba.org website should use the following criteria:



- The claim must be sent on paper with a description of the drug attached.
- Providers should submit a red drop-out ink claim with the complete name of the drug, total dosage that was administered and a National Drug Code (NDC) number.
- The claims containing the radiopharmaceutical procedure code must be sent to:
 HP, Attn: Medical Policy
 PO Box 244032
 Montgomery, AL 36124-4032

HP will determine the price of the drug.

2015 RADIATION THERAPY CODES

Effective January 1, 2015, the Alabama Medicaid Agency will use Medicare radiation therapy codes for procedures when available. The following crosswalk shows the 2014 CPT code mapped to the new 2015 HCPCS/CPT code to use when filing your claims for Alabama Medicaid recipients:

Crosswalk for 2014 CPT codes to 2105 HCPCS/CPT codes:

2014 CPT Codes	2015 HCPCS/CPT Codes
76645(deleted)	76641 or 76642
76950(deleted)	G6001
77014(deleted)	77387 or 77014
77082(deleted)	77085 or 77086
77305(deleted)	77306
77310(deleted)	77307
77315(deleted)	77307
77326(deleted)	77316
77327(deleted)	77317
77328(deleted)	77318
77402 *	G6003
77403(deleted)	G6004
77404(deleted)	G6005
77406(deleted)	G6006
77407 *	G6007
77408(deleted)	G6008
77409(deleted)	G6009
77411(deleted)	G6010
77412 *	G6011
77413(deleted)	G6012
77414(deleted)	G6013
77416(deleted)	G6014
77418(deleted)	G6015
77421(deleted)	G6002

*CPT codes are still active, but will not be used for 2015 dates of service by Alabama Medicaid.

If you have questions, please contact Russell Green at Russell.green@medicaid.alabama.gov.

REMINDER:

RECOVERY AUDIT CONTRACTOR (RAC) AUDITS

Mandatory provisions of the Affordable Care Act require the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. Goold Health Systems (GHS), a Maine-based firm, was selected to be Alabama Medicaid's Recovery Audit Contractor (RAC) for a two-year period that began January 1, 2013. A one year extension was awarded January 1, 2015.

The RAC program is designed to improve payment accuracy by identifying under and overpayments in Medicaid. The Medicaid RAC program is a separate program from the Medicare RAC which is overseen by the Centers for Medicare and Medicaid Services.

Reviews will be conducted by GHS staff to include full time medical directors, pharmacists, certified professional coders, and experienced clinicians. Audits will be conducted by GHS using a "top down" approach where data analysis, through data mining, is applied against the universe of paid claims to identify patterns of utilization or billing which look atypical based on Alabama Medicaid and/or national standards. Following the high-level claims analysis, GHS may expand its review by requesting clinical records and/or other documents in accordance with state and federal regulations.

GHS has been informed of the critical role that all providers play in a successful Medicaid program and requires that auditors be professional, objective, and consistent in performing all required audits/reviews.

Providers are reminded that the Alabama Administrative Code and their Provider Agreements require compliance with requests for medical records for Medicaid program audits.

Questions regarding the audits should be directed to Ethel Talley, RAC Program Manager, at (334) 242-5340 or ethel.talley@medicaid.alabama.gov or Bakeba Thomas, Provider Review Associate Director, at (334) 242-5634 or bakeba.thomas@medicaid.alabama.gov.

COMING: CHANGE TO CAPITATION PAYMENT LISTING FOR PATIENT 1ST REPORT



The Health Homes are statewide effective April 1, 2015. Changes have been made to the Capitations Payment Listing. This report is available for downloading by Patient 1st providers after the 1st check write each month. This listing has been updated to include this information for both the recipient and the provider. The report will list the Probationary RCOs associated with the participating provider in the provider section of the report. A new column will be added to the recipient section providing the associated Probationary RCO (s) if applicable. A code legend for the Probationary RCO will be available at the end of the report.

April 2015

REMINDER:

ELECTRONIC UPLOAD AND SUBMISSION OF MEDICAL RECORDS NOW AVAILABLE

Changes have been made to allow Long Term Care, Hospice, PEC, Swing Bed and Inpatient Psychiatric Providers to attach and upload medical records via the Medicaid Interactive Web Portal, eliminating the cost of mailing documents, in for processing. A record is available for review the same day it is uploaded. A secure logon or access to the Medicaid Interactive Web Portal must be established if one does not already exist to access this new attachment option. Documents may be uploaded two different ways:

- Medicaid Interactive Web portal (preferred)
<https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure20Site/tabId/66/Default.aspx>
- Fax information in for processing
(bar coded cover sheet required)

The August 28, 2014 Alert outlines detailed instructions on how to upload medical records. The ALERT can be accessed via the following link: http://medicaid.alabama.gov/news_detail.aspx?ID=9092.

In the near future paper submission of the medical records will not be allowed, therefore, providers are encouraged to start using the electronic upload and submission.

Providers with questions concerning the upload of medical records should contact one of their Provider Representatives. A link to the Provider Representative's contact information may be found at the following link: http://www.medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6_Provider_Representatives.aspx.

RETENTION OF RECORDS



The provider must maintain and retain all necessary records, Remittance Advices (RAs), and claims to fully document the services and supplies provided to a recipient with Medicaid coverage. These must be available, upon request, for full disclosure to the Alabama Medicaid Agency. The Alabama Medicaid Agency Administrative Code, Chapter 1, states the following:

Alabama Medicaid providers will keep detailed records in Alabama, of such quality, sufficiency, and completeness except as provided in subparagraph (5) Rule No. 560-X-16-.02, that will fully disclose the extent and cost of services, equipment, or supplies furnished eligible recipients. These records will be retained for a period of three (3) years plus the current year.

In the event of ongoing audits, litigation, or investigation, records must be retained until resolution of the ongoing action.

For more information regarding the retention of records, providers are encouraged to visit http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.1_Provider_Manuals_2015/6.7.1.1_January_2015/Jan15_07.pdf.

Provider Insider

ATTENTION: PATIENT 1ST PROVIDERS

Medicaid and HP are allowing providers an extension to begin using the Medicaid Interactive Web Portal to make Patient 1st changes. Effective June 1, 2015, providers will be required to use the Medicaid Interactive Web Portal to make Patient 1st assignment changes. If you are not already using the web portal to make Patient 1st assignment changes, please read the following information for instruction on how to begin using this user friendly tool.

If you are enrolled as an individual Patient 1st provider within a non-patient 1st group, you were mailed a letter in March 2014 with an additional web portal log on to access the web portal for each provider in the group to make Patient 1st assignment changes only. For any other features via the web portal, please continue to use your current User ID log on. The secure website is available at the following location: <https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx>.

A recipient's Medicaid number, or name and date of birth, or date of birth and SSN must then be entered to request the change. The same criteria for patient's assignments must still be met. Providers will have the capability to override panel holds, age restrictions, and gender restrictions set by the PMP. The provider's PMP panel must be open, and the caseload not be met at the time the assignment is being made. Providers will not be allowed to override the following restrictions in addition to some other restrictions:

- Recipient is locked into another physician (Not a Patient 1st assignment)
- Recipient has been previously dismissed from PMP attempting to make the assignment
- Requesting provider is not a Patient 1st participating provider
- PMP panel at contractual maximum limit
- Recipient is not currently eligible for the Patient 1st program



If the change is made by the 15th of the month, the effective date of the Patient 1st change will be the 1st day of the next month. If made after the 15th, it will be effective the following month. This eliminates the need to fax or e-mail Patient 1st change requests to HP Enterprise Services, and assures you the change has been made. If you have any questions, please contact Provider Assistance Center at 1-800-688-7989 or contact one of your Provider Representatives, contact information is available at the following location: http://www.medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6_Provider_Representatives.aspx.



ALABAMA MEDICAID RECEIVES CAQH CORE CERTIFICATION FOR ACA RULES PHASE I AND II

On January 30, 2015, Alabama Medicaid Agency received CAQH (Council for Affordable Quality Healthcare) Committee on Operating Rules for Information Exchange (CORE®) certification for Affordable Care Act (ACA) Operating Rules Phase I and Phase II. Alabama Medicaid made the commitment to become CORE-certified and, as a valued trading partner, we strongly encourage you to also complete CORE-certification. Access to eligibility, benefits, and claims data is improved with every organization that completes the certification process.

Who Can Become CORE-Certified?

Any entity that creates, transmits or uses eligibility or claims status data (clearinghouses, health plans, providers, information technology (IT) vendors) is eligible to become CORE-certified and receive the CORE Seal for Phase I (eligibility) and Phase II (claim status). The CORE Seal indicates a company has successfully completed certification testing with a CORE-authorized testing vendor, ensuring its compliance with all the CORE rules. To learn more about becoming CORE-Certified, read the information provided on the CAQH CORE website at: http://corecertification.caqh.org/CORE_voluntary.

Who Can Become CORE Endorsers?

Entities that do not create, transmit or use eligibility or claims status data, or are small providers, are eligible to become a CORE Endorser. Endorsing organizations are not eligible to become certified, but can demonstrate their support for the CORE mission and the rules by applying for and using the CORE Endorser Seal. To learn more about becoming a CORE Endorser access, read the information provided on the CAQH CORE website at: http://corecertification.caqh.org/CORE_voluntary.

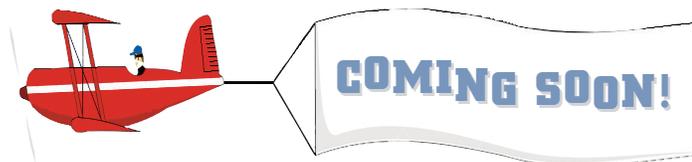
Benefits To Vendors & Clearinghouses

- Expanded and improved product offerings
- Access to standard and reliable payer coverage information that can be easily transmitted to the provider
- Cost savings from not having to design and maintain multiple plan interfaces.
- Increased provider adoption of IT solutions.

Benefits To Providers

- Reduced time and cost to verify patient insurance coverage
- Reduced bad debt related to eligibility/claim issues
- Reduced staff time devoted to insurance inquiries
- Improved information available at the point of care
- Access to all-payer IT solutions
- Improved data accuracy - information direct from the relevant health plan(s)
- More time to spend with patients

By implementing the CORE rules, CORE-certified organizations are speaking the same language, improving data consistency, reducing paperwork, advancing system interoperability, and supporting information transparency for consumers. It's time to get on the same page. Get certified to use the CORE rules or become a CORE Endorser. Learn more by visiting http://corecertification.caqh.org/CORE_certification.



AFFORDABLE CARE ACT (ACA) CHANGES

(CORE) Electronic Funds Transfer (EFT) & Electronic Remittance Advice (835/ERA) Operating Rules. The Phase III rules are Rule 350, Rule 360, Rule 370, Rule 380 and Rule 382. Information provided within this communication is in relation to some of the aforementioned rules.

Providers and trading partners should review these rules to determine impacts to their systems. The rules can be accessed on the CAQH Web site at http://www.caqh.org/ORMandate_EFT.php.

Alabama Medicaid and HP encourage providers and trading partners to access the CAQH CORE Operating Rules page on the Alabama Medicaid Agency at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_CAQH_Core_Operating_Rules.aspx. The website will be updated regularly as new information is made available.

Rule 350 Enroll for Electronic Remittance Advice (ERA) – Action Required by Providers

Electronic Remittance Advice (ERA), or the 835, is the HIPAA-compliant detailed explanation of how a submitted health care claim was processed.

Why should a provider enroll for an 835/ERA? All providers will be required to obtain a trading partner ID or identify a trading partner to receive 835s/ERAs on their behalf, and complete the ERA enrollment.

If you are not yet enrolled in 835/ERA follow the below steps:

- If you **DO NOT** have a trading partner ID, visit the Alabama Medicaid Interactive Portal at: <https://www.medicaid.alabamaservices.org/ALPortal/Tab/41/content/InformationLinks/InformationLinks.html.spage>
Click on Information/Alabama Links and download the trading partner ID Request Form. Complete the appropriate sections and submit to the Electronic Media Claims (EMC) Help Desk as directed on the form.
- If you **DO** have a trading partner ID visit the **Administrative Forms** section of the Alabama Medicaid website at: http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.
Download the Electronic Remittance Agreement.
Complete the appropriate sections and submit to the EMC Help Desk as directed on the form.

Providers can contact the EMC Help Desk toll-free at: (800) 456-1242 for more information.

Rule 360 Uniform Use of CARC/RARC Codes in 835 – Information Only

Rule 360 identifies a set of four Core-defined Business Scenarios with a maximum set of Core-required code combinations that can be used to provide details on a Provider's Remittance Advice (PDF or 835/ERA) about claims adjustments or denials.

Initial updates for Alabama Medicaid are planned for Summer 2015. Subsequent changes will be implemented three times per year to coincide with updates received from CAQH CORE.

Effective January 2015, the Explanation of Benefits (EOB) Listing are now available on the Alabama Medicaid Agency website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx and will be updated after each release. Appendix J: of the Provider Manual has been revised to contain a link to the listing on the Alabama Medicaid Agency website.

Rule 370 Re-association Request: Contact Your Bank – Action Required by Providers

Re-association is a process that supports matching of payments with claim data for posting to your patient accounts. Alabama Medicaid implemented Cash Concentration and Disbursement Plus One Addenda Record (CCD+) changes September 2013.

Providers should contact their financial institutions to request the necessary data to associate EFT payments to 835/ERAs.

A sample letter is available in the CORE section of the CAQH website at <http://www.caqh.org/benefits.php>. (Go to Mandated Operating Rules then select EFT and ERA. Scroll down to Implementation Resources section). The Sample Provider EFT Re-association Data Request Letter is available to use as a guide for creating a letter to submit to your financial institution or to use as a talking point guide when calling your financial institution to discuss re-association.

Why is it important for providers to complete the re-association request? This process allows providers to obtain data needed to associate the electronic remittance advice (835s/ERAs) to their electronic funds transfer (EFT). It does not affect claims processing. You do not need to send any information to Alabama Medicaid or HP Enterprise Services.

NOTE: An automated means of re-association cannot be supported if:

- A provider is not enrolled to receive both EFT and 835/ERA;
- A provider is not receiving the necessary 835/ERA re-association information from their trading partner, or;
- A provider has not yet made arrangements with their financial institution to receive the new CCD+ re-association information on their EFT.

Rule 370 EFT/ERA Elapsed Time Requirements - Process change Notification

In order to meet the requirements of Affordable Care Act (ACA) Operating Rule 370 (EFT and ERA Re-association Rule (CCD+/835)) elapsed time requirements, Alabama Medicaid must release the v5010 X12 835 (ERA) and the corresponding EFT within three (3) business days of each other.

Effective Summer 2015, Alabama Medicaid will begin releasing ERA/835's within three (3) business days (plus or minus) of the EFT being released. This is a change to current day processes where the 835/ERA is made available to providers even when funds related to the 835/ERA have not yet been released.

Note: There is currently no change to the availability of the proprietary RA which will continue to be available on the web portal following each check write cycle.

Providers will also receive a 277U (Unsolicited) transaction along with their proprietary RA. The Unsolicited Claim Status transaction, returned once a claims payment cycle has completed, reports all claims adjudicated to a suspended status.

Providers and trading partners are encouraged to monitor the CAQH CORE Operating Rules page on the Medicaid website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_CAQH_Core_Operating_Rules.aspx as it will be updated regularly as new information is made available.

Rule 370 Late or Missing EFT and 835/ERA Transaction Resolution Procedures

Rule 370 designates that a health plan must establish written Late or Missing EFT and 835/ERA Transaction Resolution procedures defining the process a healthcare provider must use when researching and resolving a late or missing Healthcare EFT Standards payment and/or corresponding late or missing v5010 X12 835 (ERA).

Late or Missing is defined as a maximum elapsed time greater than three (3) business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835 (ERA).

Detailed information on resolving Late or Missing EFT and 835/ERA Transaction Resolution Procedures can be found on the Alabama Medicaid website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5.2.3_CAQH_CORE_370.aspx.

If the information on the Medicaid website does not produce an answer to the late or missing EFT or 835/ERA, please contact the EMC Help Desk: Monday - Friday, 7:00 a.m. - 8:00 p.m. CST, or Saturday, 9:00 a.m. - 5:00 p.m. CST, via e-mail (AlabamaSystemsEMC@hp.com); phone (800-456-1242), or fax (334)-215-4272).

Rule 350 Health Care Claim Payment/Advice Batch Acknowledgement – Action Required by Providers

Rule 350 specifies trading partners to return a v5010 X12 999 Implementation Acknowledgement (Inbound 999) to Alabama Medicaid for each group of 835 (ERA) transactions received to indicate the transactions were either accepted, accepted with errors or rejected.

Alabama Medicaid Agency and HP will support (but not require) Inbound 999 Acknowledgement transactions from trading partners as a result of receiving an outbound 835 (ERA) transactions.

Instructions on how to submit an Inbound 999 to Alabama Medicaid using the Web Portal are provided on the Alabama Medicaid Agency website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5.2.1_CAQH_CORE_350.aspx.

Rule 380/382 Access to EFT and ERA Electronic

Registration Forms – Information Only

Available Summer 2015, an updated EFT enrollment form and a new ERA enrollment form will be accessible to providers on the Provider Enrollment Web Portal. These updated and new forms allow providers to quickly and easily access and submit requests to Alabama Medicaid electronically. Written instructions are also being developed to assist providers in completing EFT and ERA online enrolment.

EFT and ERA online forms will help you easily request:

- Initial enrollment for EFT or ERA.
- Changes to existing EFT or ERA enrollment.

In addition to the online forms, HPES and Alabama Medicaid are updating the EFT and ERA paper forms. Specific written instructions are also being developed for providers to follow when completing and submitting paper enrollment forms.

Additional information will be provided as it becomes available. Providers are encouraged to monitor the CAQH CORE Operating Rules page on the Medicaid website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.5_CAQH_Core_Operating_Rules.aspx.



Alabama Medicaid Bulletin

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ONLINE TOOL TO HELP PROVIDERS TEST ICD-10 CLAIMS

Beginning April 2015, the HP ICD-10 team will offer an online tool to help providers test ICD-10 837 Institutional and Professional batch claims. The Collaborative Testing (CollabT) tool will help providers understand how prepared they are for ICD-10.

CollabT is a web-based, secure, hosted solution covering end-to-end testing. Alabama Medicaid is able to create a collaborative testing community with providers to support the transition to ICD-10 by evaluating the usage of appropriate ICD-10 codes for various test scenarios and their impact on business processes and outcomes. Providers will have the opportunity to submit HIPAA-compliant X12 batch claim files with ICD-10 diagnosis codes through the CollabT tool for adjudication.

In order to test ICD-10 using the tool, providers must be able to login to the CollabT website. If you are interested in testing or would like to know more, please send an email to alabamaictesting@hp.com.

Important Note: CollabT uses the User Acceptance Test (UAT) environment. You will need a UAT trading partner ID to submit batch files through the tool. If you have previously used UAT and know your trading partner ID, you may continue to use it for this tool. If you do not have a UAT trading partner ID, contact alabamaictesting@hp.com or [Alabama SystemsEMC@hp.com](mailto:AlabamaSystemsEMC@hp.com) for assistance creating one.

Additional information on CollabT will be provided in upcoming ICD-10 teleconferences. All providers are encouraged to attend an ICD-10 Testing teleconferences session, even if you have previously attended, prior to starting CollabT testing. To register, access the ICD-10 Teleconference Training Information page of the Alabama Medicaid website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx.

Check Write Schedule Reminder:

04/03/15	05/01/15	06/05/15	07/10/15	08/07/15	09/04/15
04/17/15	05/15/15	06/19/15	07/24/15	08/21/15	09/11/15

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to www.medicaid.alabama.gov to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As always, the release of direct deposits and checks depends on the availability of funds.