

Provider Insider

Alabama Medicaid Bulletin

January 2015



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.

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

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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.

PROVIDER NOTICE: Physicians' Signature Designee

In the Alabama Medicaid Agency Provider Manual, there are many references to medical documentation (e.g., orders, referrals, plans of care, plans of treatment, treatment plans, etc.) requiring a physician's signature or the physician's designee signature. This is to clarify that a physician's designee, for the purpose of signing medical documentation, must be either a physician or a non-physician practitioner. Failure on the part of the provider to comply will result in non-compliance citations during Medicaid audits and may result in recoupment of funds paid by Medicaid.

DURABLE MEDICAL EQUIPMENT (DME) PROGRAM CHANGES

Attention:
DME Providers, Prosthetics & Orthotics (P&O) Providers,
Pharmacies, Physicians, Physician Assistants, Nurse Practitioners

DME Repair with "RB" Modifier Process

Effective January 1, 2015, Alabama Medicaid will implement the RB Modifier for specific wheelchair (manual or power) repair/accessory procedure codes. For recipients ages 21 years and over, repairs exceeding \$1000.00 dollars per day will require prior authorization (PA). For recipients ages 0-20, repairs will continue to require PA.

The "RB" modifier must be used with the HCPCS code(s) for all replacement parts furnished in conjunction with the repair of the beneficiary-owned base equipment. Miscellaneous parts that are not identified by a specific HCPCS code(s) are billed using procedure code K0108. Procedure code K0108 will not be included in this process and will continue to require PA.

This process will not override the current limitation audits for each of the procedure codes. For example, if the recipient has already received the yearly limit for a specific procedure code (e.g., 2 per calendar year), the repair will require PA, even if it is less than the threshold amount of \$1000.00 dollars per day.

More information, including a list of codes requiring PA, can be found on the DME fee schedule published on the Agency's website at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx.



NEED TO UPDATE THIRD PARTY INFORMATION ON A RECIPIENT?

During the eligibility verification process, if it is determined that Medicaid has a Third Party Insurance that is no longer on file; providers can contact the Third Party Division at the Medicaid Agency with a policy cancellation date and request the file be updated.

The most efficient way to contact the Third Party Division is to go to Medicaid's website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.1_Benefit_Coordination.aspx.

Select: Update Health Insurance Information, and complete the on-line form to report the change.

Providers may also call the Third Party Division by calling the direct line of the appropriate staff person to update health insurance. Please call the number listed below based on the recipient's last name:

Recipient's Last Name	A – H	334-242-5249
Recipient's Last Name	I – P	334-242-5280
Recipient's Last Name	Q – Z	334-242-5254
Fax Number:		334-353-2922

In the event that the assigned worker is unable to assist you, please contact either of the other workers. If an answering machine picks up please leave a message as all calls are returned the day they are received.

ADDRESS UPDATE CAPABILITY ON SECURE PROVIDER WEB PORTAL

The Medicaid Agency has the capability within the secure Provider Web Portal, <https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx>, to allow providers to update Service Location contact information, Payee and Mailing addresses and phone numbers. To access this functionality after signing into the secure web portal, click “Providers” on the top menu bar. The current Payee and Mailing address and service location contact information will be displayed. Providers can make changes to the displayed information. The changes will be made to the provider’s file immediately.

Prior to March 12, 2012, providers were able to submit written requests to update the above information. Now, any written requests received by Provider Enrollment after March 12, 2012, will be returned to the provider directing them to the secure Provider Web Portal to make requested updates. Providers are not presently allowed to update the service location address and must continue to contact Provider Enrollment to make those changes.



EMERGENCY

EMERGENCY SERVICES ONLY

The following aid categories are covered for “emergency services” only:

EK
EY
EC
ED
EP

In order for these “emergency services” to be paid by Medicaid, the provider must submit the recipient’s claim as an “emergency”. Please refer to chapter 5 of the Provider Billing Manual or to the Companion Guide for instructions on filing a claim for an “emergency.”

REMINDER:

ALL ACUTE CARE HOSPITALS, RESIDENTIAL TREATMENT FACILITIES AND INPATIENT PSYCHIATRIC HOSPITALS

*Reporting Hospital-Acquired
Conditions (HAC) and Present
on Admission (POA) on the
UB-04 Claim Form*



Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Present on admission is defined as present at the time the order for inpatient admission occurs-conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered present on admission.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y** – Yes.
Diagnosis **was present** at time of inpatient admission.
- **N** – No.
Diagnosis **was not present** at time of inpatient admission.
- **U** – No information in the record.
Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W** – Clinically undetermined.
Provider **unable to clinically determine** whether the condition was present at the time of inpatient admission.
- **1** – Unreported/not used. **Exempt** from POA reporting.

If the value code ‘81’ is indicated; then non-covered days must be present and the amount field must be greater than ‘0’.

When requested, it is the hospital’s responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid’s contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.



Patient 1st

Health Care Close To Home

ATTENTION: PATIENT 1ST PROVIDERS

Effective March 1, 2015, providers will be required to use the Medicaid Interactive Web Portal to make Patient 1st assignments 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 a group provider to receive your Patient 1st assignments or if you are an individual physician not enrolled as a group, you may log on to the web portal as you do for all other transactions. 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>

This site may be accessed from the Medicaid website using the drop-down menu under Providers. Providers should then access the following path: **providers/PMP assignment.**

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://medicaid.alabama.gov/CONTENT/8.0_Contact/8.2.6.1_Provider_Reps_G1.aspx

PATIENT 1ST / EPSDT REFERRALS

When conditions are identified during EPSDT Screenings and referrals are needed, the reason for the EPSDT referral must be included on the Alabama Medicaid Referral Form (Form 362) or other medical documentation. If using Form 362, the reason for the referral should be noted in the box labeled: "Reason for Referral". Completing the referral form correctly and including the reason for referral or other medical documentation will eliminate audit citations for this oversight. The referral form may be accessed in paragraph E.18, Appendix E, of the Medicaid Provider Manual on Alabama Medicaid Agency's website by clicking the following link:

http://www.medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.8_Provider_Manuals_2014/6.7.8.4_October_2014/Oct14_E.pdf



COMING SOON - ICD-10 GENERAL OVERVIEW TELECONFERENCE

The HP ICD-10 team will offer an additional “ICD-10 General Overview” teleconference on January 29, 2015 at 10:00 a.m. as the January 22, 2015 session has reached capacity. Both teleconferences will provide an overview of the changes being implemented by Alabama Medicaid for ICD-10. The session will include a segment where the ICD-10 team will be available to answer questions.

Registration is now open and available on 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.

If you have any questions or require assistance with ICD-10 testing, contact the HP ICD-10 team via e-mail at alabamaictesting@hp.com.



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 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.

Paper submission of the medical records will not be allowed in the future, 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/8.2.6.1_Provider_Reps_G1.aspx.



OUTPATIENT

ATTENTION:

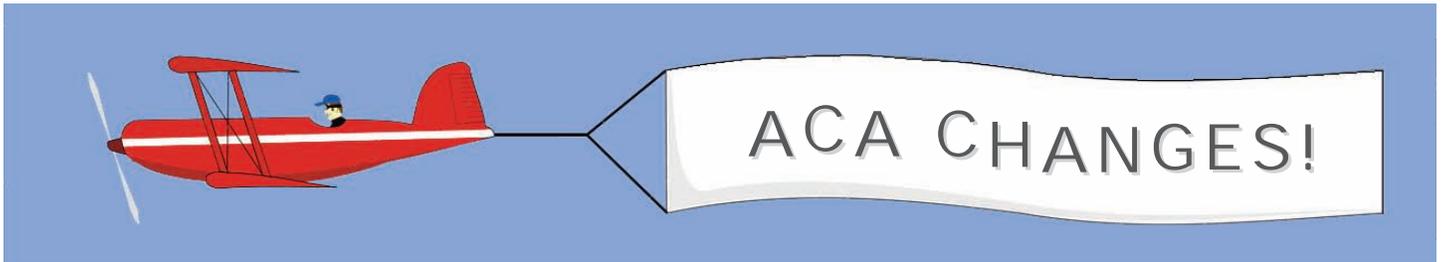
ALL HOSPITALS

**REIMBURSEMENT OF
HOSPITAL
OUTPATIENT VISITS**

Effective for dates of service January 1, 2015, and thereafter, outpatient visits will no longer be limited to 3 per calendar year. The Alabama Medicaid Agency will reimburse all in-state and out-of-state hospitals claims for medically necessary outpatient visits without regard to an annual limitation.

Note: At this time, physician office visits will continue to be limited to 14 per calendar year and physician hospital visits will continue to be limited to 16 per calendar year.

For questions, contact Solomon Williams, Associate Director, Institutional Services at 334-353-3206 or via e-mail at solomon.williams@medicaid.alabama.gov.



COMING SOON: AFFORDABLE CARE ACT (ACA) CHANGES

Effective Summer 2015, Alabama Medicaid Agency and HP will implement updates to comply with Phase III - Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (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

Monday – Friday, 7:00 a.m. – 8:00 p.m. CST, or Saturday, 9:00 a.m. – 5:00 p.m. CST at (800) 456-1242

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. Beginning January 2015, the Explanation of Benefits (EOB) Listing will be published to a dedicated page on the Alabama Medicaid Agency website after each release. An RA Banner message will be produced to coincide with each update.

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 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

Affordable Care Act Operating Rule 370, section 4.3, 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 toll-free Monday – Friday, 7:00 a.m. – 8:00 p.m. CST, or Saturday, 9:00 a.m. – 5:00 p.m. CST at (800-456-1242).

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

Rule 350, Health Care Claim Payment/Advice Batch Acknowledgement Requirement requires trading partners to return a v5010 X12 999 Implementation Acknowledgement (Inbound 999) to a health plan (Alabama Medicaid) for each group of v5010 X12 835 (ERA) transactions received to indicate the transactions were either accepted, accepted with errors or rejected. HPES and the Alabama Medicaid Agency are required to accept the Inbound 999 from trading partners.

Instructions on how to submit the Inbound 999 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.



**Alabama
Medicaid
Bulletin**

Post Office Box 244032
Montgomery, AL 36124-4032

PRSR STD
U.S. POSTAGE
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Check Write Schedule Reminder:

01/02/15	03/20/15	05/15/15	07/24/15
01/16/15	04/03/15	06/05/15	08/07/15
02/06/15	04/17/15	06/19/15	08/21/15
02/20/15	05/01/15	07/10/15	09/04/15
03/06/15			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.