

# Provider Insider

Alabama Medicaid Bulletin

October 2014

## CARDIOLOGY PRIOR AUTHORIZATION MANAGEMENT SERVICES

On October 1, 2014, CareCore National, LLC (CareCore) began implementing the Alabama Medicaid Agency prior authorization (PA) program for Cardiology procedures listed below:

1. Nuclear Cardiology – 78451, 78452, 78453, 78454
2. Diagnostic Heart Catheterization – 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461
3. Stress Echocardiography – 93350, 93351
4. Transesophageal Echo – 93312, 93313, 93314
5. Transthoracic Echo – 93303, 93304, 93306, 93307, 93308

Any of the procedures specified above will require a PA from CareCore. Information is now being accepted (i.e., online submissions, or via telephone), for services rendered on or after October 1, 2014.

The PA requirements will apply to Medicaid recipients for the State of Alabama:

1. SOBRA Children
2. Parents and Other Caretaker Relatives (POCR) Program, formerly, Medicaid for Low Income Families Program
3. Refugees, or
4. Supplemental Security Income

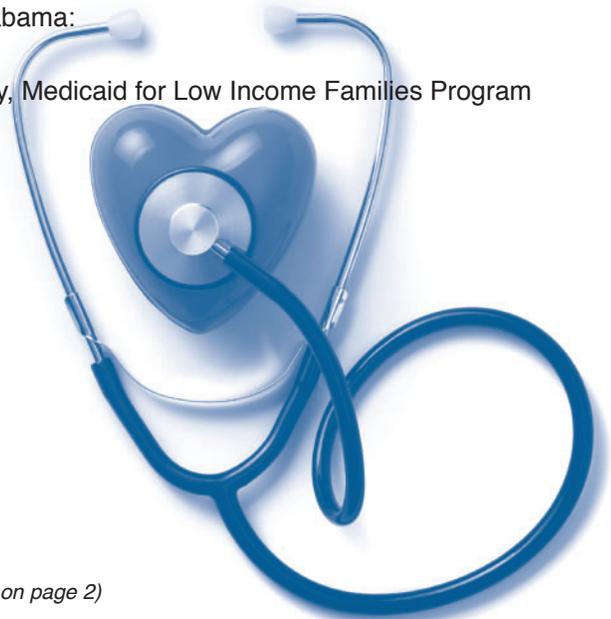
Please note that no PA is required for the following:

1. Medicare patients
2. Cardiology services performed as an inpatient hospital service, or
3. Cardiology services performed as an emergency room service

This Program is applicable to services provided in the following settings:

1. Freestanding imaging facilities
2. Hospital outpatient facilities
3. Physician offices
4. Public Health Clinics
5. Rural Health Clinics
6. Federally Qualified Health Clinics

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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.

# PCL

## TO ALL HOSPITAL COST REPORT PREPARERS:

You must now request a Paid Claims Listing (PCL) to assist you in the preparation of your Medicare and Medicaid Cost Reports from Medicaid's Provider Audit Division. The PCL will be customized to your specifications.

All requests should be submitted by e-mail to

[Gladys.Gray@medicaid.alabama.gov](mailto:Gladys.Gray@medicaid.alabama.gov)

or you may contact her at  
(334) 242-2327.



## ATTENTION HOSPITALS

Claims that overlap  
September 30 and October 1  
must be split billed.

Services prior to 10/01  
must be billed on one claim and  
services on or after 10/01  
must be on a separate claim.

Physicians may request a PA by contacting CareCore using one of the following methods:

1. Telephone (Alabama Medicaid) 1-855-774-13188924, or  
Online: [www.carecorenational.com](http://www.carecorenational.com)

### Training:

CareCore provided training webinars during the month of September 2014, to facilitate providers understanding about our program. The webinars addressed the scope of the cardiology PA process; provided guidance on obtaining a PA, and answered providers' questions. To learn more about the PA cardiology process, please visit the Tools and Criteria Page at: [www.carecorenational.com](http://www.carecorenational.com). You may find additional information about CareCore, and their policies, and procedures that you and your staff will need to participate in the program on CareCore's website at: [www.carecorenational.com](http://www.carecorenational.com). Providers may register on-line to set up an account to use CareCore's web site to submit PA requests.

### Questions

Frequently Asked Question (FAQ) are available on CareCore's website, along with a complete list of Cardiology procedures. You may also telephone CareCore at 1-800-918-8924, and then choose option "2".

Providers with additional questions may contact Russell Green, Associate Director, Medical Services Division, at (334) 353-4783. Thank you for your services to Alabama Medicaid recipients.

**Attention  
Patient 1st  
Providers**

**Patient 1st**  
Health Care Close To Home

Changes were recently implemented to allow providers to make Patient 1st assignment changes on the Medicaid Interactive Web Portal. 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>.

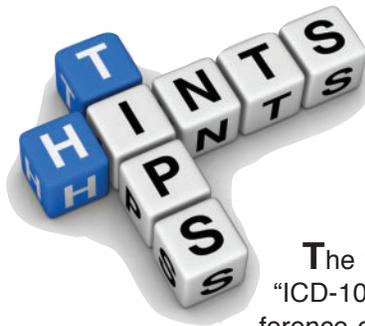
This site may be linked from the Medicaid website using the drop-down menu under Providers. Providers should then access the following path:  
**providers/PMP assignment**

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.



## **Coming Soon - General Overview ICD-10 Teleconference**

The HP ICD-10 team will offer an “ICD-10 General Overview” teleconference on October 21, 2014 at 10:00 a.m. The teleconference 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](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](mailto:alabamaictesting@hp.com).

### ***Cascading Referrals***

**A** Specialist may refer to another Specialist on a Cascading referral as long as the Referring Patient 1st provider has received documentation that the referral has occurred. A non-Patient 1st provider should not be referring to a specialist, unless it is a Cascading referral.

*All Specialists should be communicating with the referring Patient 1st PMP to ensure proper case management has occurred.*

### ***Written Referrals Given Within 72 Hours of Verbal Approval***

**A**labama Medicaid encourages providers to continue to authorize Referrals **prior** to the treatment of patients. It will be re-enforced to the PMP; **if** verbal referrals are given prior to the treatment of the patient, a written Referral Form must follow within **72-hours** of the verbal authorization. The form can be obtained by accessing Medicaid’s Form’s Library link:

[http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.7\\_Referral\\_Forms/5.4.7\\_Referral\\_Form362\\_fillable\\_7-10\\_Revised.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.7_Referral_Forms/5.4.7_Referral_Form362_fillable_7-10_Revised.pdf)

### ***Patient 1st Referrals***

**T**he Alabama Medicaid Agency made changes to the Patient 1st Referral process on June 1, 2014, that no longer allowed a specialist or Primary Medical Physician to bill/refer using a Group NPI number. The effective date of this change has been extended to allow more time to implement this change.

In the interim, the Group’s NPI number on the referral /claim/prior authorization as the Referring Provider will be accepted. However, Medicaid requests that specialists and PMP’s continue to write referrals and bill Medicaid utilizing the individual NPI number whenever possible.

The reasons Medicaid is requesting providers continue to bill/refer utilizing the individual NPI include:

- Reinforce Medical Home Concept
- Ensure referrals are managed by the PMP
- Ensure PMP is responsible for recipient’s total care
- Properly track caseload assignment for PMP’s
- Obtain accurate profiler reports for case management

Medicaid will notify providers through an ALERT, prior to implementing a new effective date, when the change will resume. Please contact Latonda Cunningham, Associate Director of the Patient 1st Program via e-mail at [latonda.cunningham@medicaid.alabama.gov](mailto:latonda.cunningham@medicaid.alabama.gov) or via phone at (334) 353-4122 for any questions.

## Synagis® Criteria for 2014-2015 Season

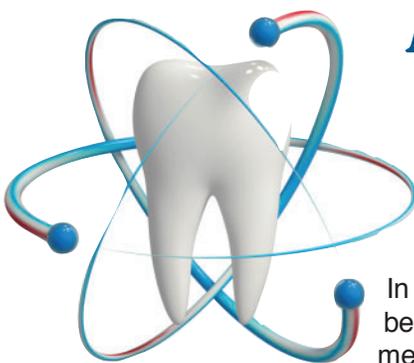
- The Alabama Medicaid Agency has updated its prior authorization criteria for the Synagis® 2014 - 2015 season. Below are some highlights for the season. Complete criteria can be found on the website at the following link: [http://medicaid.alabama.gov/CONTENT/4.0\\_Programs/4.5.0\\_Pharmacy/4.5.14\\_Synagis.aspx](http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.5.0_Pharmacy/4.5.14_Synagis.aspx)
- The approval time frame for Synagis® will begin October 1, 2014 and will be effective through March 31, 2015. Up to five doses will be allowed per recipient in this timeframe. There are no circumstances that will result in the approval of a 6th dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form. Subsequent doses will be denied if child experiences a breakthrough RSV hospitalization during the RSV season.
- **Prescribers**, not the pharmacy, manufacturer or any other third party entity, are to submit requests for Synagis® on a separate prior authorization form (Form 351) directly to Health Information Designs and completed forms may be accepted beginning September 2, 2014 (for an October 1 effective date).
- Stamped or copied physician signatures will not be accepted and will be returned to the provider.
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all Synagis® PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.
- Medicaid is the payor of last resort. Claims must be billed to the primary payor if other third party coverage exists. Use of NCPDP Other Coverage Codes will be reviewed and inappropriately billed claims will be recouped.



### Criteria

Alabama Medicaid follows the 2014 American Academy of Pediatrics (AAP) Redbook guidelines regarding Synagis® utilization. The AAP Guidelines were updated 7/28/14 and there are major changes that may affect your patients in the upcoming RSV season. For more details, please review a copy of the guidelines found at <http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665>.

Additional questions regarding Synagis® criteria can be directed to the Agency's Prior Authorization contractor, Health Information Designs at 1-800-748-0130.



## ATTENTION: DENTAL PROVIDERS

### *Reimbursement Changes for Dental Claims with TPL*

Effective October 01, 2014, Alabama Medicaid will be changing its reimbursement for dental claims that have TPL. HP will begin capturing Third Party Liability patient responsibility amounts at both header and detail levels for Dental claims.

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 dental claims.

## Coming Soon - Important Affordable Care Act (ACA) Related Changes

Section 1104 of the Patient Protection and Affordable Care Act (ACA) establishes new requirements for administrative transactions that will improve the effectiveness of the existing Health Insurance Portability and Accountability Act (HIPAA) transactions and reduce administrative costs. 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 (ERA) Operating Rules.

The rules should be reviewed by all providers and their trading partners to determine impacts to their systems. The rules can be accessed on the CAQH Web site at [http://www.caqh.org/ORMandate\\_EFT.php](http://www.caqh.org/ORMandate_EFT.php).

Medicaid now has a section on our website dedicated to CAQH CORE Operating Rules. The information can be found at the following link: [http://www.medicaid.alabama.gov/CONTENT/6.0\\_Providers/6.5\\_CAQH\\_Core\\_Operating\\_Rules.aspx](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 for providers.

### Rule 350 Health Care Claim Payment/Advice (835) Infrastructure – Action Required by Providers

Rule 350 defines dual-delivery (paper/electronic) of remits. Alabama Medicaid currently offers electronic v5010 835 remittance advice (ERA) transactions to enrolled submitters as well as proprietary remittance advice reports via web access. All providers will be required to have access to the Electronic Remittance Advice (ERA).

#### Provider Next Steps – Enroll for ERA

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 return to the EMC Help Desk via mail, email or by fax. EMC will process the form. A PIN letter will be generated and mailed to you.

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](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 return to the EMC Department via mail, or by fax.

Providers can contact the EMC Help Desk toll-free at: (800) 456-1242 or (334) 215-0111 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 Remittance Advice about claims adjustments or denials to providers. Explanation of Benefit Codes (EOB) will now be assigned to a particular Business Scenario and only valid combinations of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) defined by CAQH CORE for the assigned Business Scenario will be allowed for return on the 835. Alabama Medicaid currently provides a crosswalk between its proprietary error codes and the HIPAA (Core defined) CARC in Appendix J: Provider Remittance Advice (RA) Codes of the Alabama Medicaid Provider Manual.

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 Listing will be published to a dedicated page on the Medicaid website after each release. Appendix J: of the Provider Manual will be revised to contain a link to the listing on the Medicaid website.](#) An RA Banner message will be produced to coincide with each update.

### Rule 370 EFT & ERA Re-association (CCD+/835) – Action Required by Providers

To comply with the EFT & ERA Re-association (CCD+/835) Operating Rule, Alabama Medicaid will provide standardized data to match the EFT payment to the 835 Remittance Advice detail. This data is delivered to providers using the following:

- Version 5010 X12 835 Remittance Advice (ERA) transaction
- Automated Clearing House (ACH) Cash Concentration and Disbursement Plus One Addenda Record (CCD+) transaction format for EFT as specified in the National Automated Clearing House Association (NACHA) Operating Standards

## Provider Next Steps – Request Re-association Information

Alabama Medicaid implemented CCD+ changes September 2013. Providers must contact their financial institutions to request that the necessary data for re-association is sent with each EFT payment.

CAQH CORE has developed a sample letter you may customize and email to your bank or use as talking points for a phone or in person meeting with bank contacts. The sample letter is available in the CORE section of the CAQH website at [http://www.caqh.org/Host/CORE/EFT-ERA/Sample\\_Provider\\_EFT\\_Re-association\\_Data\\_Request\\_Letter.pdf](http://www.caqh.org/Host/CORE/EFT-ERA/Sample_Provider_EFT_Re-association_Data_Request_Letter.pdf).



# ATTENTION:



## Hospital Providers

### Reimbursement Changes for Inpatient Claims with TPL

Effective October 1, 2014, Alabama Medicaid will be changing its reimbursement for inpatient claims that have TPL. Inpatient claims will continue to capture Third Party Liability patient responsibility amounts at the header.

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 inpatient claims.

**System changes will be implemented at a later date for the payment methodology for Outpatient claims.**

## Hospice Providers

### Changes to Reimbursement for Levels of Care - Claims Processing for the Hospice Program

Effective October 1, 2014, the following billing changes will be implemented for Hospice levels of care:

1. Hospice Providers will be required to span bill claims (up to one month) – billing only one detail line per claim.
2. Hospice Providers should bill one procedure code for one unit/per day of service for all hospice procedure codes except T2045 General Inpatient Care/per day, which can be billed with T2042 Routine Home Care/per day. T2042 should be billed on a separate claim with overlapping dates of service.

**NOTE:** This does not include T2042-SC Continuous Care. The Continuous Care billed amount must be calculated based upon the number of hours of care provided. The units will continue to be based upon the number of days.

The Agency will conduct a retrospective review of Hospice claims going back one year. If a Hospice Provider has “double-billed” and received reimbursement from the Agency within the review period, the Agency will recoup monies that were reimbursed for the erroneous billing.

For questions regarding Claims Processing for the Hospice Program, please contact Felicha Fisher, Hospice Program Manager @ (334) 353-5153 or [felicha.fisher@medicaid.alabama.gov](mailto:felicha.fisher@medicaid.alabama.gov).

# REMINDER:

## Recovery Audit Contractor (RAC) Audits

**M**andatory 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 Sandra Shaw, RAC Program Manager, at (334) 242-5372 or [sandra.shaw@medicaid.alabama.gov](mailto:sandra.shaw@medicaid.alabama.gov) or Jacqueline Thomas, Program Integrity Division Director, at (334) 242-5318 or [jacqueline.thomas@medicaid.alabama.gov](mailto:jacqueline.thomas@medicaid.alabama.gov).





**Alabama  
Medicaid  
Bulletin**

PRSRRT STD  
U.S. POSTAGE  
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MONTGOMERY AL

Post Office Box 244032  
Montgomery, AL 36124-4032

**Check Write Schedule Reminder:**

**Note:** There will be 3 check writes in October.  
There will be 1 check write in November  
There will be 2 back-to-back check writes in December.

10/03/14	12/12/14	03/06/15	05/15/15
10/17/14	01/02/15	03/20/15	06/05/15
10/31/14	01/16/15	04/03/15	06/19/15
11/14/14	02/06/15	04/17/15	07/10/15
12/05/14	02/20/15	05/01/15	07/24/15

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](http://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.