Provider Insider

Alabama Medicaid Bulletin — April 2013

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05/03/13 • 05/17/13 • 06/07/13 • 06/21/13 • 07/05/13 • 07/19/13 • 08/02/13 • 08/16/13 • 09/06/13 • 09/13/13
As always, the release of direct deposits and checks depends on the availability of funds.

PCP Rate Increase

As the result of the Affordable Care Act (ACA), eligible primary care physicians will soon receive increased payments for certain primary care services provided to Medicaid recipients between January 1, 2013 and December 31, 2014.

The primary care services subject to the increased payment are Current Procedural Terminology (CPT) Evaluation and Management procedure codes 99201 to 99499, and VFC Vaccine Administration codes. The Alabama Medicaid Agency requires the VFC administration fees to be billed using the specific product code (vaccine codes). These VFC codes are: 90633, 90636, 90645, 90647, 90648, 90649, 90650, 90655, 90656, 90657, 90658, 90660, 90669, 90670, 90680, 90681, 90696, 90698, 90700, 90702, 90707, 90710, 90713, 90714, 90715, 90716, 90718*, 90721, 90723, 90732, 90733, 90734, 90744, and 90748. *CPT deleted 90718 effective 12/31/2012; however, this code would still be used in calculating the 60% threshold for CY 2012.

Eligible physicians include those with a specialist designation of family medicine, general internal medicine and pediatric medicine or subspecialists related to one of these primary care specialists. They must be board certified in the specialty or subspecialty; or can verify that 60 percent or more of the Medicaid codes paid in the previous year were primary care codes and the above listed codes for vaccine administration codes.

Increased payment will also be made for primary care services rendered by physician assistants or certified nurse practitioners working under the personal supervision of a qualifying physician. In this case, the physician must assume professional/financial responsibility and is legally liable for the quality of services provided under his or her supervision.

Eligible providers must self-attest to being board certified by the American Board of Physician Specialties, American Osteopathic Association, or the American Board of Medical Specialties in one of the eligible physician categories or verify that 60 percent or more of the Medicaid codes they billed in 2012 were E&M codes and Vaccine Administration codes. Letters were mailed in late February to all physicians who are currently enrolled with a primary care specialty or subspecialty designation.

Before payments can be made, the Agency must obtain final approval from the Centers for Medicare and Medicaid Services (CMS) for the planned payment changes, determine the rate that will be paid to providers, and make the necessary system changes to issue the payments. Medicaid will make retroactive payments for the increase for services that qualify under the federal regulations by reprocessing the affected claims in order for the physician to receive the increased payment.

In This Issue

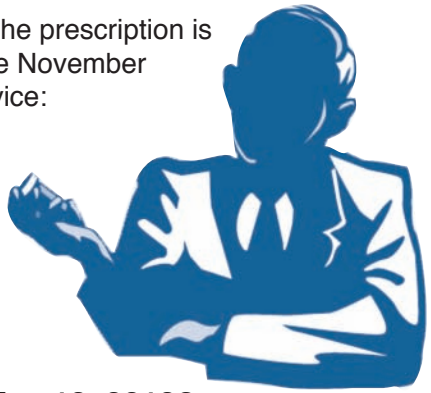
Pass It On!

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

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

New Edits to be Activated Soon - Drug Enforcement Administration (DEA) Validation for Controlled Substances

Effective May 13, 2013, Alabama Medicaid will DENY any claim for a controlled drug written by a prescriber who does not have their DEA number registered with the Department of Justice (DOJ) **and** on file at Medicaid.



These edits are designed to prevent controlled substances from being filled when the prescription is written by an unauthorized prescriber. The following edits have been in place since November 2012 and are currently displaying as informational on the provider's remittance advice:

Edit	Description
1038	DEA NOT ON FILE FOR PRESCRIBER
1039	PRESCRIBER DEA NOT EFFECTIVE FOR DATE PRESCRIBED
1040	PRESCRIBER DEA DOES NOT PERMIT DRUG SCHEDULE

NOTE: *The claims which are currently paying and posting one of the informational edits above, will deny effective May 13, 2013.*

What action needs to be taken to prevent claims from denying on May 13, 2013?

PHYSICIANS – Make sure your DEA number is registered with DOJ and is on your enrollment file at Medicaid. **Medicaid deadline for submission: May 1, 2013.**

To confirm if your DEA number is appropriately registered with the DOJ, and to ensure your correct address/contact information is registered with the DOJ, **you may call the Department of Justice Registration Number Toll Free: (888) 514-7302 or (888) 514-8051**. Prescribers of controlled substances are mandated to re-register their DEA license every three years.

To ensure your DEA is on file at Medicaid, fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate. Medicaid will apply the DEA to all service locations based on the provider's NPI and license number. **The DEA information should be received by Provider Enrollment prior to May 1, 2013**. This deadline will allow Provider Enrollment time to enter the information in the provider's file before the May 13, 2013, implementation date.

PHARMACIES – If you are receiving the informational edits, contact the provider who ordered the prescription and advise them to fax a copy of the provider's DEA Registration Certificate to Provider Enrollment (fax 334-215-4298) and include the provider's Name, NPI number, and license number on the certificate.

Why is Medicaid implementing these changes?

In September 2009, the Government Accountability Office (GAO) issued the report "Medicaid Fraud and Abuse Related to Controlled Substance Identified in Selected States" which highlighted fraudulent, improper, or abusive actions in prescribing and dispensing of controlled substances. One of the report's primary recommendations was that states should use the Drug Enforcement Administration (DEA) Controlled Substance Registration file as part of their Medicaid claims processing efforts to prevent paying for controlled substances ordered by unauthorized prescribers.

PRESCRIBERS: Please take a moment to validate your DEA number information. Medicaid encourages all providers to be proactive and ensure the DEA number of the prescribing provider is registered with the Department of Justice (DOJ) and on file at Medicaid prior to May 1, 2013.

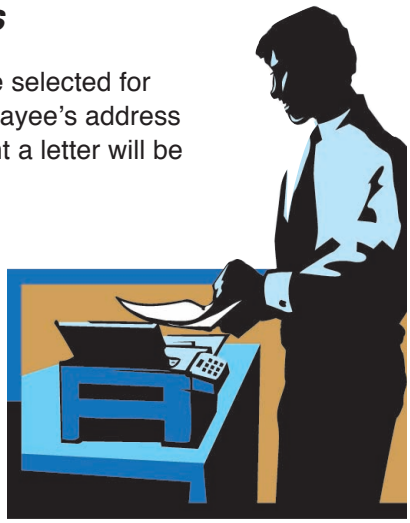
Revision to January 2013 Article "Important Changes for Providers Performing Reconstructive/Cosmetic Procedures"

CPT Codes **11200** and **11201** Removal of skin tags, coverage will continue for all eligible benefit types. These CPT codes will be diagnosis restricted to prevent payment when billed with diagnosis codes for hypertrophic and atrophic skin conditions.

Strabismus surgery CPT codes **67311** – **67340** coverage will continue for all eligible benefit types without prior authorization.

Effective March 1, 2013, CPT Code **54163 Repair Incomplete Circumcision**, will require a **Prior Authorization** before services are rendered to the recipient to determine medical necessity.

Important Provider Re-enrollment Reminders



Re-enrollment for providers is on-going for Alabama Medicaid providers. Providers are selected for re-enrollment monthly based on the longest date of enrollment. A letter is sent to the payee's address on file for the provider when it is time for them to re-enroll. Only providers who are sent a letter will be able to download a facsimile from the Medicaid Interactive website.

When a provider receives a letter it is time to re-enroll, they should log onto the Interactive Website and download a facsimile for review. Instructions for downloading the facsimile can be found on the Medicaid Agency website. Once the information has been printed and reviewed, the provider should sign page three of the facsimile, complete the appropriate forms and mail to HP using the address on the letter and facsimile. If changes are necessary, providers should make the appropriate changes on the facsimile. Please read all information on the facsimile carefully, because additional information is required (For example, provider agreement and provider disclosure forms). Documentation requirements can be found on the Medicaid Agency Website.

It is important to point out the facsimile is not the only information needed for re-enrollment. The facsimile indicates which additional forms are required.

If unsure of required forms, please contact Provider Re-enrollment at 888-223-3630 Option 2 for assistance. **Failure to send in additional documentation delays your re-enrollment.** Approximately 50% of the re-enrollments received lack the required paperwork to complete re-enrollment upon receipt and require outreach.

Individual practitioners enrolled under the group do not complete an agreement until the provider has received notification to re-enroll. Not all providers within a group will re-enroll at the same time.

How will providers know when it is time for re-enrollment? In addition to the letter sent to the payee address on file, providers are sent two final notice letters. Providers may also log onto the Medicaid website after the 5th working day of each month to view a list of providers scheduled for re-enrollment. The list includes the provider's name, NPI and Medicaid identification number.

The Affordable Care Act requires some providers have an onsite visit prior to a new enrollment or prior to re-enrollment. The onsite visits are conducted by Medicaid's fiscal agent, HP Enterprise Services. The visits are unscheduled and not announced prior to the time of visit. When a Provider Relations Representative arrives at your facility, please make time to answer questions, and allow them access to your facility. The HP representatives will wear an identification badge with the HP logo and their photograph; they will also provide you with a business card. Failure to answer their questions or assist could affect your current enrollment or re-enrollment with Alabama Medicaid.

What happens if re-enrollment is not completed timely? Failure to re-enroll and provide appropriate documentation (including required additional forms) to complete re-enrollment will result in an end-date being placed on the provider file. Once a provider has been closed to failure to timely re-enroll, providers will have to submit a new application for enrollment. Please do not hesitate to contact Provider Re-enrollment with any questions at 1-888-223-3630 Option 2.

Correction to the January 2013 Insider Article "Attention Providers"

Audits 5664, Initial office visit/ prior visit contra, and 5665, Prior visit/initial office visit contra, are effective for claims received on or after 10/24/2012.

Effective for claims received on or after 10/24/2012: Audit 5664, Initial office visit/ prior visit contra, has been established to deny the reimbursement of an initial office visit procedure (99201 - 99205) when billed for the same recipient, by the same billing provider, same rendering provider specialty, within 3 (three) years after any subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499).

Effective for claims received on or after 10/24/2012: Audit 5665, Prior visit/initial office visit contra, has been established to deny the reimbursement of subsequent office, hospital, or nursing home evaluation and management service (99211 - 99499) when billed for the same recipient, by the same billing provider, same rendering provider, provider specialty, anytime within 3 (years) prior to an initial office visit procedure (99201 - 99205).

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

REMINDER: Claims Processing for the Hospice Program

Below are a few tips in an effort to assist Hospice Providers with the processing of Hospice claims:

- For a dually eligible recipient in the community, the recipient is not on the Level of Care panel and the hospice provider does not bill Medicaid for services.
- For a dually eligible recipient in a nursing home, if financially eligible, the recipient is on the Level of Care panel. Medicaid reimburses the hospice provider 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing home (Revenue Code 659/Procedure Code T2046-SE). Hospice bills Medicare for routine care services.
- For a straight Medicaid recipient (meaning Non-Medicare) in the community, if financially and medically eligible, the recipient is on the Level of Care panel. Medicaid reimburses the hospice provider for every day service is rendered at the appropriate care level (Revenue Code 651/Procedure Code T2042 for Routine Home Care or Revenue Code 652/Procedure Code T2042-SC for Continuous Home Care).
- For a straight Medicaid recipient in a nursing facility, if financially and medically eligible, the recipient is on the Level of Care panel. Medicaid reimburses the hospice provider for the appropriate care level for every day service is rendered + 95% of the nursing home rate applicable for that year for the room & board that would have been paid to the nursing home (Revenue Code 659/Procedure Code T2046 for Nursing Home Room and Board, Routine Care or Revenue Code 659/Procedure Code T2046-SC for Nursing Home Room and Board, Continuous Care).

NOTE: For a straight Medicaid recipient, Medicaid will reimburse Hospice for every day services are rendered. This includes reimbursement for Date of Death or Discharge when the recipient is in a nursing facility for a straight Medicaid recipient (meaning Non-Medicare). If the recipient revokes hospice or is discharged from hospice, but does not physically leave the nursing facility, the hospice provider can submit a claim to the Agency for reimbursement regarding room and board and other hospice services that were administered to the recipient.

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website at www.medicaid.alabama.gov (Refer to Hospice Provider Manual Chapter 18 NOTE under 18.2.9 Reimbursement for Levels of Care).

For questions or concerns regarding claims processing for Hospice Program, please contact Felicha Fisher at (334) 353-5153.

Provider Payment Accuracy is Focus of State-based RAC Program

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, has been selected to be Alabama Medicaid's Recovery Audit Contractor (RAC) for a two-year period beginning 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 with questions about the RAC requirements may contact Vanesia Boyd, Contract Manager, the Alabama Medicaid Agency at (334) 242-5339, or by email at vanesia.boyd@medicaid.alabama.gov .

ICD-10 Updates

CMS has delayed implementation for ICD-10 from October 1, 2013 to October 1, 2014. The Alabama Medicaid Agency is preparing for ICD-10 implementation as early as October 1, 2013, but no later than October 1, 2014. This means Medicaid will have its claims processing system ready for ICD-10, but will not accept nor require the provider to use ICD-10 codes on their claims until the CMS mandate of October 1, 2014. Providers are encouraged to review updates related to ICD-10 implementation on the Alabama Medicaid website.
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx

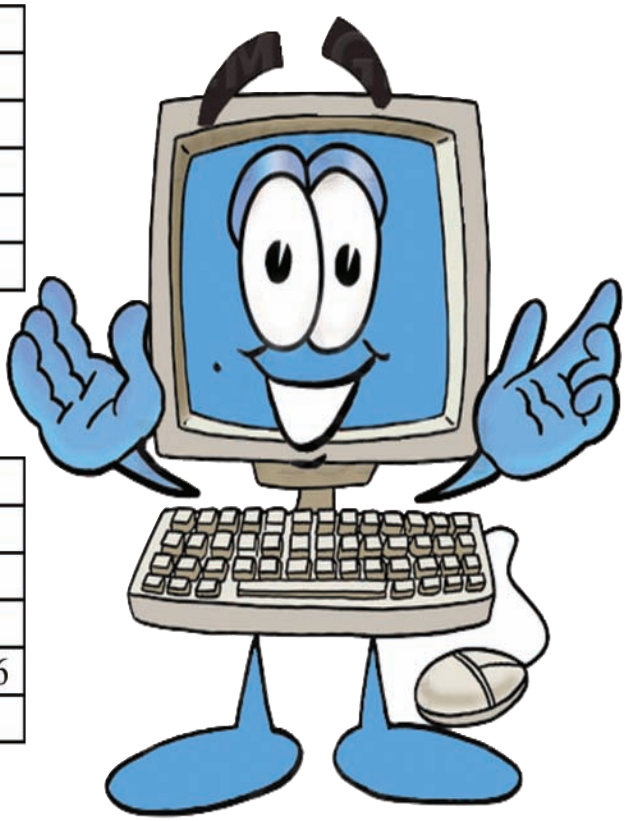
If you would like to receive e-mail notifications concerning ICD-10 changes, please log on to the Alabama Medicaid Provider Web Portal and update your Account Maintenance e-mail address. Providers and trading partners may update their e-mail by logging onto the Provider Web Portal.
https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20Site/tabId/66/Default.aspx
Navigation: Account>Account Maintenance

Provider Electronic Solutions Software version 3.02 includes modification for ICD-10.
Please download version 3.02 to ensure you are submitting claims with the latest version of the software.
You should not start to use ICD-10 diagnosis codes until you are advised to submit them by Medicaid.

Vendor and provider surveys related to ICD-10 readiness will continue until implementation.
The next survey for **vendors** will be open April 2-19, 2013.
The next survey for providers will be May 16 - June 4, 2013.
The survey will be available on the Medicaid website in the ICD-10 section under Provider information.
We encourage providers and vendors to complete our surveys (which should take less than 5 minutes).
The surveys will help us track the progress, uncover issues, and identify training that may be helpful to providers.

QUARTERLY VENDOR SCHEDULE:

Quarter	Scheduled
1st Quarter 2013	January 2 – January 21
2nd Quarter 2013	April 2 – April 19
3rd Quarter 2013	July 1 – July 18
4th Quarter 2013	October 1 – October 18
1st Quarter 2014	January 10 – January 29



PROVIDER QUARTERLY SURVEY SCHEDULE:

Quarter	Scheduled
1st Quarter 2013	February 14-March 5
2nd Quarter 2013	May 16-June 4
3rd Quarter 2013	August 14-September 2
4th Quarter 2013	November 7-November 26
1st Quarter 2014	February 18-March 7

ATTENTION:

All Long Term Care, Hospice and Inpatient Psychiatric Facilities

Please be reminded that records requested for retrospective review, or which require a medical review must be mailed to HP with a correctly completed HP coversheet. All 13 digits of the recipient's Medicaid ID are required. Records received at HP without a correctly completed HP coversheet, or no coversheet, will be returned to the provider. This may result in penalties for nursing home providers which fail to submit records timely and/or a delay in the review of the record. **Providers submitting more than one record should clearly separate each record and ensure that a HP coversheet is included for each recipient.** Providers are also encouraged to review each submission and to send only what is requested for an audit, and/or to meet criteria. For example, it is not necessary to send social work, chaplain or aide visit notes for a hospice record.

HP coversheets are found on the Medicaid website at this link,
http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Forms.aspx

ATTENTION:

All DME Providers

Please be reminded that durable medical equipment is a covered service under the hospice benefit and therefore should not be billed separately. Per Chapter 18, Hospice, of the Billing Manual on page 17, *"Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care."* Therefore, if the requested DME is related to the terminal diagnosis and the recipient's eligibility response indicates hospice, neither a prior authorization request nor a claim should be submitted to Medicaid.

Referring NPI Numbers Now Validated on All Claims Received for Processing

All claims submitted with a referring provider number will be validated during claims processing. If a referring NPI is placed on the claim but is NOT required, the claim will deny if the number is not valid in the HP claims processing system.

Providers should not place referring NPI numbers on claims unless it is required for processing.

A written order or a signed prescription from the attending physician must be dated prior to or on the delivery date, unless a different effective date is clearly documented on the prescription. Otherwise, the effective date is the date of the physician signature. (Verbal orders must be signed within 48 hours of the order being issued.) An effective date that is handwritten on a prescription and differs from the date of the physician's signature, must be initialed and dated by the physician to verify the effective date.

ESRD Laboratory Services

Laboratory tests listed in Chapter 35 (Renal Dialysis Facility) are considered routine and are included as part of the composite rate of reimbursement. When any of these tests are performed at a frequency greater than specified,the additional tests are separately billable and are covered only if they are medically necessary and billed directly by the actual provider of the service. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of additional tests. The nature of the illness or injury (diagnosis, complaint, or symptom) requiring the performance of the test(s) must be present on the claim.

PERM Provider Education Sessions

The Centers for Medicare and Medicaid Services (CMS) is hosting four PERM Provider Education Webinar/Conference calls during Cycle 2.The purpose of Payment Error Rate Measurement (PERM) Provider Education Webinars/Conference Calls is to provide opportunities for the providers of the Medicaid and CHIP communities to enhance their understanding of specific provider responsibilities during PERM. The webinars/conference calls will cover the PERM process and provider responsibilities during a PERM review, frequent mistakes and best practices for documentation submission, and an overview of the Electronic Submission of Medical Documentation (ESMD) program. Dates, times and other information for the four sessions that will be hosted by CMS are listed below.

1. **Tuesday, May 21, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web1/

2. **Wednesday, June 5, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web2/

3. **Tuesday, June 18, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web3/

4. **Tuesday, July 2, 2013**, 2:00 p.m. - 3:00 p.m. **Central Time**

   To Join Meeting:
   Audio: 1-877-267-1577; Meeting ID# 4964
   Webinar: https://webinar.cms.hhs.gov/permcycle2web4/

There will be time available for Q&As at the end of the presentations. However, CMS encourages all participants to submit questions in advance to the designated PERM Provider email address at PERMProviders@cms.hhs.gov.

Presentation materials and participant call-in information will be posted on the Provider Education Calls link at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Provider_Education_Calls.html.

The webinars are being presented on a Connect Pro platform. To test your connection in advance, launch: https://webinar.cms.hhs.gov/common/help/en/support/meeting_test.htm.

Alabama Medicaid Bulletin

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2013 State Checkwrite Schedule

~~01/04/13~~	04/05/13	07/05/13
~~01/18/13~~	04/19/13	07/19/13
~~02/08/13~~	05/03/13	08/02/13
~~02/22/13~~	05/17/13	08/16/13
~~03/08/13~~	06/07/13	09/06/13
~~03/22/13~~	06/21/13	09/13/13

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 aways, the release of direct deposits and checks depends on the availability of funds.