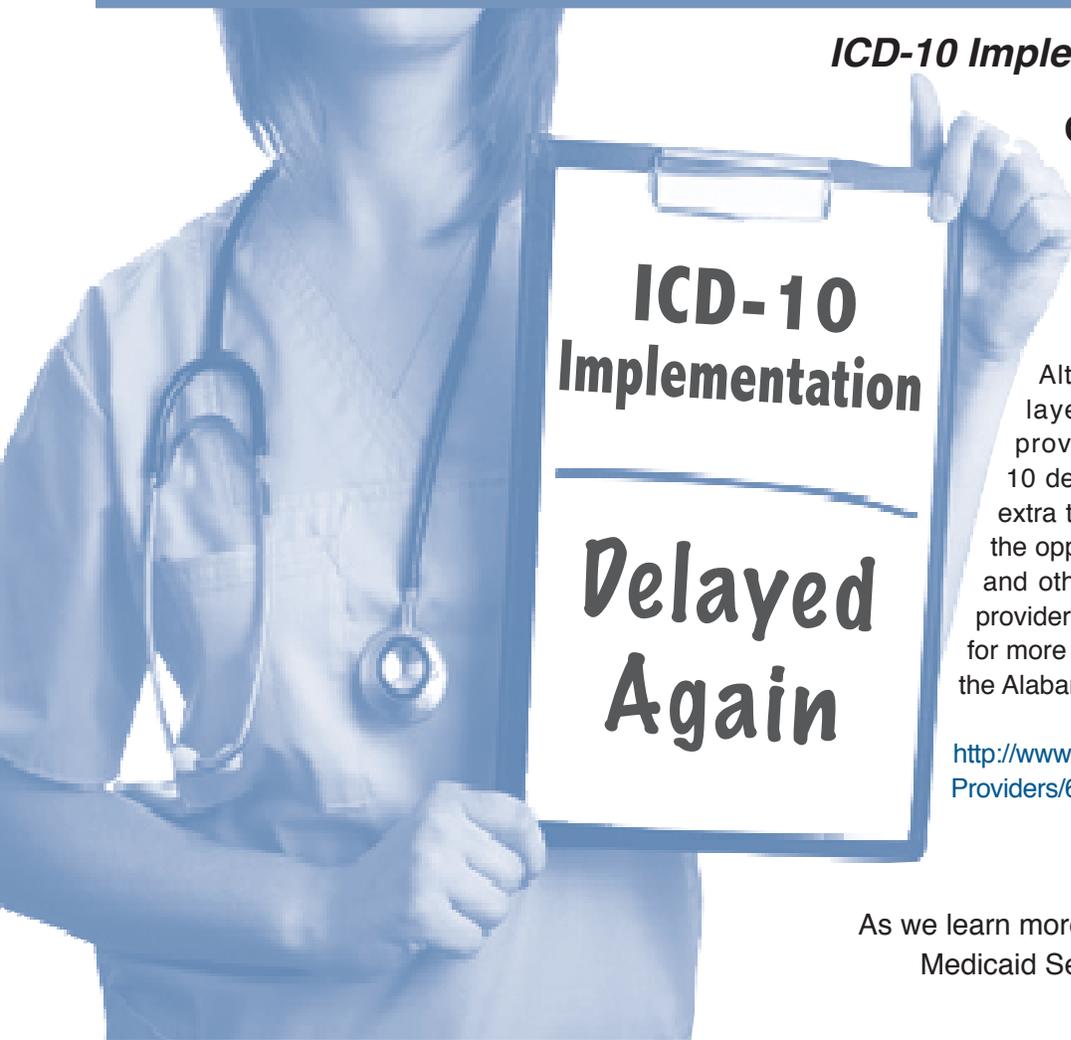


Provider Insider

Alabama Medicaid Bulletin

July 2014

ICD-10 Implementation



ICD-10 Implementation

Delayed Again

On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary **may not adopt ICD-10 prior to October 1, 2015.**

Although implementation has been delayed, Alabama Medicaid urges the providers and vendors to use the ICD-10 delay to maximize your readiness. The extra time created by the delay, will give you the opportunity to test with Alabama Medicaid and other payers. Our testing is open to all providers and vendors. Please visit our website for more information on ICD-10 and testing with the Alabama Medicaid Agency.

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

As we learn more from the Centers of Medicare and Medicaid Services (CMS), we will let you know.

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Pass It On!

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

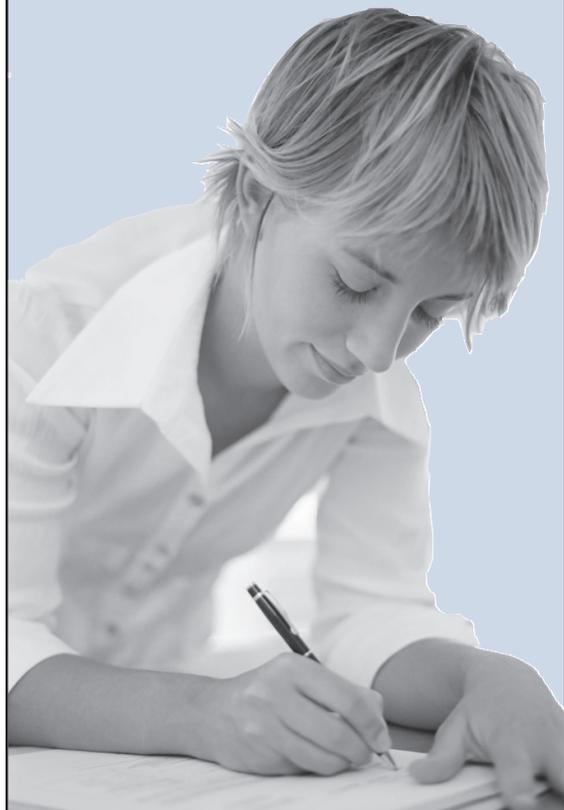
- Office Manager
- Billing Dept.
- Medical/Clinical Professionals
- Other _____

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

Clarification on Provider Signatures on the 362 Form

In Rule No. 560-X-1-18 (2) (d), Provider/Recipient Signature Requirements, Referral Forms, the Alabama Medicaid Administrative Code says the following: 'For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. Photocopied signatures will not be accepted. For electronic referrals, provider certification shall be in accordance with the electronic signature policy in subsection (1) (a) of this rule'.

This means that a signature signed by the physician's designee, **must be a complete signature, not initials.**



ICD-10 End To End Testing Continues With Alabama Medicaid

Alabama Medicaid encourages providers and vendors to test end to end to ensure ICD-10 readiness prior to the CMS federal mandate date, which is currently October 1, 2015. It is critical that providers and trading partners test with Alabama Medicaid prior to implementation. We continue to encourage early testing, please do not wait until the federal mandate date to test. Information on how to test can be found at the following link:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.3_ICD-10_Testing.aspx

Webinar materials related to testing are also located at this link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12.6_ICD-10_Teleconference_Training.aspx Additional teleconferences on how to test will be scheduled in the future.

In order to facilitate testing both the end of ICD-9 code submission and the beginning of ICD-10 code submission, Alabama Medicaid has provided testing dates different than the CMS mandate date that will allow a provider to submit claims with ICD-9 codes and claims with ICD-10 codes to ensure processing will work as expected in anticipation of the CMS implementation.

CURRENT TEST DATES

> **ICD-9 END DATE** **09/30/2013**
> **ICD-10 START DATE** **10/01/2013**

Attention Provider Submitting Paper Claims for Processing

In support of the changes for ICD-10, all **paper** claim forms submitted must have the new ICD Version field populated with a '9' indicating ICD-9 until such time that ICD-10 is implemented. ICD-10 implementation has been delayed and cannot be implemented before October 1, 2015.

When ICD-10 is implemented the indicator must be either a '9' indicating ICD-9 or '0' indicating ICD-10. ICD-9 and ICD-10 diagnosis codes and/or surgical procedure codes may not be billed on the same claim. The ICD Version entered on the claim form applies to all diagnosis codes and/or surgical procedure codes entered.

ICD Version form fields:
CMS1500 = Block 21
Form 340B (Medical Medicaid/Medicare Related Claim (Crossover) = Block 4
UB04 = Block 66



Attention Physical Therapists: Medicaid is Expanding the Locum Tenens and Substitute Physician Policy to Include Physical Therapists. This change is effective April 1, 2014.

Locum Tenens and Substitute Physical Therapist Under Reciprocal Billing Arrangements

It is common practice for physical therapists to retain substitute physical therapists to take over their professional practices when the regular physical therapists are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physical therapist to bill and receive payment for the substitute physical therapists services as though he/she performed them. The substitute physical therapist generally has no practice of his/her own and moves from area to area as needed. The regular physical therapist generally pays the substitute physical therapist a fixed amount per diem, with the substitute physical therapist having the status of an independent contractor rather than of an employee. The substitute physical therapists are generally called “locum tenens” physical therapists.

Reimbursement may be made to a physical therapist submitting a claim for services furnished by another physical therapist in the event there is a reciprocal arrangement. The reciprocal arrangement may not exceed 14 days in the case of an informal arrangement. Effective for claims submitted on or after June 15, 2012, the reciprocal arrangement may not exceed 60 continuous days in the case of an arrangement involving per diem or other fee-for-time compensation. Providers participating in a reciprocal arrangement must be enrolled with the Alabama Medicaid Agency. The regular physical therapist should keep a record on file of each service provided by the substitute physical therapist and make this record available to Medicaid upon request. Claims will be subject to post-payment review.



Coming in July! Digital Submission of Certain Medical Records

Providers will be able to fax or upload Hospice, Long Term Care (LTC), Inpatient Psychiatric (IP), Psychiatric Retrospective Review, Post Hospital Extended Care (PEC) Bed and Swing Bed medical records for review via the Forms menu of the Alabama Medicaid Interactive Web Portal starting in July. Providers will be able to access a listing of digital LTC forms currently only available in paper within the Forms Library of the Alabama Medicaid Website. The recipient's 13-digit Alabama Medicaid number, providers' Medicaid ID number, and recipient's first and last name will be required to submit medical records for review. Additionally, Source of Admission is required for Psychiatric records.

The required format for document upload is that of PDF. If a provider does not have the capability to create PDF versions of the medical records, a fax cover sheet will be provided on the Alabama Medicaid Interactive Web Portal for the submission of documentation via fax.

Please note an Alabama Medicaid Interactive Web Portal account is required to access this functionality.

The start date and instructions for Digital Submission will be available on the Forms Library of the Alabama Medicaid Website. Instructions for Digital Submission will also be available via the Forms menu of the Alabama Medicaid Interactive Web Portal.

Oncotype DX™

Effective July 1, 2013, Medicaid began covering the Oncotype DX™ genetic profiling lab test for patients meeting Medicaid's prior authorization criteria. Oncotype DX™ is a genetic profiling test developed to classify the risk of recurrence among women treated for early stage breast cancer. **The PA request must be received by the Agency's fiscal agent, HP, within 30 days from the requested date of service.** Please read Chapter 4, Obtaining Prior Authorization, in the Provider Manual for information about submitting a PA request,

http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.8_Provider_Manuals_2014/6.7.8.2_April_2014/Apr14_04.pdf

The use of the 21-gene RT-PCR Assay (i.e., Oncotype DX™) to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy meets Alabama Medicaid's medical criteria for coverage in women with early stage breast cancer with **all** of the following characteristics:

- Newly diagnosed, primary, early stage breast cancer (stage I or stage II) in a female without significant co-morbidities;
- Unilateral, non-fixed tumor;
- Hormone receptor positive (ER-positive or PR-positive);
- HER2-negative;
- Tumor size 0.6 - 1 cm with moderate/poor differentiation or unfavorable features OR tumor size > 1 cm;
- Node negative;
- Will be treated with adjuvant endocrine therapy, e.g., tamoxifen or aromatase inhibitors; AND
- When the test result will aid the patient in making the decision regarding chemotherapy (i.e., When chemotherapy is considered a therapeutic option); AND
- When ordered within 6 months following breast cancer diagnosis.



Limitations:

- The 21-gene RT-PCR Assay Oncotype DX™ should only be ordered on a tissue specimen obtained during surgical removal of the tumor and after subsequent pathology examination of the tumor has been completed and determined to meet the above criteria (i.e., the test should not be ordered on a preliminary core biopsy).
- The test should be ordered in the context of a physician-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy. This discussion must be documented in the patient's clinical record and a copy of the progress note (signed by the ordering physician) must accompany the PA request (Form 342).
- The Oncotype DX™ test will be limited to one per lifetime, per recipient.
- Repeat tests will not be covered.
- The test will be limited to the following diagnoses: malignant neoplasm of the female breast, carcinoma in situ of breast, and personal history of malignant neoplasm, breast.

Providers must bill procedure code S3854 (gene expression profiling panel for use in the management of breast cancer). The Oncotype DX™ will be exempt from Patient 1st and EPSDT requirements. The Form 342 **must be** completely filled out, signed by the ordering physician and indicate the name and phone number of the ordering physician. The Form 342 will suffice as the prescription for the test. The form 342 is located at this link on the website, http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.1_Billing/5.4.1_PA_Form_342_Revised_Fillable_12-7-11.pdf.

The test must be performed by an enrolled independent laboratory and ordered by a physician.

Please contact Russell Green at Russell.Green@medicaid.alabama.gov for any questions.

All Hospitals: Change of Ownership (CHOW) and Closures

Effective July 1, 2014, and thereafter, hospitals are to notify Medicaid of any Change of Ownership (CHOW) or closure as soon as it is known to ensure proper payment and prevent recoupments.



Procedures Following a Change in Ownership:

- When Medicaid or HP Enterprise Services (HPES) verifies an ownership change or closure of an acute care hospital (Public or Private), the hospital's contract will be end dated effective with the date of the sale or closure.
- The facility's new owner should submit an enrollment application to Medicaid as soon as the purchase has been finalized. When HPES approves the new enrollment application, the hospital will be assigned a Medicaid provider number and a temporary six-month contract based on the effective date of the CHOW.
- This temporary enrollment will allow the new owners to bill for services provided on or after the CHOW effective date. It will also allow Medicaid time to receive the Certification and Transmittal (C&T) form from the Alabama Department of Public Health (ADPH). Once the C&T is received from ADPH, then Medicaid will update the hospital's contract. If Medicaid is not notified of the CHOW within six months, the contract will automatically expire.

Claims Processing:

- Claims for dates of service on or after the ownership change must be filed using the NPI/Medicaid ID for the new owner.
- Claims for dates of service prior to the date of the ownership change will continue to be billed under the previous owner's NPI.

Procedure Following a Closure

In the event that a hospital is closed, HPES will end date the hospital's contract effective the date of the closure. Any claims paid for dates of service after the closure will be recouped.

For Additional Information

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

ATTENTION

EPSDT SCREENING PROVIDERS

When submitting a claim for an EPSDT screening, you must enter the modifier 'EP' in the first modifier position. If other modifiers are necessary, please append in the other positions.

Eye Care Providers

HP has made the necessary system changes to allow benefit limits for recipients under 21 to display during the eligibility verification process (Medicaid Secure web portal, Provider Electronic Solutions and Automated Voice Response System). The Provider Assistance Center will no longer provide eligibility verification to eye care providers for recipients less than 21 years of age.



Provider Application Fees Required by the Federal Government

Federal regulations now require States to collect an application fee from all reenrolling or newly enrolling institutional providers. States must collect this fee from institutional providers prior to enrollment or reenrollment if these providers have not paid a fee to Medicare or another State or are not enrolled with Medicare, another State's Medicaid program, or CHIP. Physicians and non-physician practitioners are not subject to the fee. The application fee amount is established by CMS and is updated annually. Currently the FY2014 fee amount is \$542.

Institutional providers who are required to submit a fee include, but are not limited to the following: ambulance service suppliers, ambulatory surgical centers, hospitals, community mental health centers, DME suppliers, rural health clinics, outpatient therapy groups, hospices, home health agencies, rehabilitation facilities, extended care facilities, laboratories, federally qualified health centers, end stage renal disease centers, etc. (A complete list can be viewed on the Agency website at www.medicaid.alabama.gov.)

Institutional providers must submit the application fee in the form of a certified or cashier's check at the time of their initial enrollment or reenrollment. The application fee should be mailed to HPES Provider Enrollment Department at P. O. Box 241685, Montgomery, Alabama 36124-1685. Those institutional providers who have paid the application fee to Medicare or another State or are enrolled with Medicare, another State's Medicaid program, or CHIP will be exempt from paying the fee to Alabama Medicaid. Proof of this payment or enrollment must be submitted by the provider at the time of initial enrollment or reenrollment. Providers may also request a hardship exception from CMS as needed. If a hardship exception is granted by CMS, proof of the exception should be submitted to Alabama Medicaid at the time of initial enrollment or reenrollment. Providers can obtain more information on the hardship exception by visiting www.cms.gov.

Changes to Medicaid's provider enrollment system and the enrollment web portal are being developed and will be implemented by July 1, 2014. Any initial applications or revalidations from institutional providers already submitted or to be submitted will be subject to the application fee.

If you have any questions, please contact Provider Enrollment at 1-888-223-3630, option 1.

Institutional providers who are required to submit a fee include but are not limited to the following:

- Ambulance service suppliers
- Ambulatory surgical centers
- Hospitals
- Community mental health centers
- DME suppliers
- Rural health clinics
- Outpatient therapy groups
- Hospices
- Home health agencies
- Rehabilitation facilities
- Extended care facilities
- Laboratories
- Federally qualified health centers
- End stage renal disease centers, etc.

A complete list can be viewed on the Agency website at www.medicaid.alabama.gov.)



CareCore National to Process Cardiology Prior Authorizations

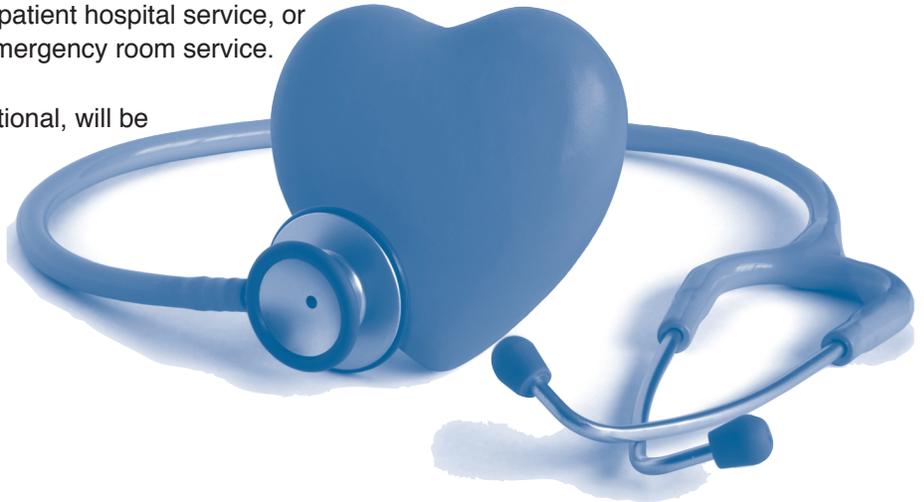
The Alabama Medicaid Agency contracted with CareCore National to implement a Cardiology prior authorization program. Additional information will be forthcoming regarding the date when CareCore will begin accepting PA requests in the next few months. CareCore National is a healthcare solutions company with a specialty in cardiac imaging and cardiac implantable management.

For all cardiology services such as Nuclear Cardiology, Diagnostic Heart Catheterization, Stress Test (ECHO), Transesophageal Echo, and Transthoracic Echo, ordering providers will be required to request and receive prior authorization (PA) from CareCore National. Additional information will be forthcoming regarding the time schedule when CareCore National will begin accepting PA requests.

Exclusions from the PA requirement will be:

- Cardiology services performed as an inpatient hospital service, or
- Cardiology services performed as an emergency room service.

During the upcoming months, CareCore National, will be sending you more information to facilitate a smooth and successful transition regarding our cardiology management program. Providers with additional questions may contact Russell Green, Associate Director, Medical Services Division at Russell.Green@medicaid.alabama.gov, or by telephone at (334) 353-4783.



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



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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.