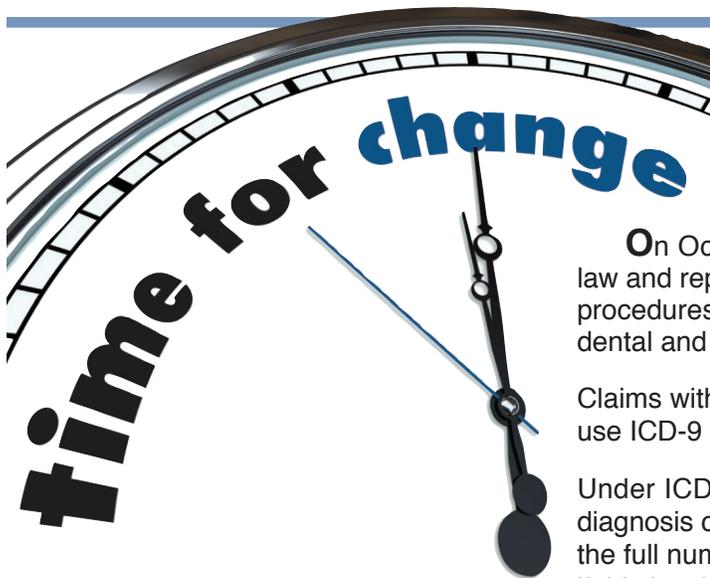


# Provider Insider

Alabama Medicaid Bulletin

October 2015



## October 1, 2015

### ICD-10 IMPLEMENTATION

On October 1, 2015, Alabama Medicaid will comply with federal law and replace ICD-9 code sets used to report diagnosis and inpatient procedures with ICD-10 code sets. All providers, with the exception of dental and pharmacy providers, are affected by this change.

Claims with dates of service prior to October 1, 2015, must continue to use ICD-9 codes.

Under ICD-10, diagnosis codes will be more detailed. Valid ICD-10 diagnosis codes will contain 3 to 7 characters and must be taken out to the full number of characters required for the code. The claim will deny if this level of information is not provided.

Surgical procedure codes will be substantially different with ICD-10. Surgical procedure codes under ICD-10 use 7 alphanumeric digits instead of the 3 or 4 numeric digits under ICD-9.

In response to requests from the provider community, CMS released additional guidance in July that allows flexibility in Medicare claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set. While the guidance speaks specifically to Medicare, it is the intent of Alabama Medicaid Agency to follow a similar policy. To that end, program integrity auditors and contractors will not deny physician or other practitioner claims as long as the provider used a valid ICD-10 code from the right family of codes.

A “family of codes” is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. However, the code may require more than three characters to be valid.

Other guidance for providers related to the implementation of ICD-10 is available on the Agency’s website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) > Providers > ICD-10.

## In This Issue

ICD-10 Implementation .....	1
How to File Claims that Span October 1, 2015 ICD-10 Implementation Date .....	2
ATTENTION: All Providers .....	2
FAQ Questions Related to Review of Denied Claims .....	3
REMINDER: Recovery Audit Contractor (RAC) Audits .....	4
Modifiers Matter when Coding Multiple Procedures/Services .....	4
Ordering, Prescribing and Referring Providers Must Enroll Electronically .....	5
PERM Reviews Begin October 2015 .....	5
Common Errors that Slow Down the Review Process of Denied Claims .....	5
Emotional and Behavioral Assessment .....	5
Claims for Drug Testing Performed in Providers’ Offices .....	6
Radiopharmaceutical Drugs (Invoice Priced) .....	6
HP Provider Representatives .....	7
Check Write Schedule .....	8

## 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.

## **HOW TO FILE CLAIMS THAT SPAN OCTOBER 1, 2015 ICD-10 IMPLEMENTATION DATE**

Alabama Medicaid will follow the same guidelines published by CMS for general claims submission and for claims that span the ICD-10 mandated implementation date.

**Institutional Claims: Split Bill According to Bill Type in the table below:**

Bill Type	Claims Processing Requirement	Use From or Through Date
11X	Do Not Split Claims	Through
12X	Split Claims	From
13X	Split Claims	From
14X	Split Claims	From
18X	Do Not Split Claims	Through
21X	Do Not Split Claims	Through
22X	Split Claims	From
23X	Split Claims	From
33x	Split Claims	From

**IF Bill Type uses a THROUGH date, do not split bill:**

Dates of service covers period from: 9/15/15 – 10/01/15

One claim should be submitted.

Entire claim is to be billed using ICD-10 codes.

**If Bill Type uses a FROM date, split bill:**

Dates of service covers period from: 9/28/15 – 10/28/15

One claim for dates of service 9/28/15 through 9/30/15 is to be billed using ICD-9 codes

AND

One claim for dates of service 10/1/15 through 10/28/15 is to be billed using ICD-10 codes

**Professional Claims: Split Bill All claims except:**

- Anesthesia: Anesthesia procedures that begin on 09/30/15 but end on 10/01/15 are to be billed with ICD-9 diagnosis codes **AND** are to use 09/30/15 as both the “from” and “through” date of service.

**How to file claims if your software vendor is not ready.**

You may use the free Provider Electronic Solutions software furnished by HPE, or the Alabama Medicaid Provider Web Portal to submit your claims. Both methods are ICD-10 compliant.

## **ATTENTION: ALL PROVIDERS**

Please review the Provider Manual, Appendix O, Assistant at Surgery Codes. Medicaid requires the use of modifier AS to report non-physician assistant-at-surgery services. In general, Medicaid recognizes modifier AS according to Medicare standards. Page 2 of Appendix O, has a listing of surgical codes that may be appended with the AS modifier.

## FAQ QUESTIONS RELATED TO REVIEW OF DENIED CLAIMS

**Q: I have a claim that has denied for multiple surgeries, same DOS, how can the claim receive a review?**

**A:** If a claim denies multiple surgery same DOS, and the provider believes the procedures are medically necessary and would like the claim reviewed, a clean claim (error free on an original red drop out ink form) along with Operative Notes should be sent in to HP for processing. *There is no request form for this review request. Please include a letter with your notes and reference the applicable ICN.*



**Q: I have a claim that has denied for quantity restriction, how can the claim receive a review?**

**A:** A claim denies for quantity restriction, and the provider believes the additional units are medically necessary and would like the claim reviewed, a letter explaining the reason for review, a clean claim (error free on an original red drop out ink form) along with Operative Notes should be sent to the Medicaid Agency for review. *There is no request form for this review request. Please include a letter with your notes and reference the applicable ICN.*



**Q: I have a claim that has denied for an NCCI error, how can the claim receive a review?**

**A:** If a claim has denied for an NCCI error, and the provider believes the services should be allowed and would like the claim reviewed, an NCCI redetermination form, along with a clean claim (error free on red drop out ink form) along with any clinical documentation should be attached. First level review should be sent to HP for processing.

HP Enterprise Services  
Attention: NCCI Review  
PO Box 244032  
Montgomery, AL 36124

**Q: I have a claim that has denied for past timely filing limit, how can the claim receive a review?**

**A:** If a claim is more than one year old, but is within 60 days of becoming outdated, a provider may request an administrative review of a claim. If the provider believes an administrative error on behalf of HP or the Medicaid Agency prevented processing of the claim within the filing limit, and the provider would like the claim reviewed, Form 402 (Request for Administrative Review) must be completed, along with a clean claim (error free on an original claim form), and attach necessary documentation to support administrative review request. This request should be sent to the Medicaid Agency for review.

Alabama Medicaid Agency  
Attention: System Management Unit (Room 2046)  
PO Box 5624  
Montgomery, AL 36103-5624

If you have any questions related to claims processing or a question regarding a claim denial, please call the Provider Assistance Center at 1-800-688-7989.

# REMINDER:

## RECOVERY AUDIT CONTRACTOR (RAC) AUDITS

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

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

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

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

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

Questions regarding the audits should be directed to Ethel Talley, RAC Program Managers, (334) 242-5340 or [ethel.talley@medicaid.alabama.gov](mailto:ethel.talley@medicaid.alabama.gov) or Sandra Shaw at (334) 242-5372 or [Sandra.shaw@medicaid.alabama.gov](mailto:Sandra.shaw@medicaid.alabama.gov) or Bakeba Thomas, Provider Review Associate Director, at (334) 242-5634 or [bakeba.thomas@medicaid.alabama.gov](mailto:bakeba.thomas@medicaid.alabama.gov).

## MODIFIERS MATTER WHEN CODING MULTIPLE PROCEDURES/SERVICES

### Modifier 59 (Distinct Procedural Service)

Modifier 59 is used to identify procedures/services, other than E&M services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries). **Medicaid does not limit Modifier 59 for use only when overriding an NCCI modifier.** Modifiers XE, XP, XS, and XU are effective for dates of service beginning January 1, 2015, and thereafter. These modifiers provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) The modifiers are defined as follows:

- **XE – Separate encounter:**  
A service that is distinct because it occurred during a separate encounter.
- **XP – Separate practitioner:**  
A service that is distinct because it was performed by a different practitioner.
- **XS – Separate structure:**  
A service that is distinct because it was performed on a separate organ/structure.
- **XU – Unusual non-overlapping service.**

### Modifier 76 (Repeat Procedure by Same Physician)

The physician may need to indicate that a procedure or service was repeated **subsequent** (following-generally indicates coming at a later time on the same date of service) to the original procedure or service. This circumstance may be reported by adding the modifier 76 to the repeated procedure/service. From a coding perspective, modifier 76 is intended to describe the **same procedure or service repeated at a later time that day**, rather than the same procedure being performed at multiple sites during the same encounter.

## **ORDERING, PRESCRIBING AND REFERRING PROVIDERS MUST ENROLL ELECTRONICALLY**

In October of 2014, an electronic enrollment application was implemented for OPR (Ordering, Prescribing and Referring) providers. For future enrollments, OPR providers should begin utilizing the Electronic Provider Enrollment Application Portal. The following is a link to the portal: <https://medicaidhcp.alabamaservices.org/providerenrollment/Home/ProviderEnrollment/tabid/477/Default.aspx>.

By selecting Enrollment Application on the Home Page, the user is taken to a series of pages where data for the enrolling provider is to be entered. Users should select the Enrollment Type of OPR to access pages applicable to an OPR application.

Please be aware as of November 1, 2015, the downloadable, paper OPR application will no longer be available on the Alabama Medicaid Agency website and will also no longer be accepted by the HPES Provider Enrollment Department.

## **PERM REVIEWS BEGIN OCTOBER 2015**

The Payment Error Rate Measurement (PERM) audits authorized by the Centers for Medicare & Medicaid Services (CMS) will begin October 1, 2015. The PERM program measures improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP) and produces state and national-level error rates for each program. APlus Government Solutions is the CMS PERM Review contractor for this audit. If contacted by the Contractor requesting medical records, it is very important that providers comply with the requests and submit documentation in a timely manner. Providers should ensure records are legible and complete (i.e. physician signatures, correct dates, treatments plans, progress notes, etc.). For questions, please contact Bakeba R. Thomas, PERM Program Manager via email:

[Bakeba.Thomas@medicaid.alabama.gov](mailto:Bakeba.Thomas@medicaid.alabama.gov).



## **COMMON ERRORS**

### **THAT SLOW DOWN THE REVIEW PROCESS OF DENIED CLAIM**

The following is a list of common errors that the Alabama Medicaid Agency encounters which will slow down the process of reviews:

1. **Using an incorrect form.** For example, sending NCCI denials on an Outdated Claim form. These reviews are handled by different staff and sending on the incorrect form causes delays. Make sure you have the correct form.
2. **Sending an NCCI Administrative Review directly to the Alabama Medicaid Agency BEFORE sending your appeal to HPE.** All NCCI denials MUST be appealed to HPE first.
3. Not including the red drop-out ink form for review.
4. No medical documentation for review.

## **ASSESSMENT**

### **EMOTIONAL AND BEHAVIORAL**

Effective for dates of service October 1, 2015, and thereafter. Alabama Medicaid will cover procedure code 96127 (Emotional and Behavioral Assessment) for children age 3 - 20. Assessments must be ordered and signed by a Physician, or non-physician practitioner (i.e., Psychologist, Physician Assistant, and Certified Registered Nurse Practitioner).



## **CLAIMS FOR DRUG TESTING PERFORMED IN PROVIDERS' OFFICES**

Effective for claims with dates-of-service of January 1, 2015, and thereafter, Alabama Medicaid will cover CMS HCPCS G-codes (G0434 and G6058). A QW modifier must be used for crossover claims. The coverage will permit payment of claims submitted by providers with a valid CLIA certificate.

- HCPCS code G0434 will cover one drug screen, regardless of the number of drugs or classes, procedure(s)/methodology (ies), any source(s), per appropriately billed date of service. (Only one claim per date of service will be paid regardless of the number of drug screens performed.)
- HCPCS code G6058 will cover one drug test (confirmatory and/or definitive, qualitative and quantitative), regardless of the number of drugs or drug classes, procedure(s)/methodology (ies), source(s), including sample validation. (Only one appropriately billed claim per date of service will be paid regardless of the number of confirmatory and/or definitive, qualitative and quantitative drug tests performed.)

These codes will remain in effect until CMS creates new G-codes, modifies and publishes its new drug test policy, or until notified otherwise. Providers may resubmit drug test screening claims which were denied in 2015 **for CLIA indicator reasons**. If any other reason exists for the denial either in part or as the entire reason, the claim may **not** be resubmitted. Resubmitted claims should use the appropriate G-code above (use the "QW" modifier with crossover claims only). If there are any questions concerning this matter, providers may contact Russell Green at (334) 242-5554, or (334) 353-5017, by email at [Russell.Green@medicaid.alabama.gov](mailto:Russell.Green@medicaid.alabama.gov).

## **RADIOPHARMACEUTICAL DRUGS (INVOICE PRICED)**

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

- Providers must send invoice price for payment.
- The claim must be sent on paper with a description of the drug attached.
- Providers should submit a red drop-out ink claim with the complete name of the drug, total dosage that was administered and a National Drug Code (NDC) number.
- The claims containing the radiopharmaceutical procedure code must be sent to:

HP  
Attn: Medical Policy  
PO Box 244032  
Montgomery, AL 36124-4032

HP will determine the price of the drug.



## HP PROVIDER REPRESENTATIVES

855-523-9170

HP Provider Representatives may be reached by dialing 1-855-523-9170 and entering the appropriate seven digit extension. Provider Representatives travel throughout the state of Alabama and into bordering states within a 30 mile radius. They are available for onsite training for issues related to billing, Medicaid Interactive Web Portal, or Provider Electronic Solutions software. Please contact any Provider Representative for assistance with billing related issues.



**ALEETRA ADAIR**  
aleetra.adair@hpe.com  
Ext. 1121057



**CATHERINE JACKSON**  
catherine.jackson@hpe.com  
Ext. 1121067



**KARITA PATILLO**  
karita.patillo@hpe.com  
Ext. 1121047



**WHITNEY ANDERSON**  
whitney.anderson@hpe.com  
Ext. 1121025



**LAURYN MORGAN**  
lauryn.morgan@hpe.com  
Ext. 1121048



**DEBBIE SMITH**  
debbie.smith2@hpe.com  
Ext. 1121066



**MISTY NELSON**  
misty.nelson@hpe.com  
Ext. 1121077



**MELISSA GILL**  
Melissa.gill@hpe.com  
Ext. 1121058



**GAYLE SIMPSON-JONES**  
gayle.simpson-jones@hpe.com  
Ext. 1121065



**TORI TILLERY-DENNIS**  
tori.tillery-dennis@hpe.com  
Ext. 1121064



**CEDRIC RICHARDSON**  
cedric.richardson@hpe.com  
Ext. 1121043



**Alabama  
Medicaid  
Bulletin**

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**Check Write Schedule Reminder:**

10/02/15	02/05/16	06/03/16
10/16/15	02/19/16	06/17/16
11/06/15	03/04/16	07/08/16
11/13/15	03/18/16	07/22/16
12/04/15	04/08/16	08/05/16
12/11/15	04/22/16	08/19/16
01/08/16	05/06/16	09/09/16
01/22/16	05/20/16	09/16/16

The release of funds is normally the second Monday after the check write (remittance advice) date. Please verify direct deposit status with your bank. As always, the release of direct deposit and checks depends on the availability of funds.