

Provider Insider

Alabama Medicaid Bulletin

July 2015

MAJOR CHANGE: Effective for check writes July 24, 2015, and thereafter, Providers' 835 electronic remittance advices will NOT be available to providers immediately following the check write.

After implementation of Rule 370 on 7/15/15, the 835 electronic remittance advices will be released on the same date (or within three business days) as the EFTs are released.

For Example:

Currently check write is 07/10/15:
835 electronic remittance advices are available on 07/13/15.
EFTs are released on 7/20/15.

After 7/15/15 implementation; Check write is 07/24/15:
EFTs will be released on 8/3/15. 835 electronic remittance advices will be available between 8/3/15 and 8/6/2015 (within 3 business days of the EFT release).

Please see the article "EFT and 835/ERA Elapsed Time Requirement – Rule 370" for more details.



ONE HEALTH RECORD®

EVEN MORE BENEFICIAL FOR MEDICAID PROVIDERS

As a provider, would you like to know if your patient has a medical history with other providers? Would it be helpful to know if your patient has received treatment or prescriptions from another source? One Health Record®, Alabama's statewide health information exchange (HIE), can be a particular benefit for Medicaid providers in answering those questions. All Medicaid claims data since 2008 is part of available information in One Health Record® as well as medical history from any providers that are already a part of our HIE (and the number of providers on that list is growing each month.)

One Health Record® can work with your EHR vendor to provide connectivity into your medical records system. We can even provide a web based interface for you to view our medical information. If you have not yet taken the plunge into an electronic medical records system yet, we would love the opportunity to discuss how we can benefit your practice. For more information please contact Stella Stewart at 334-353-3651.

In This Issue

Major Change	1
One Health Record® Even More Beneficial for Medicaid Providers	1
Recipient Signature	2
REMINDER: Recovery Audit Contractor (RAC) Audits	2
Huckabee Takes Lead of Dental Team at Alabama Medicaid	3
Resubmission of Previously Denied Cardiology Claims	3
Implementation of Affordable Care Act (ACA) Phase III Operating Rules	4-5
Durable Medical Equipment (DME) Program Changes and Reminders	7
HP Provider Representatives	6
ICD-10 General Overview and Testing Teleconferences	7-8
Check Write	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.

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 the following people:

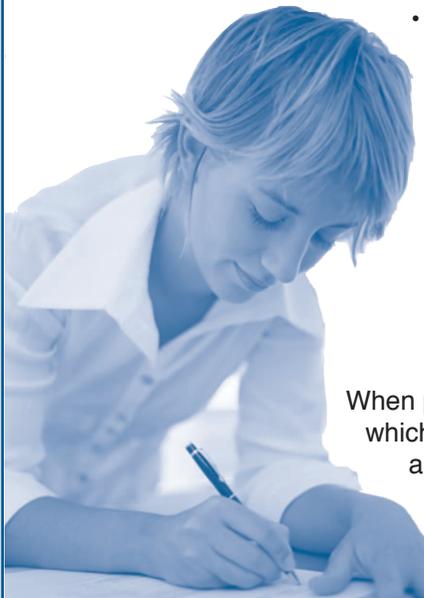
- Ethel Talley, RAC Program Manager, at (334) 242-5340 or ethel.talley@medicaid.alabama.gov
- Sandra Shaw at (334) 242-5372 or Sandra.shaw@medicaid.alabama.gov
- Bakeba Thomas, Provider Review Associate Director, at (334) 242-5634 or bakeba.thomas@medicaid.alabama.gov

RECIPIENT SIGNATURE

All providers must obtain a signature to be kept on file as verification that the recipient was present on the date of service for which the provider seeks payment (e.g., release forms or sign-in sheets). A recipient signature is not required on individual claim forms. Recipient signatures are required on all pharmacy and Durable Medical Equipment (DME) claims to ensure the recipient was offered appropriate counseling (if applicable) and to validate the billed and reimbursed service was rendered to the recipient. For pharmacy and DME items that have been delivered, the provider must ensure that the delivery service obtains the recipient's signature upon delivery. Exceptions to the recipient signature are listed below.

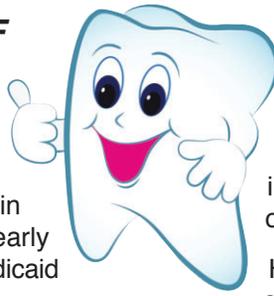
- The recipient signature is not required when there is no personal recipient/provider contact (e.g. laboratory or radiology services). This exception does not apply to pharmacy and/or DME claims.
- Illiterate recipients may make their mark, for example, "X" witnessed by someone with their dated signature after the phrase "witnessed by."
- Interested parties may sign claim forms for recipients who are not competent to sign because of age, mental, or physical impairment.
- Home Health recipient signatures are obtained on the Home Health certification form which acknowledges services are medically necessary and approved for payment.
- The recipient signature is not required when a home visit is made by a physician. The physician must provide documentation in the medical record that the services were rendered.
- For services rendered in a licensed facility setting, other than the provider's office, the recipient's signature on file in the facility's record is acceptable.
- Unless clinically contraindicated, the recipient will sign the treatment plan to document the recipient's participation in developing and/or revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent/foster parent/legal guardian must sign the treatment plan.

- Treatment plan review, mental health consultation, prehospitalization screening, crisis intervention, family support, Assertive Community Treatment (ACT), Program for Assertive Community Treatment (PACT), and any nonface-to-face services that can be provided by telephone do not require recipient signatures when provided by a Rehabilitation Option Provider.



When payment has been made on claims for which the recipient signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recovered.

HUCKABEE TAKES LEAD OF DENTAL TEAM AT ALABAMA MEDICAID



The Alabama Medicaid Agency has named Elizabeth Huckabee as the Dental Team Lead in the Medical Support Unit. Huckabee brings nearly eight years of knowledge and experience in Medicaid eligibility to the job.

Huckabee's experiences in managing Medicaid eligibility caseloads at the Montgomery Resource Center, as well as in the Medicaid Third Party Division, and as a food stamps caseworker with the Department of Human Resources make

her a valuable asset to the Dental Program, said Beverly Churchwell, Associate Director of the Medical Support Unit. Huckabee has a Bachelor's of Science in English as well as Master's degree in Foundations of Education with an English concentration.

Huckabee says she is excited to learn and work with our dental providers to give the state's children the best oral health possible.

Please contact Beth at Elizabeth.huckabee@medicaid.alabama.gov for questions regarding Alabama Medicaid dental policy.

RESUBMISSION OF PREVIOUSLY DENIED CARDIOLOGY CLAIMS

Providers with cardiology claims that were denied for no prior authorization may resubmit those claims for payment under certain conditions.

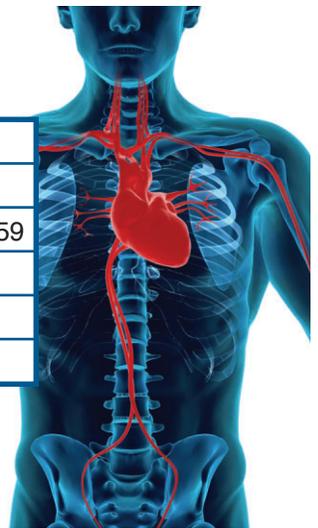
In order to resubmit a denied claim, the following criteria must be met:

1. The date of service occurred between October 1, 2014, and June 30, 2015.
2. Provider obtained a PA for a cardiology procedure code, but during or after the procedure was performed, the procedure code required a change based on medical necessity. For example, procedure code 93303 was prior authorized but 93306 was actually performed. The claim then denied for no PA.
3. The new procedure code must be an authorized substitute code within the same category of the procedure code authorized on the original PA. For example, the original PA was for 93303, but 93306 was actually performed. Since 93306 is in the same category (Transthoracic Echo), the substitute code 93306 is allowed.

- Payment will be allowed for the resubmitted cardiology claims if all the above criteria are met. Otherwise, providers should not resubmit claims for payment.
- If no PA was obtained prior to date of service, providers may not submit or resubmit a cardiology claim for payment.
- If a new, unrelated procedure code (not in the same category) was performed in lieu of the procedure authorized on the PA, payment will not be allowed.
- In the event a procedure was performed without obtaining a PA and subsequently a PA is requested, Medicaid's urgent guidelines will be utilized to evaluate the request.

Providers are required to obtain PAs for the following cardiology procedure codes:

Category	Procedure Codes
Nuclear Cardiology	78451, 78452, 78453, 78454
Diagnostic Heart Catheterization	93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459
Stress Echocardiography	93350, 93351
Transesophageal Echo	93312, 93313, 93314
Transthoracic Echo	93303, 93304, 93306, 93307, 93308



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 service

Providers may request a PA by contacting eviCore (formerly CareCore) using one of the following methods:

1. Telephone 1-855-774-1318, or
2. Online: www.carecorenational.com

If there are any questions concerning this matter, providers may contact Russell Green at (334) 353-4783, or (334) 242-5554, by email at Russell.Green@Medicaid.Alabama.Gov.

IMPLEMENTATION OF AFFORDABLE CARE ACT (ACA) PHASE III OPERATING RULES

On July 15, 2015, Alabama Medicaid and HP Enterprise Services will implement updates to comply with Affordable Care Act (ACA) Phase III – Electronic Funds Transfer (EFT) & Electronic Remittance Advice (835/ERA) Operating Rules.

WHAT IS ACA PHASE III - EFT & ERA OPERATING RULES?

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

This article describes the changes being made as a result of the implementation of ACA Phase III - EFT & ERA Operating Rules, which include:

- Standardized Reporting on ERA - Rule 360
- 835/ERA Auto-Enrollment of Providers - Rule 350
- Availability of Electronic EFT and ERA Registration Forms - Rule 380/382
- EFT and ERA Re-association - Rule 370
- EFT and 835/ERA Elapsed Time Requirements - Rule 370
- Resolving Late or Missing EFT and 835/ERA Transactions - Rule 370
- Availability of Health Care Claim Payment/Advice Batch Acknowledgement - Rule 350

Alabama Medicaid has been communicating with providers regarding the upcoming implementation of ACA Phase III Operating Rules since October 2014 via Provider Insider articles, RA Banner Messages, Alabama Medicaid website updates, provider alerts, and targeted provider mailings.

Providers can find previous Provider Insider publications on the Medicaid website at:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.8_News_and_Notices.aspx

STANDARDIZED REPORTING ON ERA - RULE 360

The ERA explains the payment a provider receives for a service claim. If a service is denied or the payment is adjusted, the ERA contains the required explanation in the form of Claim Adjustment Group Codes (CAGC), Claims Adjustment Reasons Codes (CARC) and Remittance Advice Reason Codes (RARC). The Committee on Operating Rules for Information Exchange (CAQH CORE) has established a minimum set of CORE defined claims adjustment/denial business scenarios and a maximum set of CORE required CARC/RARC/CAGC combinations for each scenario.

Initial updates for Alabama Medicaid will be completed July 15, 2015. Subsequent changes will be implemented three times per year to coincide with updates received from CORE.

Explanation of Benefits (EOB) Listings are available on the Alabama Medicaid Agency website at: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.7_Manuals.aspx and will be updated after each release.

835/ERA AUTO-ENROLLMENT OF PROVIDERS - RULE 350

Upon implementation of the Phase III Operating Rules, providers who have NOT enrolled in to receive an 835/ERA will be automatically enrolled. If you have enrolled to receive an 835/ERA by the time of implementation on July 15th NO further action will be required.

What does Auto-Enrollment Mean?

The following actions will occur for Providers who have NOT enrolled for 835/ERA at the time of the implementation of ACA III:

- Trading Partner ID will be created and automatically assigned to providers.
- Personal Identification Number (PIN) Letter will be generated and mailed along with a cover sheet outlining the instructions on how to proceed.

Providers can contact the EMC Help Desk toll-free at: (800) 456-1242 if they have any questions about enrolling for the 835/ERA.

AVAILABILITY OF ELECTRONIC EFT AND ERA REGISTRATION FORMS - RULE 380/382

Upon implementation of Rules 380/382, an updated electronic EFT enrollment form and a new ERA electronic enrollment form will be accessible to providers on the Provider Enrollment Web Portal. The following graphic depicts the two new options available to providers upon accessing the Provider Enrollment Web Portal:



These updated and new forms allow providers to quickly and easily access and submit requests to Alabama Medicaid electronically. Written instructions will also be available to assist providers in completing EFT and ERA online enrollment.

EFT and ERA online forms will help you easily request:

- Initial enrollment for EFT or ERA
- Changes to existing EFT or ERA enrollment

EFT and ERA online enrollment will be available upon implementation on the Provider Enrollment portal at: <https://medicaidhcp.alabamaservices.org/providerenrollment/Home/ProviderEnrollment/tabid/477/Default.aspx>

In addition to the online forms, HPES and Alabama Medicaid updated the EFT and ERA paper forms. Specific instructions were also developed for providers to follow when completing and submitting paper enrollment forms. The revised paper forms will become available on July 15, 2015 and can be found on the Alabama Medicaid Agency website at:

http://www.medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx

EFT AND ERA RE-ASSOCIATION - RULE 370

Re-association is a process that supports matching 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.

Re-association 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.

Please contact your financial institution to request the necessary data to associate EFT payments to 835/ERAs.

Additional information on re-association, including an example letter that can be used to communicate with your bank 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.

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.

EFT AND 835/ERA ELAPSED TIME REQUIREMENTS - RULE 370

Upon implementation of Phase III Operating Rules, Alabama Medicaid will begin releasing 835/ERAs within three (3) business days (plus or minus) of the EFT being released (release of funds). This is a change to current day processes where the 835/ERA is made available to providers immediately following a checkwrite cycle even when funds related to the 835/ERA have not yet been released. 835/ERA files will be held until all corresponding funds are released. However, the 835/ERA reflecting non-payment or zero payments will be released immediately following each checkwrite cycle.

Availability of the proprietary claim Remittance Advice (RA) and 277U (Unsolicited) transaction will continue to be available on the Provider Web Portal immediately following each checkwrite cycle.

RESOLVING LATE OR MISSING EFT AND 835/ERA TRANSACTIONS - RULE 370

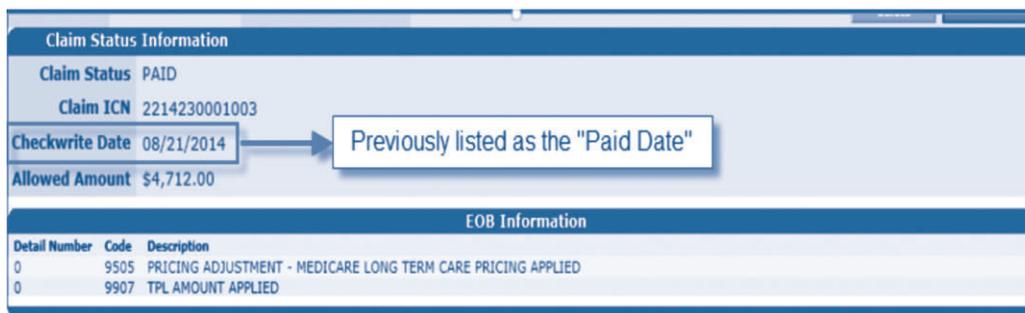
As required by Rule 370, Alabama Medicaid has developed detailed information on resolving Late or Missing EFT and 835/ERA Transactions. Late or Missing is defined as a maximum elapsed time greater than three (3) business days following the receipt of either the Healthcare EFT Standards or v5010 X12 835/ERA.

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: Monday - Friday, 7:00 a.m. - 8:00 p.m. CST, or Saturday, 9:00 a.m - 5:00 p.m. CST, via e-mail (AlabamaSystemsEMC@hp.com); phone (800-456-1242), or fax (334)-215-4272).

Provider Web Portal Change

Dental, Professional, Pharmacy and Institutional Claim Status Information panels were updated to reflect "Checkwrite Date" rather than "Paid Date". This is the date the claim is finalized through adjudication. This is not the date the EFT or 835/ERA are released.



Claim Status Information		
Claim Status	PAID	
Claim ICN	2214230001003	
Checkwrite Date	08/21/2014	
Allowed Amount	\$4,712.00	
EOB Information		
Detail Number	Code	Description
0	9505	PRICING ADJUSTMENT - MEDICARE LONG TERM CARE PRICING APPLIED
0	9907	TPL AMOUNT APPLIED

AVAILABILITY OF HEALTH CARE CLAIM PAYMENT/ADVICE BATCH ACKNOWLEDGEMENT - RULE 350

Rule 350 specifies trading partners to return a v5010 X12 999 Implementation Acknowledgement (Inbound 999) to Alabama Medicaid for each group of 835/ERA transactions received to indicate the transactions were either accepted, accepted with errors or rejected.

Alabama Medicaid Agency and HP will support (but not require) Inbound 999 Acknowledgement transactions from trading partners as a result of receiving an outbound 835/ERA transactions.

Instructions on how to submit an Inbound 999 to Alabama Medicaid 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

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.



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DURABLE MEDICAL EQUIPMENT (DME) PROGRAM CHANGES AND REMINDERS

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

RE: Revised External Ambulatory Insulin Infusion Pump Criteria

- Prerequisite Criteria
- Additional Criteria
- Required Documentation
- Criteria Checklist (required)

Revised External Ambulatory Insulin Infusion Pump

Effective **July 1, 2015**, Alabama Medicaid DME Program will be implementing the revised criteria for the External Ambulatory Insulin Infusion Pump.

All of the following criteria must be met in determining medical necessity for the insulin pump:

1. Patient must be Medicaid eligible, less than 21 years of age, and EPSDT eligible.
2. Patient must have a documented* diagnosis of insulin dependent diabetes mellitus (IDDM, also known as type I).
3. A board certified endocrinologist (BCE) must have evaluated the patient and ordered the insulin pump.
4. Patient must have been on a program of multiple daily injections (MDI) of insulin (i.e., at least three injections per day) for at least six months prior to initiation of the external ambulatory insulin infusion pump. Supporting documentation* must be submitted.
5. Patient has documented* frequency of glucose self-testing an average of at least four times per day during the six weeks prior to initiation of the insulin pump.
6. Patient and/or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with regimen of pump care, diet, exercise, medications, and glucose testing at least four times a day. Supporting documentation* must be submitted.
7. Education on insulin pump MUST have been conducted prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document* their understanding.
8. Documentation* of active and past recipient compliance with medications and diet, appointments, and other treatment recommendations must be provided.

***Documentation may include notes from the patient chart and/or pharmacy printouts (to support medication compliance history).**

One or more of the following criteria must also be met with supporting documentation*:

1. Two elevated glycosylated hemoglobin levels (HbA1c > 7.0%) within a 120-day time span, while on multiple daily injections of insulin.
2. History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements).
3. Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dL).
4. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL.

Criteria checklist must accompany the prior authorization form. The checklist is located on the Medicaid website at the link below:

http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.3.0_LTC/4.3.3.1_Durable_Medical_Equipment.aspx

If you have any questions, please contact Vivian Bristow at 334-353-4756 or Vivian.Bristow@medicaid.alabama.gov.

ICD-10 GENERAL OVERVIEW AND TESTING TELECONFERENCES

Alabama Medicaid is conducting virtual teleconferences to prepare providers and vendors for the mandated implementation of ICD-10 on October 1, 2015. Virtual training lets you take advantage of training from the convenience of your own office - all you need is a computer and telephone. There are two ICD-10 classes being offered as described below:

• **ICD-10 General Overview** - Discuss the changes being made by Alabama Medicaid for ICD-10. Topics to be covered during the session include: Alabama Medicaid website overview, affected /unaffected transactions, provider web portal and PES software changes, claim form changes, and new and modified EOBs. Time will be available for questions and answers.

• **ICD-10 Testing** - Provide information on how the changes being made by Alabama Medicaid will affect you and the transactions you submit, as well as the types of testing that should be completed prior to the CMS ICD-10 implementation date. Specific topics to be covered include: test data set-up, tips for testing, testing contact information, ICD-10 testing dates, and testing strategies. Information will also be provided on the Collaborative Testing (CollabT) tool. CollabT is a web-based, secure, hosted solution covering end-to-end testing. Alabama Medicaid is able to create a collaborative testing community with providers to support the transition to ICD-10 by evaluating the usage of appropriate ICD-10 codes for various test scenarios and their impact on business processes and outcomes.

To register for a class, follow the instructions provided below. If you have a suggestion on a topic to be covered during the teleconference or need additional information, contact the HP ICD-10 team via email at alabamaicdtesting@hp.com.

Register To attend ICD-10 Teleconference Training

Registration is required in order to attend an ICD-10 teleconference session. You may register for one or multiple sessions. To register, access the ICD-10 Teleconference Training Information page of 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

The table on the following page identifies the current schedule of teleconferences being offered by Alabama Medicaid.



Alabama Medicaid Bulletin

PRSRRT STD
U.S. POSTAGE
PAID
PERMIT # 77
MONTGOMERY AL

Post Office Box 244032
Montgomery, AL 36124-4032

This table identifies the current schedule of teleconferences being offered by Alabama Medicaid.

Class	Date	Time
ICD-10 General Overview	July 7, 2015	10:00 – 11:00 AM
ICD-10 Testing	July 7, 2015	2:00 - 3:00 PM
ICD-10 Testing	July 22, 2015	10:00 – 11:00 AM
ICD-10 General Overview	August 5, 2015	10:00 – 11:00 AM
ICD-10 Testing	August 5, 2015	2:00 - 3:00 PM
ICD-10 Testing	August 19, 2015	10:00 – 11:00 AM
ICD-10 General Overview	September 08, 2015	10:00 – 11:00 AM
ICD-10 Testing	September 08, 2015	2:00 - 3:00 PM
ICD-10 Testing	September 22, 2015	10:00 - 11:00 AM

Select the registration link associated with the session, date, and time you wish to attend. We encourage you to register today. Once your registration has been received, a confirmation e-mail will be sent along with both conference line and virtual room link instructions. We encourage testing your connectivity prior to the start of the session to confirm that you are able to successfully connect. **Please check the Alabama Medicaid website for future updates.**

Check Write Schedule Reminder:

07/10/15	01/08/16
07/24/15	01/22/16
08/07/15	02/05/16
08/21/15	02/19/16
09/04/15	03/04/16
09/11/15	03/18/16
10/02/15	04/08/16
10/16/15	04/22/16
11/06/15	05/06/16
11/13/15	05/20/16
12/04/15	06/03/16
12/11/15	06/17/16

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.