

Provider Insider

Alabama Medicaid Bulletin

October 2012

10/05/12 • 10/19/12 • 11/02/12 • 11/16/12 • 12/07/12 • 12/14/12 • 01/04/13 • 01/18/13 • 02/08/13 • 02/22/13 • 03/08/13 • 03/22/13

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



Provider Re-enrollment In Progress for All Providers

New for Re-enrollment

Starting in October, on the 5th working day of each month a list of the providers scheduled for re-enrollment will be available on the Medicaid Agency website. The list will include the provider's name, NPI and Medicaid identification number. Providers can access this list to determine if they are scheduled for re-enrollment.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Alabama Medicaid's fiscal agent, HP Enterprise Services, began the provider re-enrollment process in July 2012. Providers are selected for re-enrollment monthly based on the longest date of enrollment. A letter will be sent to the payee address on file for the provider when it is time for the provider to re-enroll. Only providers who are sent a letter will be allowed to download a facsimile from the interactive website. Please **do not** notify other providers or everyone in your network of the need to complete re-enrollment, as this has caused mass panic to those who had not yet been selected (not because they were omitted but because they were not due yet), and problems with HP receiving an influx of calls and unnecessary information.

The letter instructs the provider to log onto the Interactive Medicaid Secure website and download a facsimile of the information on file. Instructions for downloading the facsimile can also 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 Enterprise Services using the address provided on the letter and the facsimile. If changes are necessary, providers should make the appropriate changes on the facsimile. Please read the information on the facsimile carefully, as some providers have to send in additional information (For example EPSDT screening providers have to complete another EPSDT screening agreement form and return for processing). Documentation requirements can be found on the Medicaid Agency Website.

FACILITY OR GROUP: If the provider enrolling is a facility or a group (not an individual practitioner), the signed facsimile, a provider agreement for the group, any additional forms as outlined below and a provider disclosure form for each individual that is an owner, Agent, Managing employee, Officer, Directors, and Shareholders with 5% or more controlling interest must be completed and returned.

STATE AGENCIES: A list will be sent from the Medicaid program area to the DMH/DHR/DYS state agencies as providers are selected for re-enrollment. This list will be distributed by the state agencies to all of their contractors. Please check the list to see if your facility has been selected. If your facility has been selected, please complete the re-enrollment process.

NOTE: The individuals *practitioners* enrolled under the group do not complete an agreement until the provider has received notification to re-enroll. It is important to know that not all providers within the group will re-enroll at the same time.

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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 _____



Alabama Medicaid's ePrescribe System is Now Available

Medicaid formulary and prescribing history are now available to any provider utilizing an eprescribing tool. Additionally, any prescriber can now enroll to transmit prescriptions electronically through the existing Medicaid web portal.

To use the HPES Healthcare ePrescribe System, available through the Medicaid web portal, providers must be a Medicaid registered provider and request a log-on which is separate from the web portal log-on.

If the provider is permitted to prescribe electronically, the ePrescribe link will appear on the provider page of the provider portal. A provider is required to register with the Healthcare ePrescribe System. The one-time ePrescribe prescriber registration process requires entry of several key pieces of information. This includes name and contact information, DEA number (for prescribing controlled substances on paper), provider specialty and a self-created Personal Identification Number (PIN) which is used by the prescriber to finalize prescriptions written using this system. In addition, the prescriber must indicate if he/she grants access to portal delegates to perform clerical functions such as updating the patient profile or performing an eligibility transaction. If the Grant Delegate Access is set to 'Yes', provider portal delegates for that prescriber can have the ability to access the clerical functions of ePrescribe. Please note that delegates do not have the capability to finalize a prescription because the prescriber PIN is needed to complete this process. Upon completion of the prescriber profile, the only time the prescriber needs to access the profile is to update any profile information.

For questions please contact the EMC help desk at 1-800-456-1242.

Provider Re-enrollment In Progress for All Providers (continued)

INDIVIDUAL PRACTITIONER: If the re-enrollment is for an individual practitioner (not a facility or group), the provider must return the signed facsimile, the completed additional forms outlined below, the provider agreement, and the individual disclosure form.

The following forms may be required based on the provider's current enrollment:

- **EPSDT Agreement** - The agreement is required if the EPSDT specialty is indicated on the facsimile or if the Provider is adding the EPSDT specialty.
- **Plan First Agreement** - The agreement is required if the Plan 1st specialty is indicated on the facsimile or if the Provider is adding the Plan First specialty.
- **Corporate Board of Directors Resolution** - The form is required if the provider is a Physician group that operates as a corporation.
- **Electronic Funds Transfer Form** - The form is required if the facsimile has "Y" after the EFT indicator on page 2 of the facsimile.

The following documents may be required based on changes indicated on the submitted facsimile:

- **W-9 Tax Form** - The form is required if changing the service location address or the tax name.
- **CLIA Certificate** - A copy of the certificate is required if changing the CLIA certificate number.
- **DEA Certificate** - A copy of the DEA certificate is required if changing or adding a DEA number.

ON-SITE VISITS: The Affordable Care Act requires some providers have an on-site visit prior to a new enrollment and prior to re-enrollment. The on-site visits are being conducted by Medicaid's fiscal agent, HP Enterprise Services. When a Provider Relations Representative makes an on-site visit to your facility, they are done by walk-in without notification or appointment. The HP representatives will wear an employee badge with the HP logo and their photograph present; they will also provide you with a business card.

When an HP representative arrives at your office, please take a few moments to answer their brief questions, and allow them access to your facility. This will help to complete your enrollment/re-enrollment smoothly. Failure to answer their questions or assist could affect your current enrollment or re-enrollment with Alabama Medicaid.

FAILURE TO RE-ENROLL: Failure to re-enroll *and* provide appropriate documentation (including the Provider Agreement and Disclosure forms) to complete re-enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment and enroll. Providers will be REQUIRED to use the web portal application to (re)enroll with Medicaid.

If you have questions related to Provider Reenrollment, you may contact 1-888-223-3630.

Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers – Grace Period Extended Until December 31, 2012

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable only if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section: http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

HPES Provider Enrollment
P.O. Box 241685
Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict).

Medicaid will allow a grace period until December 31, 2012 for OPR providers to become enrolled. On January 1, 2013 claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the January 1, 2013 deadline.



DME Complex Rehabilitation Technology (CRT) Category

Effective October 1, 2012, Alabama Medicaid provides recognition for individually configured complex rehabilitation technology (CRT) products and services for complex needs patients under the age of 21. These HCPCS codes include complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment such as standing frames and gait trainers. Refer to Appendix P, Durable Medical Equipment (DME) Procedure Codes and Modifiers, for applicable CRT procedure codes.

Continuous Positive Airway Pressure Device (CPAP) Capped Rental

Effective January 1, 2013, the CPAP will be a capped rental to purchase item. The equipment can be rented for up to 3 months. After 3 months, if the recipient continues to meet criteria and must continue on the CPAP, the CPAP machine will transition to a purchase, with the total rental payments during the first 3 months and a subsequent one month payment equaling the purchase rate. No additional payment will be made by Alabama Medicaid on the CPAP machine and the machine will be considered to be owned by the recipient. The monthly payment will include delivery, in-service for the care giver, maintenance, repair and supplies. Recertification is required after the initial three months until the recipient no longer meets the criteria, the device is removed from the home, or the device becomes a purchased item for the recipient. If the CPAP is determined not to be medically necessary (i.e., the criteria is no longer met) and if the total rental amount paid is less than the established purchased price, the device will be returned to the supplier.



ICD-10 IMPLEMENTATION

Providers and Vendors Should Be Preparing Now For ICD-10 Implementation

The International Classification of Diseases, 10th Revision (ICD-10) medical coding system is mandated for use by the U.S. Department of Health and Human Services (DHHS); replacing ICD-9 CM codes (volumes 1-3). Due to the enhanced specificity and level of detail of the ICD-10 code set, the transition is anticipated to have a significant impact on the Alabama Medicaid program, health care providers and trading partners. ICD-10 Clinical Modification (CM) and the ICD-10 Procedure Code System (PCS) codes will improve the ability to monitor the incidence and prevalence of diseases, track treatment and health care delivery, prepare for Electronic Health Record (EHR) use, and manage reimbursement.

The current implementation date for this code set is October 1, 2013. DHHS proposed a rule that would delay the compliance date for ICD-10 from October 1, 2013 to October 1, 2014. Public comments gathered during the comment period are being analyzed and the Department will issue a final rule as expeditiously as possible.

Alabama Medicaid is currently in the process of making system modifications for ICD-10. To keep providers informed, we have created a link on the Medicaid website for ICD-10 information and updates. The link will be updated regularly as new information becomes available for providers and vendors. The link is located on the Medicaid website on the provider tab.

HP will also be asking providers and vendors to complete a readiness survey beginning in January. The links will be available on the Medicaid website, and information will be used to ensure a smooth transition for ICD-10.

ICD-10 COMMUNICATION

To receive email or fax updates concerning ICD-10 changes please take a moment to update contact information.

- **Providers**

Providers interested in receiving updates concerning ICD-10 should ensure email and fax numbers are updated by logging onto the Provider Web Portal and updating contact information.

Website: <https://www.medicaid.alabamaservices.org/ALPortal/default.aspx>

Navigation: Providers > Provider Maintenance > Provider Location Contact Information

- **Trading Partners**

Trading Partners interested in receiving updates concerning ICD-10 should ensure email addresses are updated by logging onto the Provider Web Portal and updating account information.

Website: <https://www.medicaid.alabamaservices.org/ALPortal/default.aspx>

Navigation: Account > Account Maintenance

Medicaid now has a section on our website dedicated to ICD-10. The information can be found at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx

The website will be updated regularly as new information is made available for providers.

ICD-10 TESTING

Medicaid now has a section on our website dedicated to ICD-10. The information can be found at the following link: http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.12_ICD-10/6.12_ICD-10.aspx

Testing will be available summer of 2013. Once a firm start date and further testing definition is established the website will be updated so continue to check back regularly.

ICD-10 TESTING PARTICIPATION

Alabama Medicaid would like to engage Providers and Trading Partners interested in testing ICD-10 in summer 2013. Please submit the following to alabamaictesting@hp.com.

- Provider/Trading Partner Name
- Testing Contact Name
- Testing Contact Number, Email
- List transactions interested in testing

If interested in testing and continuing to receive updates on testing please ensure your communication contact information is up to date. Please go back and review the ICD-10 Communication section on this page for directions on updating this information.

ICD-10 TYPES OF TESTING

Testing is highly encouraged and will focus on transactions that provide for the submission of ICD-10 codes.

The following is a list of transactions anticipated for testing:

- Claims - 837 Professional, 837 Institutional
- Prior Authorization
- 835 Remittance Advice

ICD-10 END-TO-END TESTING

Full End-to-End Testing will be available. The following information provides direction for setup and what to expect.

- To ensure claims submitted will be available on the 835 a link between the Trading Partner ID and the Provider ID submitted in the claims transactions must be established. The following form 835 Testing TP Link Form must be copied into an email and submitted to alabamaictesting@hp.com prior to the start of end-to-end testing. An email notification will be returned once the link has been completed and end-to-end testing may begin.
- Please submit claims transactions with an ISA15 Interchange Usage Indicator value of a "P" if an 835 is desired.
- 835 files will be available for download through the trade files option on the web portal each Friday after 3:00 pm.

ICD-10 SECURE TESTING WEBSITE

<https://www.alabama-uat.com/ALPortal/>

ICD-10 TEST MONITORING AND STATUS REPORTING

Alabama Medicaid would like to hear from Providers and Trading Partners who are actively testing and will be asking for feedback on testing efforts in general. A testing progress form will be made available once testing begins and all parties testing will be asked to complete this testing progress form.

ICD-10 GENERAL TESTING INQUIRIES

For general questions about ICD-10 testing please send an email to alabamaictesting@hp.com.

ICD-10 PROVIDER ELECTRONIC SOLUTIONS (PES) SOFTWARE

The Provider Electronic Solutions Software is currently undergoing modifications for ICD-10 and a test version will be made available for testing summer 2013.



Diagnosis Restricted Procedure Codes

In the near future, a link will be available on the Alabama Medicaid Agency's website under the Provider tab for providers to use as a reference to identify procedure codes that are diagnosis restricted. The link will list J, Q, & S procedure codes and the covered diagnosis codes. This list is not all inclusive and does not imply Medicaid coverage, reimbursement, or lack thereof. Other restrictions such as age, prior authorization, and max units may apply and can be found on the physician administered drug fee schedule. The pricing file through the Automated Voice Response System (AVRS) can also be used to determine coverage and reimbursement amounts. Providers may access AVRS by calling 1-800-727-7848. For additional information, please contact the Provider Assistance Center at 1-800-688-7989.

Payment Error Rate Measurement (PERM) Results for FY 2010 and Announcement of FY 2013 PERM Review

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. The Centers for Medicare and Medicaid Services (CMS) developed PERM to comply with the Improper Payments Information ACT (IPIA) of 2002.

Results are in for the FY 2010 PERM review. The top three reasons for Medicaid FFS Medical Review errors in terms of projected dollars in error are: policy violation, insufficient documentation, and no documentation. These errors account for over 83% of Alabama's Medical Review errors. Other errors include number of units, policy violation, pricing errors, and non-covered service. Alabama's overall error rate is 1.5% for the fee-for-service component.

The measurement for the FY 2013 cycle will begin October 1, 2012. Once the medical record review process begins, it is very important for providers to comply with the requests and submit documentation in a timely manner. Providers should ensure records are complete (i.e. physician signatures, correct dates, treatments plans, progress notes, etc.).

CMS uses contractors to conduct the PERM reviews. For FY 2010, CMS used Livanta, LLC as the statistical contractor and APlus Government Solutions as the review contractor. For the FY 2013 cycle, CMS has contracted with The Lewin Group as the statistical contractor. However, the review contractor has not been named at this time. For questions, please contact Patricia Jones (334) 242-5609, PERM Program Manager, or Jacqueline Thomas (334) 242-5318, Program Integrity Division Director.

National Correct Coding Initiative

The Centers for Medicare and Medicaid Services (CMS) initially developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Medicare Part B claims. The coding policies were based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national Medicare policies, coding guidelines developed by national societies, standard medical and surgical practice, and current coding practice.

Medicaid introduced the NCCI edits into the Medicaid claims processing system on November 9, 2010. These edits were initially set as “informational” edits. On March 23, 2011, these edits were set to deny for services that do not meet the NCCI edit criteria and were furnished on or after October 1, 2010.

CMS publishes the NCCI Coding Policy Manual for Medicare and Medicaid Services and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>).

NCCI includes two types of edits: NCCI Procedure-to-Procedure (PTP) edits and Medically Unlikely Edits (MUE).

NCCI PTP edits prevent inappropriate payment of services that should not be reported together. Services that are integral to another service are component parts of the more comprehensive service. *For example*, vaccine administration code and an evaluation and management visit code when the patient only presented for immunizations. Each edit has a column one and column two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied. The edits do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of “0”, an appeal can NEVER overturn the denial. These claims are final and no appeal is applicable except for an administrative law judge who can determine that the denied column two code should be paid. These instances will be rare.

If the NCCI edit responsible for an NCCI denial has a modifier indicator of “1”, an appeal can be submitted for review. See the example chart showing the modifier indicators 0, 1, 9.

October 2012

Column 1	Column 2	Effective Date	Deletion Date	Modifier Indicator 0=not allowed 1= allowed 9= not applicable
00100	0228T	20110101		1
00100	0230T	20110101		1
00100	0251T	20110101		1
00100	0253T	20110101	20110101	9
00100	31505	20101001		1
00100	31515	20101001		1
00100	31527	20101001		1
00100	31622	20101001		1
00100	31634	20110101		1
00100	31645	20101001		1
00100	38000	20101001		1
00100	36010	20101001		0
00100	36011	20101001		1

NCCI MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. A MUE for a HCPCS/CPT code is the maximum number of units of service (UOS) under most circumstances reportable by the same provider for the same beneficiary on the same date of service.

If a claim is denied for an NCCI MUE, the provider can resubmit the claim with the correct units as long as the units are equal to or lesser than the NCCI MUE allowed units. If the units are more than the NCCI MUE allowed units, then an appeal must be requested. See the example chart below:

HCPCS/CPT Code	Practitioner Services MUE Values
17000	1
17003	13
17004	1
17106	1
17107	1
17108	1
17110	1
17111	1
17264	3

Reminder

- Providers must report services correctly
- Providers should not report multiple HCPCS/CPT codes when a single comprehensive HCPCS/CPT

code describes these services. For example, vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy should be reported with one single code 58262.

- Providers should not fragment a procedure into component parts. For example, Upper GI Endoscopy with biopsy of stomach should be reported with 43239. It is improper to unbundle this procedure and bill 43235 (Upper GI Endoscopy Diagnostic) and 43242 (with transendoscopic ultrasound...fine needle aspiration/ biopsy).
- Providers should not unbundle services that are integral to a more comprehensive procedure (surgical access, insertion of urinary catheter, wound irrigation...).
- Providers must avoid down coding.
- Providers must avoid up coding (code only if all services described by that code are performed).
- Providers must report units of service correctly using HCPCS/CPT criteria for that code. Some codes are reported in fifteen minute increments and other codes may be reported per session. Providers should not report a "per session" code using fifteen minute increments.
- Providers should use applicable NCCI modifiers if the clinical circumstances justify the use of the modifier. A modifier should not be appended to a HCPCS/CPT code solely to bypass an NCCI edit if the clinical circumstances do not justify its use. In general these circumstances 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) not ordinarily encountered or performed on the same day by the same physician.

NCCI Administrative Review and Fair Hearing

Individual claim denials may be appealed at three levels. The levels listed in order, are:

1. Redetermination Request
2. Administrative Review
3. Fair Hearing

Redetermination

HP is responsible for the redeterminations, which is the first level of appeals and adjudication functions.

A *redetermination* is an examination of a claim and operative notes/medical justification by HP personnel. The provider has **60 days from the date of receipt of the initial claim determination to request a redetermination**. The provider must complete the HP Enterprise Services Request for NCCI Redetermination Review form. The request for a redetermination must include:

- Completed NCCI Redetermination Review form:
http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx

- Corrected Paper Claim for the procedure codes that denied
- Operative Notes/Medical Justification

Send the request for a Redetermination Review along with all supporting documentation to:

**HP Enterprise Services
Request for NCCI Redetermination
PO Box 244032
Montgomery, AL 36124-4034**

HP will normally issue a decision via the remittance advice within 90 days of receipt of the redetermination request. The ICN region for the redetermination request will begin with '91'. For example: 9111082123456.

Administrative Review

When the redetermination request results in a denial by HP, the provider may request an *administrative review* of the claim. A written request for an administrative review **must be received by the Alabama Medicaid Agency within 60 days of the date of the redetermination denial from HP**. The request should clearly explain why the provider disagrees with the redetermination denial. The request for an administrative review must include:

- Completed Form 403 - Request for National Correct Coding Initiative (NCCI)
http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.1_Billing_Forms.aspx
- Correct Paper Claim for the procedure codes that denied
- Copy of previous request for redetermination correspondence sent to HP
- Copies of all relevant remittance advices or HP's redetermination denial notification
- Copy of any other useful documentation

Send the request for an Administrative Review along with all supporting documentation to:

**NCCI Administrative Review
Alabama Medicaid Agency
Attn: System Support Unit
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624**

Fair Hearing

When the administrative review does not resolve the issue, the provider has the option to request a fair hearing. A written request must be received within 60 days of the date of the administrative review decision. The request must identify any new or supplemental documentation. Send the written request for a fair hearing to:

**Alabama Medicaid Agency
Attn: Office of General Counsel
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624**

2013 State Checkwrite Schedule

10/05/12	01/04/13	04/05/13	07/05/13
10/19/12	01/18/13	04/19/13	07/19/13
11/02/12	02/08/13	05/03/13	08/02/13
11/16/12	02/22/13	05/17/13	08/16/13
12/07/12	03/08/13	06/07/13	09/06/13
12/14/12	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 always, the release of direct deposits and checks depends on the availability of funds.

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