Alaska Medical
Assistance Program

Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, Orthotics, and Home Infusion Therapy

Provider Billing Manual

Prepared By

First Health Services Corporation
A Coventry Health Care Company

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

DIVISION OF HEALTH CARE SERVICES

FRANK MURKOWSKI, GOVERNOR

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ANCHORAGE, AK 99503-7167
PHONE: (907) 334-2400
FAX: (907) 561-1684

Dear Medical Assistance Provider:

We are pleased to provide you with the enclosed provider billing manual to help you prepare your Medical Assistance claim forms.

This billing manual has been prepared by First Health Services Corporation for the State of Alaska. First Health Services is the fiscal agent for the Alaska Department of Health and Social Services.

The manual contains basic information on coverage and billing for medical services you provide to qualified recipients of our various medical assistance programs. It is designed to help you: 1) fill out health insurance claim forms for your eligible patients, 2) understand what medical services are reimbursable, and 3) understand the policies and procedures of these programs.

As policies and procedures change, you will receive the updated information through bulletins and replacement pages to this manual. Your manual has been arranged in a loose-leaf format divided by sections and numbered so that replacement pages can be easily inserted.

It is important to review and insert the updated information promptly to keep a current reference. Claim forms with outdated information may cause the automated payment system to reject the claim request. It is extremely important that you and your claims personnel follow the instructions described in the manual for your claims to be processed quickly and efficiently.

It is our intention to make this manual useful to you, and we welcome any suggestions about the format that you believe would be helpful.

Sincerely,

Dwayne B. Peeples

Director

How To Use This Manual

Information about how to bill the Alaska Medical Assistance program for reimbursement of services rendered to medical assistance recipients is contained in this provider billing manual.

Provider billing manuals are specific to type of service (for example, there are separate manuals for inpatient hospital, physician services, pharmacy, chiropractic, etc.). Manual pages are printed on three-hole paper and mailed to providers in a loose leaf format to make updating easy. The manuals are organized in three numbered sections to assist you in finding the information you need.

- Section I contains specific information about how to bill Medical Assistance for a particular type of service.
- Section II contains information about supplemental documents and instructions.
- Section III contains general Medical Assistance program information.
- Appendices are included at the end of the manual for additional information.

A Table of Contents is included at the beginning of each provider billing manual. Use the Table of Contents to help locate information in your manual.

Updated 01/06

Current Procedural Terminology (CPT) Copyright Notice

Updated 01/06

Written Correspondence and Provider Training

The provider billing manuals are meant to be used in conjunction with other provider communication, including Remittance Advice (RA) Messages, letters and other written correspondence, and information delivered at provider training seminars.

Providers are notified of changes in billing and reimbursement policy in weekly RA Messages. An RA is issued weekly to providers with claims activity. The Message Page of the RA will contain important provider billing information (including new information, clarifications and reminders). Revised manual pages are mailed to providers after the RA Messages are issued.

Provider training topics, dates and locations are also announced in the RA Messages.

For information, questions or suggestions about the provider billing manuals, other correspondence, or provider training, contact **First Health** Services Corporation or the Division of Health Care Services at the phone numbers or addresses listed on pages v and vi.

Updated 08/03

Telephone Inquiries

First Health Services Corporation

Questions? Please call **First Health** Services Corporation at **(907) 644-6800** or our in-state toll free number, **1-800-770-5650**, about your participation in Alaska Medical Assistance. The First Health Services staff has been fully trained to answer most of your questions immediately. The following numbers can help you with other, more specific, questions:

Billing Procedures

(8:00 a.m. – 5:00 p.m.)	in-state toll free	1-800-770-5650 (907) 644-6800

Claims & Eligibility Status

(8:00 a.m. – 5:00 p.m./Claims) (8:00 a.m. – 5:00 p.m./Eligibility)	in-state toll free	1-800-770-5650 (907) 644-6800

Electronic Data Interchange (EDI)

	in-state toll free	1-800-770-5650 (907) 644-6800

Electronic Commerce Customer Support (ECCS) Coordinator

		(907) 644-6800

Eligibility Verification System (EVS)

(24-hour access)	toll free	1-800-884-3223

Enrollment

(8:00 a.m. – 5:00 p.m.)	in-state toll free	1-800-770-5650 (907) 644-6800

Fax

for Provider Inquiry (PI)	(907) 644-8126 or (907) 644-8127
for Prior Authorization (PA)	(907) 644-8131
for EDI Attachments	(907) 644-8122 or (907) 644-8123
for Resubmission Turnaround Documents	(907) 644-8122 or (907) 644-8123

Prior Authorization (PA)

(8:00 a.m. – 5:00 p.m.)	in-state toll free	1-800-770-5650 (907) 644-6800

Provider Inquiry/Provider Services

(8:00 a.m. – 5:00 p.m.)	in-state toll free	1-800-770-5650 (907) 644-6800

Report Fraud, Waste, Abuse, or Misuse of the Medicaid Program by Providers or Recipients

(24-hour access)	toll free	1-800-256-0930

Internet

First Health Services Corporation – Alaska	http://alaska.fhsc.com

Updated 04/04

Addresses

Adjustment/Voids		First Health Services Corporation P.O. Box 240807 Anchorage, AK 99524-0807
Appeals:	1st Level	First Health Services Corporation Appeals P.O. Box 240808 Anchorage, AK 99524-0808
	2nd Level	Division of Health Care Services Claims Appeal Section 4501 Business Park Boulevard, Suite 24 Anchorage, AK 99503-7167
Claims:	Hospital, ESRD, and LTC	First Health Services Corporation P.O. Box 240729 Anchorage, AK 99524-0729
	(IHS) Indian Health Services	P.O. Box 241609 Anchorage, AK 99524-1609
	Pharmacy	P.O. Box 240649 Anchorage, AK 99524-0649
	All Others	P.O. Box 240769 Anchorage, AK 99524-0769
Electronic Media Claims (EMC)/Electronic Commerce Customer Support (ECCS)		First Health Services Corporation EMC Department/ECCS Department P.O. Box 240808 Anchorage, AK 99524-0808
Enrollment		First Health Services Corporation Provider Enrollment P.O. Box 240808 Anchorage, AK 99524-0808
Inquiries and Correspondence		First Health Services Corporation Provider Services Unit P.O. Box 240808 Anchorage, AK 99524-0808
Prior Authorization		First Health Services Corporation Prior Authorization Unit P.O. Box 240808 Anchorage, AK 99524-0808
SURS (Surveillance and Utilization Review Subsystem)		First Health Services Corporation Surveillance and Utilization Review P.O. Box 240808 Anchorage, AK 99524-0808

Updated 04/04

State of Alaska

Alaska Department of Health and Social Services*

Internet Web Site: http://www.hss.state.ak.us

Call: (907) 465-3030

Alaska Medical Assistance/Division of Health Care Services

Internet Web Site: http://www.hss.state.ak.us/dhcs/contacts.htm

Call: (907) 465-3355

Medicaid Provider Fraud Control Unit, Department of Law

To report fraud of the Medicaid program *by providers*

Call: (907) 269-6279

Write: Medicaid Provider Fraud Control Unit
State of Alaska, Department of Law
Criminal Division
310 K Street, Suite 300
Anchorage, AK 99501

Fraud Control Unit, Division of Public Assistance, Department of Health and Social Services

To report *recipient* Fraud and Abuse of Medicaid and other public assistance programs

Call:

Toll free:	1-800-478-6406
In Anchorage	(907) 269-1060
In Wasilla	(907) 352-2534
In Kenai	(907) 283-2947
In Fairbanks	(907) 451-2802

Write: Fraud Control Unit
State of Alaska, DHSS
Division of Public Assistance
3601 C Street, Suite 200
Anchorage, AK 99503

Updated 08/04

* For more contact information, see Appendix A.

Prior Authorization Contacts

DME Prior Authorizations

- **First Health Services Corporation**

  Prior Authorization Unit
  P.O. Box 240808
  Anchorage, AK 99524-0808

  Phone: 1-800-770-5650 (toll-free in Alaska) or (907) 644-6800
  Fax: 907-644-8131

- **Qualis Health** (case managed patients)

  1-800-783-9207 (5:30 a.m. - 4:45 p.m., Alaska Standard Time)

SME Prior Authorizations

- **Division of Senior and Disability Services (DSDS)**

  Home and Community-Based Waiver Services
  3601 C St., Suite 310
  Anchorage, AK 99503

  Phone: 907-269-3666
  Fax: 907-269-3688

Updated 01/06

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Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, Orthotics, and Home Infusion Therapy

Table of Contents Updated 01/06

Section I
Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, Orthotics, and Home Infusion Therapy Policies and Claims Billing Procedures

Provider Participation Requirements

Durable Medical Equipment, Medical Supplies, Specialized Medical Equipment, Home Infusion Therapy, and Non-customized Fabricated Orthotics

The department may enroll a provider under this section that provides the department with evidence that the provider holds a valid business license issued under AS 43.70 and 12 AAC 12. The department will enroll a provider under this section as a provider of durable medical equipment (DME) and medical supplies (MS) including enteral and oral nutritional products, specialized medical equipment (SME), home infusion therapy services, and noncustomized-fabricated orthotics.

As of January 1, 2007, all durable medical equipment, prosthetics, orthotics, and supplies providers must submit proof of Medicare enrollment to First Health Services in accordance with Alaska Medicaid enrollment regulations in 7 AAC 43.1900(n). Information on how to enroll with Medicare may be obtained from the Centers for Medicare and Medicaid at: http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf .

Updated 06/07

Prosthetics and Orthotics

The department may enroll a provider under this section that provides the department with evidence that the provider holds a valid business license issued under AS 43.70 and 12 AAC 12. The department may only enroll a provider under this section as a provider of prosthetics and orthotics if the provider is certified by the American Board of Certification in Prosthetics and Orthotics, the Board for Orthotist/Prosthetist Certification, the National Examining Board of Ocularists, Inc., or other similar certifying agencies approved by the department.

Updated 05/06

Respiratory Therapy Equipment, Supplies and Assessment Visits

The department will pay a provider enrolled under 7 AAC 43.1900 for respiratory therapy equipment and supplies if the provider employs or contracts with a

- registered respiratory therapist who holds a valid national registry number and certificate from the National Board for Respiratory Care (NBRC) or a certificate from another body that the NBRC recognizes as a credentialing equivalent;
- certified respiratory therapy technician who holds a valid national certificate from the NBRC or a certificate from another body that the NBRC recognizes as a credentialing equivalent.

The department will enroll a registered respiratory therapist or a certified respiratory therapy technician as a rendering provider. These providers must enroll separately with the department to render respiratory therapy assessment visit services to eligible Medical Assistance recipients.

Updated 01/06

Home Infusion Therapy

The department will enroll a provider of home infusion therapy services if the provider

- holds a valid business license issued under AS 43.70 and 12 AAC 12;
- presents evidence of a pharmacy or pharmacist license issued under AS 08.80; and
- documents that it meets the guidelines for pharmacies and pharmacists under 12 AAC 52.400 - 12 AAC 52.440, by completing the Home Infusion Therapy Addendum.

The department will pay a provider that employs or contracts with a registered nurse who performs home infusion nursing services and has provided to the provider documentation of training and skills in

- intravenous insertion techniques;
- parenteral administration;
- line and site management; and
- the proper use of equipment.

Updated 01/06

Out-of-State Providers

To be paid by the department, an out-of-state provider of durable medical equipment, supplies, respiratory therapy services, home infusion therapy, prosthetics, and orthotics must be licensed and enrolled in the Medicaid program in the state in which service is provided, and must be enrolled as a Medicaid provider in Alaska.

See Section III of this manual for general enrollment requirements.

Updated 01/06

Identifying DME, MS, Customized Equipment, SME, and Miscellaneous Items or Services

Definitions

"Durable medical equipment" means equipment that

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- generally is not useful to an individual in the absence of an illness or injury; and
- is appropriate for use in the home, school, or community.

"Medical supplies" means supplies that

- do not withstand repeated use
- are primarily and customarily used to serve a medical purpose;
- generally are not useful to an individual in the absence of an illness or injury; and
- are appropriate for use in the home, school, or community.

"Customized durable medical equipment" means durable medical equipment that is uniquely constructed or substantially modified for a specific recipient according to the description and orders of a physician, physician assistant, or advanced nurse practitioner, and that is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.

"Specialized medical equipment and supplies" are devices, controls, or appliances that enable a recipient to increase the recipient's ability to perform activities of daily living or to perceive, control or communicate with the environment in which the recipient lives, or are ancillary supplies and equipment necessary for the proper functioning of those items.

"Miscellaneous" means an item or service listed in the HCPCS 2005 that is described as "miscellaneous," "not otherwise classified," or "not otherwise specified"; or without a specific description or identifier.

Updated 01/06

Noncovered Services

Concurrent Care

The department will not pay separately for durable medical equipment while the recipient is

- in a hospital[1], SNF, or ICF;
- receiving hospice care; or
- receiving DME provided by, or under arrangements made by, a home health agency.

The department will not pay for the repair of durable medical equipment while the recipient is in a SNF or ICF.

Updated 01/06

Repairs

The department will not pay separately for the repair, return shipping, or preventive maintenance or service of durable medical equipment, prosthetics, or orthotics for which the cost of repair, return shipping, or preventive maintenance or service is included in the rental fee. Payment will not be made for labor and repair parts for a rented item; the provider shall ensure that a rented item functions as intended after the provider repairs or replaces the item.

The department will not pay for labor and repair parts if the item is covered under a manufacturer's or supplier's warranty, or if the labor or parts are necessary to repair an item that needs repair because of a manufacturer's defect.

Updated 01/06

Administrative Expenses

The department will not pay separately for the cost of administrative expenses. The following costs are considered administrative expenses and are included in the payment for the durable medical equipment, medical supplies, prosthetics, orthotics, and noncustomized-fabricated orthotics:

- telephone responses to questions, calls or long distance charges
- mileage
- travel expenses
- travel time
- setting up an item
- installation
- orientation and training regarding the proper use of equipment.

Updated 01/06

[1] See "Changes During Rental Periods."

Covered Services

The department will pay an enrolled provider for medically necessary durable medical equipment, medical supplies, prosthetics, orthotics, or noncustomized-fabricated orthotics furnished to a recipient if the item

- is prescribed by the attending physician, physician assistant, or advanced nurse practitioner acting within the scope of that person's license;
- is appropriate for use in the recipient's home, school, or community.

Updated 01/06

Services while under Hospice Care

The department will pay a provider under this section, for medically necessary medical supplies, respiratory therapy assessment visits furnished to a recipient who is receiving hospice care services, if the supplies or assessment visits are

- not related to the treatment of the terminal illness that qualifies the recipient for hospice care;
- not provided by, or under arrangements made by, the hospice program.
- ordered by a physician as part of a written hospice plan of care and the physician reviews the recipient's continuing medical need for the items; and
- appropriate for use in the recipient's home, school, or community.

Equipment is provided by the hospice while the recipient is under hospice care.

Updated 01/06

Services in a Long Term Care Facility

The department will pay an enrolled provider for continuous oxygen used by a recipient in a skilled nursing facility (SNF) or intermediate care facility (ICF) if prior authorization (PA) is received and if the SNF or ICF has not been authorized to provide continuous oxygen under 7 AAC 43.255. The department may authorize the purchase or rental of durable medical equipment for a recipient in a SNF or ICF if the purchase or rental is medically necessary for the recipient's preparation for discharge or for the actual discharge to home as indicated in the discharge plan. A rental or purchase may be arranged no sooner than 30 days before the scheduled discharge and will be authorized only if the equipment is not provided by the SNF or ICF. The department may pay for trial use of rental equipment necessary for preparing a recipient for discharge.

Updated 01/06

30 Day Period

The department will only pay for medical supplies that are required by a recipient for a 30-day period. The department may seek recovery under 7 AAC 43.081 of payment for services or items determined to be medically unnecessary and impose sanctions under 7 AAC 43.950(8).

Updated 01/06

Delivery Expenses

The department will pay an enrolled provider for the reasonable and necessary costs of delivery and dispensing expenses incurred in the delivery of the items from the dispensing provider to the recipient if the

- recipient resides outside the municipality where the business of the enrolled servicing provider is located; and
- durable medical equipment, supplies, prosthetics, and orthotics are unavailable from any enrolled DME or prosthetics and orthotics provider in the municipality in which the recipient resides.

If the charge is over $50, the provider can submit a claim electronically or on paper. In either instance, the claim must include the following information:

- the recipient's name;
- the recipient's address;
- information, such as a serial number, that identifies the item;
- the delivery date; and
- the total actual charges.

The electronic claim must contain the information. The paper claim must include an invoice showing the information.

Updated 01/06

Repairs

The department will pay separately for labor and repair parts for damaged durable medical equipment, supplies, prosthetics, and orthotics with the following limitations:

- payment for labor costs will not exceed $20 for each 15 minutes;
- the billing for a repair part must reflect a charge that complies with the applicable standards in 7 AAC 43.040;
- labor and repair parts for the item must be documented as necessary; and documentation in the provider's record must include
  - a statement signed by the recipient or the recipient's authorized representative, that describes the cause for and nature of the repair;
  - a description of the item being repaired and its serial number, if available;
  - the beginning and end dates of warranty coverage, if available; and
  - documentation for labor charges that includes the amount of actual time spent on the repair, rounded up to the nearest quarter hour, and the hourly rate charged for the repair.

The department will pay a quarter hour unit charge when the time spent on the labor or repair is between 8 to 15 minutes. If the time spent is 7 minutes or less, the department will not reimburse for a quarter hour unit charge. The total time spent on all labor and repair charges must be itemized when indicated on the claim.

Updated 01/06

Purchase of Items

The department may authorize the purchase of new durable medical equipment, medical supplies, prosthetics, orthotics, and noncustomized-fabricated orthotics. The item becomes the property of the recipient for whom it is purchased. The enrolled provider shall

- transfer ownership of the item, including any warranty, to the recipient; and
- assure that the item was not previously used by a person other than the recipient.

The department will not authorize the purchase of an item that requires continuous rental including an apnea monitor, oxygen equipment, and an electric breast pump.

Updated 01/06

Replacement of Items

The department will pay for the purchase or rental of replacement durable medical equipment, prosthetics, orthotics, and noncustomized-fabricated orthotics if the

- replacement is necessary to an item that has been in continuous use by the recipient for the item's reasonable useful lifetime[2] and the department determines that the item is lost or irreparably damaged;
- item is not covered by a manufacturer's warranty; and
- provider replaces the item with a like item, and if the original item was rented, continues renting the replacement item according to 7 AAC 43.1940.

A replacement that is needed because of item wear or a change in the recipient's condition must be supported by current documentation of medical necessity. If an item is not irreparably damaged, the department may authorize the replacement of the item if the department determines that the cost of replacement would be more cost-effective than repair.

The department may authorize the replacement of equipment if the department determines that the cost of replacement would be more cost-effective than repair.

Payment will not be made for the replacement of an item that requires rental and is never purchased, such as an electric breast pump, apnea monitor, or oxygen equipment.

Updated 01/06

Bathtub and Toilet Rail Installation Charges

Charges for grab bars including bathtub wall rails, bathtub rails, or toilet rails, dispensed and installed by a provider may include labor costs for installation. A provider may not separately charge for labor costs to install a grab bar under HCPCS code E1340. Only the dispensing provider may include the labor cost for installation in the charges for a grab bar.

Updated 01/06

Oximeter Device for Measuring Blood Oxygen Levels Non-Invasively

A pulse oximetry meter measures oxygen saturation levels using a noninvasive probe. Pulse oximetry meters provide an estimate of arterial oxyhemoglobin saturation (SaO2), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO2). A pulse oximeter is a covered medical equipment item eligible for reimbursement when:

- used in a personal residence as an alternative to hospitalization to manage the care of oxygen dependent recipients;
- used for ventilator dependent patients;
- used to monitor oxygen saturation in order to determine appropriate supplemental oxygen levels;
- the oximeter has printing capabilities; and
- a trained caregiver is available to respond to changes in oxygen saturation.

Home pulse oximetry is not covered for the purpose of qualifying or requalifying a patient for home oxygen.

Updated 01/06

[2] "Useful lifetime" is based on when the item is delivered to the recipient, not the age of the item, but in no case is less than the useful lifetime of the item established by the manufacturer.

Diagnostic Monitoring

"Diagnostic monitoring" means monitoring for periods of up to twenty-four hours in length. Prior authorization is required for diagnostic monitoring.

All prior authorization requests must include a physician prescription which includes certification that the only alternative to home oximeter monitoring is hospitalization, recipient prognosis, and documentation by the provider that the recipient's caregivers have been or will be trained in the appropriate use of the monitoring equipment and that the home environment is conducive to the monitoring. Additionally, the following criteria and documentation requirements must be met to establish medical necessity:

- diagnostic monitoring may be approved for payment to assess oxygen saturation:
  - when a recipient is weaning from oxygen and/or prior to weaning; or
  - on a periodic basis for oxygen dependent, clinically unstable recipients.
- diagnostic monitoring may be considered for authorization when provided to a recipient in response to a significant clinical event or exacerbation of clinical status which results in a critical change in oxygen saturation or which requires diagnostic monitoring in order to assess oxygen saturation. Since oximeter monitoring under these circumstances must be provided immediately after the clinical event in order to assure timely assessment of oxygen requirements, authorization for payment will only be considered after the service has been provided.
- prior authorization requests must include documentation of one or more of the following:
  - risk for critical fluctuations in oxygen saturation;
  - history of clinical instability;
  - history of chronically compromised respiratory and/or cardiac function;
  - history of frequently varying oxygen requirements; or
  - other risk factors which may compromise recipient's ability to wean.
  - in addition, oximeter printouts of any prior oximeter monitoring and documentation of the resulting impact on the management of the recipient's care must be provided.

Updated 01/06

Continuous Monitoring

"Continuous monitoring" means twenty-four-hour monitoring, seven days a week. Prior authorization is required for rental or purchase of an oximeter for use in continuous monitoring and may be requested for three months at a time when equipment is rented.

Continuous oximeter monitoring in the home may be appropriate in the management of recipients with prolonged oxygen dependency who are at risk for a critical fluctuation in oxygen saturation. Requests for prior authorization of continuous home oximeter monitoring should include documentation by the attending physician that the recipient is clinically unstable with chronically compromised respiration and frequently varying oxygen requirements, at risk for critical fluctuations in oxygen saturation, and experiencing one or more of the following:

- frequent bradycardia;
- frequent oxygen desaturation;
- chronic lung disease;
- ventilator dependent;
- poor growth and development and suspect for inadequate oxygenation;
- other risk factors which may result in sudden, critical fluctuations in oxygen saturation (hyperoxia, hypoxia).

Rental payments will be made for oximeters used for diagnostic and continuous monitoring. Oximeters will be considered for purchase only when continuous monitoring is authorized for periods in excess of 12 months; monthly rental payments, less the cost of the probes, will be applied to the purchase price. The monthly rental payment amount includes reimbursement for:

- set up and instructions;
- maintenance and repair;
- emergency service visits or other interim visits;
- supplies and accessories (cable, printer/printer tape, carrying case, etc.);
- permanent, reusable, or disposable probes (transducers) and probe wraps or tape.

Oximeter probes may be purchased when prior authorized for use in conjunction with continuous monitoring when a monitor is purchased by Medicaid and when a monitor is owned by the recipient, if continuous monitoring has been determined to be medically necessary in accordance with this rule. Oximeter probes must be billed using the code established for that purpose.

Updated 01/06

Incontinence Supplies

Disposable Diapers

Medical Assistance will reimburse incontinence supplies when the PA request includes a statement of the qualifying medical condition including, but not limited to the following:

- Recipients who are at least 3 years of age and incontinent due to any of the following specific medical conditions:
  - spina bifida,
  - spinal cord injury,
  - nerve degeneration (including neurogenic bladder),
  - myelodysplasia,
  - lipomeningocele,
  - myelomeningocele,
  - cerebral palsy,
  - Hirschsprung's disease,
  - imperforate anus, or
  - mental retardation with inconsistent response to bowel/bladder training.
- Adults who are incontinent due to any of the following medical conditions:
  - chronic female urinary tract infection,
  - enlarged prostate,
  - prostatectomy (6 weeks following surgery),
  - post transurethral resection,
  - CVA or stroke,
  - multiple sclerosis,
  - amyotrophic lateral sclerosis,
  - cerebral palsy,
  - spinal cord injury,
  - Parkinson's disease,
  - Alzheimer's disease or senile dementia (with documentation of failure to respond to any other intervention such as a regular toileting schedule or bowel/bladder training program),
  - neurogenic bladder,
  - mental retardation, or
  - urinary muscle deterioration/prolapsed bladder.

Updated 01/06

Table I-1. Procedure Codes: Incontinence Supplies

HCPCS Code	HCPCS Description	Maximum Allowed Amount
A4927	Gloves, non-sterile, per 100	$8.00
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks	$0.05 Diaper wipes
T1999	Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in remarks	$0.08 Disposable washcloths
T4521	Adult sized disposable incontinence product, brief/diaper, small, each	$0.65
T4522	Adult sized disposable incontinence product, brief/diaper, medium, each	$0.70
T4523	Adult sized disposable incontinence product, brief/diaper, large, each	$0.80
T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	$0.93
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each	$0.65
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each	$0.70
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	$0.80
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each	$0.93
T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	$0.35
T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	$0.50
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each	$0.50
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, large size, each	$0.65
T4533	Youth sized disposable incontinence product, brief/diaper, each	$0.50
T4534	Youth sized disposable incontinence product, protective underwear/pull-on, each	$0.65
T4535	Disposable liner/shield/guard/pad/undergarment, for incontinence, each	$0.30
T4537	Incontinence product, protective underpad, reusable, bed size, each	$15.00
T4540	Incontinence product, protective underpad, reusable, chair size, each	$15.00
T4541	Incontinence product, disposable underpad, large, each	$0.40
T4542	Incontinence product, disposable underpad, small size, each	$0.35

Updated 01/06

Enteral and Oral Nutritional Products

The department will pay a provider enrolled under 7 AAC 43.1900 for enteral and oral nutritional products at the rate established in 7 AAC 43.1920 if the products are

- contained on the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) list
- not provided by, or under arrangements made by, a home health agency or hospice program;
- prescribed by the attending physician, physician assistant, or advanced nurse practitioner;
- certified as medically necessary by the attending physician, physician assistant, advanced nurse practitioner, or licensed dietitian on a form provided by the department; certification of medical necessity must indicate that sufficient caloric or protein intake is not obtainable through regular, liquefied, or pureed food.

Updated 01/06

Rental of Items

The department will authorize the following rentals of items:

- rental for anticipated short-term use;
- capped rental[3], when
  - a short-term rental becomes long-term and the total rental period is 12 months; or
  - an item requires rental but the department limits payment to no more than 12 months; and
- continuous rental of an item that required frequent servicing and maintenance, including an apnea monitor, oxygen equipment, and an electric breast pump.

Regardless of rental type under this section:

- The department will only pay the remaining portion of the full purchase price, not rental plus the full purchase price. (This does not apply to an item that is continuously rented.)
- The department will review the length of need for the item and its cost before authorizing payment for rental or purchase.
- The cost of any necessary repair, return shipping, or maintenance is included in the rental fee.
- When total rental payments reach the purchase price, except for an item that is continuously rented, repair is covered after 60 days of the final payment or when the warranty expires, whichever is later.

The department will pay for the capped rental of an item if the provider

- transfers ownership of the item, including any warranty, to the recipient for whom it was rented; and
- replaces the item with a new item if it was previously used by a person other than the recipient before it was rented to the recipient.

Updated 01/06

[3] "Capped rental" means the rental of durable medical equipment, prosthetics, and orthotics for no more than 12 months.

Changes During Rental Periods

Except as otherwise provided in this section, an interruption in a rental period[4] affects the department's payment as follows:

- a rental period is not affected by an interruption of less than 30 days; if an interruption continues beyond the end of the rental month in which use ceases, the department will pay for the rental month in which use ceased, but will not make an additional payment until use resumes; a new date of service will be established when use resumes;
- rental units[5] for which prior authorization has been received, but for which no payment is made, do not apply toward a capped rental period;
- if an interruption is or exceeds 30 consecutive days, or if the original rental period expires during the interruption, the provider shall submit to the department a new prior authorization request under 7 AAC 43.1910, with a statement that explains the reason for the interruption; if the department approves the request, a new rental period begins.
    - A recipient's change of address does not affect the rental period for that recipient.
    - Except as otherwise provided in this section, if an item is modified or replaced with a different item, the rental will continue to be applied against the current rental period and payment will be based on the least expensive item that is medically suited to the rental purpose. If the rental period has expired, additional payment will not be made for a modified or replaced item unless the provider summits to the department, on a form provided by the department, certification of medical necessity for the modified or replaced item from a physician, physician assistant, advanced nurse practitioner, physical therapist, occupational therapist, or speech-language pathologist. If the department approves the request, a new rental period begins.
    - If an addition is made to an existing item because of a substantial change in the recipient's medical need, the rental period for the original item continues uninterrupted and a new rental period begins for the added item.
    - If the recipient changes providers during the rental period, a new rental period does not begin. The new provider shall continue to supply the item during the remaining rental period.

Updated 01/06

[4] "Rental period" means the number of rental units authorized by the department.
[5] "Rental unit" means one day for anticipated short-term rental, and one 30-day period for anticipated long-term or continuous use.

Respiratory Therapy Equipment, Supplies, and Assessment Visits

Providers of DME and medical supplies who rent or sell respiratory therapy equipment must employ or have a contract with a registered respiratory therapist or certified respiratory therapy technician. Only providers with respiratory therapy renderers will be reimbursed for the ventilator/oxygen equipment.

Updated 01/06

Respiratory Therapy Assessment Visit for Ventilator-Dependent Patient (procedure code 99504)

All respiratory therapy assessment visit services require prior authorization (PA). The assessment will

a) establish a plan of care and the equipment and services required each month to meet the recipient's specific medical needs;

b) include instructions and training to recipients and their caregivers in safe and proper use of oxygen therapy equipment, if this has not been done before the recipient's discharge or as part of the assessment;

c) determine the recipient's home communications needs, which includes notifying power and telephone companies and emergency medical services that a ventilator-dependent individual is in the home and may require emergency phone numbers; and

d) include helping develop an emergency evacuation plan to remove the recipient from the home in case of fire, earthquake, etc.

e) Making follow-up visits to ensure that the equipment is used correctly, is accurate, and meets the needs of the recipient.

f) Assessing recipient's needs and informing the physician of any concerns or recommendations for changes to the plan of care.

The plan of care will be maintained in the provider's files with the physician's prescription that supports the plan of care. Any changes in equipment or needs will be reviewed as part of a respiratory therapy visit.

Updated 01/06

Specialized Medical Equipment (SME) and Supplies for Home and Community-based Waiver Clients

General

The federal government has approved waivers to the Alaska Medical Assistance program to allow reimbursement for Home and Community-Based Waiver Services not otherwise furnished under Medical Assistance. These waivers offer an array of services that allow an eligible individual to avoid institutionalization (e.g., nursing facility, acute care hospital, or intermediate care facility for the mentally retarded) and remain at home. To be eligible for these waivered services, a person must meet specific income criteria and also be in one of the following population groups:

- Aged (65+)
- Physically Disabled (21-64)
- Developmentally Disabled or Mentally Retarded (any age)
- Children with Complex Medical Conditions (0-21)

Individuals must be approved for waiver services. All four waivers must be approved by the Division of Senior and Disability Services (DSDS). See Appendix A, Directory Assistance.

After a recipient's eligibility for Medical Assistance waiver services is determined, the recipient may receive one or more of the Specialized Medical Equipment and Supplies for Waiver Services (listed in Table I-2 in this section) in addition to the regular Medical Assistance-covered services.

Updated 01/06

Waiver Covered Specialized Medical Equipment

The following items are covered under the home and community-based waiver programs as specialized medical equipment and do not require FHSC to review requests for prior authorization. Prior authorization is requested from the Division of Senior and Disabilities Services via the Plan of Care and Cost Sheet approval process:

- Hand controls for vehicle;
- Van lift;
- Ramp;
- Pediatric potty chair;
- Therapy mat;
- Eating device;
- Bib;
- Reclining lift chair;
- Reacher;
- Handheld shower; and
- Rental and installation of the Personal Emergency Response System (PERS)/Lifeline.

Updated 01/06

SME Repairs

SME labor time and repair parts are covered the same as under DME and if repair or replacement of parts that are necessary for a recipient's environmental modification services are provided, they must be prior authorized by DSDS before payment will be made.

Updated 01/06

Table I-2. Procedure Codes: Specialized Medical Equipment and Supplies

Description	Max Allowable	HCPCS Code	HCPCS Description
Hand controls for vehicle; Van lift	$700.00 (Hand Controls)	T2039	Vehicle modifications, waiver; per service
Ramp	As Approved	T2029	Specialized medical equipment, not otherwise specified, waiver
Pediatric Potty chair	$525.00	T2029	Specialized medical equipment, not otherwise specified, waiver
Therapy Mat	$400.00	T2029	Specialized medical equipment, not otherwise specified, waiver
Eating Device	$13.00	T2029	Specialized medical equipment, not otherwise specified, waiver
Bib	As Approved	T2029	Specialized medical equipment, not otherwise specified, waiver
Reclining Lift Chair	$895.00	T2029	Specialized medical equipment, not otherwise specified, waiver
Reacher	As Approved	A9281	Reaching/grabbing device, any type, any length, each
Handheld shower	$48.00	T2029	Specialized medical equipment, not otherwise specified, waiver
Rental PERS/Lifeline	$40.00	S5161	Emergency response system; service fee, per month (excludes installation and testing)
Install PERS/Lifeline	$45.00	S5160	Emergency response system; installation and testing
Unlisted SME	As Approved	T2028	Specialized **supply**, not otherwise specified, waiver
Unlisted SME	As Approved	T2029	Specialized medical **equipment**, not otherwise specified, waiver

Updated 01/06

Home Infusion Therapy Services

Home Infusion Therapy Covered Services

The department will pay an enrolled provider under this section for home infusion therapy services if the services are

- ordered by
  - the attending physician as part of a written home health plan of care under 7 AAC 43.801; or
  - a physician as part of a written hospice plan of care under 7 AAC 43.938(d);
- reviewed at least every 60 days by the attending physician to determine the ongoing medical need for the service; and
- is appropriate for use in the recipient's home, school, or community.

Updated 01/06

Home Infusion Therapy Noncovered Services

The department will not pay separately for home infusion therapy services

- while the recipient is in a hospital, skilled nursing facility, or an intermediate care facility;
- if the services are provided by or under arrangements made by a home health agency; or
- while the recipient is receiving hospice care services and the services are
  - related to the treatment of the terminal illness that qualifies the recipient for hospice care; or
  - provided by or under the arrangements made by the hospice program.

The department will not separately pay a provider under this section for the following items identified in the HCPCS 2005:

- routine servicing of an infusion device for equipment already included in the per diem payment;
- catheter care and maintenance identified as "not otherwise classified";
- nursing services only for insertion of a peripherally inserted central venous catheter (PICC);
- nursing services only for insertion of a midline central venous catheter;
- the following items, without a specific dosage timing or quantity:
  - pain management infusion;
  - chemotherapy infusion
  - total parenteral nutrition (TPN);
  - hydration therapy;
  - antibiotic, antiviral, or antifungal therapy;
  - professional pharmacy services;
- continuous insulin infusion therapy;
- after-hours care;
- home injectable therapy;
- dietician services;
- delivery or service to high-risk areas requiring escort or extra protection;
- high-technology registered nursing services;

- infusion suite services;
- home therapy enteral nutrition;
- home administration of aerosol drug therapy;
- home transfusion of blood products;
- home irrigation therapy.

Updated 01/06

Home Infusion Therapy Payment

Home Infusion Administrative Services, Professional Pharmacy Services, Care Coordination, Supplies and Equipment

The department will pay an enrolled provider on a per diem basis for home infusion administrative services, professional pharmacy services, care coordination, and necessary supplies and equipment as follows:

- the maximum allowed amount on the Home Infusion Therapy Services Fee Schedule;
- for services not listed on the fee schedule, the department will establish and publish a maximum allowed amount using the method described in the Pricing Methodology section; and
- the department will pay a percentage of the maximum allowed amount under (1) and (2) that is
  - 100 percent for the first administered therapy;
  - 80 percent for the second concurrently administered therapy; and
  - 75 percent for the third and each subsequent concurrently administered therapy.

Home Infusion Therapy Nursing

The department will pay an enrolled provider per visit for home infusion and specialty drug administration billed with 99601 and 99602. The department will pay for 99601 and 99602 at 68 percent of billed charges for the first nine billings that reflect a charge for the service that complies with the applicable standards in 7 AAC 43.040. Thereafter, the fee will be established and published based on 85 percent of the 90th percentile of the first 10 billings.

Drugs

The department will pay an enrolled provider in accordance with 7 AAC 43.591 for drugs covered under 7 AAC 43.590 and used in home infusion therapy.

Updated 01/06

Home Infusion Therapy Claim Instructions

A provider may not include compounding and dispensing fees paid under this section on the claim for drugs. Drugs are paid for under the pharmacy billing number as usual except that no charges should be included for compounding or dispensing fees.

For drugs covered under 7 AAC 43.590 and used in home infusion therapy, the department will accept electronic claims in the standard claim format adopted under 45 C.F.R. 162.1102(b)(1) by the United States Secretary of Health and Human Services.

Providers should bill for home infusion therapy services on the CMS-1500 claim form. Claims must be billed with single dates of service and may not be span-dated. (See “Health Insurance Claim Form (CMS-1500) Instructions” for more information).

Updated 01/06

Table I-3. Procedure Codes: Home Infusion Therapy Services

HCPCS code	Description[6]	Fee	Second Concurrent Infusion Therapy (Modifier SH)	Third Concurrent Infusion Therapy (Modifier SJ)
S5036	HIT device repair	$80.00	$0.00	$0.00
S5498	HIT simple cath care	$7.50	$6.00	$5.63
S5501	HIT complex cath care	$11.25	$9.00	$8.44
S5502	HIT interim cath care	$11.25	$9.00	$8.44
S5517	HIT declotting kit	$30.00	$0.00	$0.00
S5518	HIT cath repair kit	$10.00	$0.00	$0.00
S5520	HIT PICC insert kit	$90.00	$0.00	$0.00
S5521	HIT midline cath insert kit	$90.00	$0.00	$0.00
S9326	HIT cont pain per diem	$78.75	$63.00	$59.06
S9327	HIT int pain per diem	$78.75	$63.00	$59.06
S9328	HIT pain imp pump diem	$90.00	$72.00	$67.50
S9330	HIT cont chem diem	$112.50	$90.00	$84.38
S9331	HIT intermit chemo diem	$112.50	$90.00	$84.38
S9336	HIT cont anticoag diem	$78.75	$63.00	$59.06
S9338	HIT immunotherapy diem	$56.25	$45.00	$42.19
S9346	HIT alpha-1-proteinase diem	$93.75	$75.00	$70.31
S9347	HIT long-term infusion diem	$93.75	$75.00	$70.31
S9348	HIT sympathomim diem	$86.25	$69.00	$64.69
S9349	HIT tocolysis diem	$93.75	$75.00	$70.31
S9351	HIT cont antiemetic diem	$93.75	$75.00	$70.31
S9355	HIT chelation diem	$93.75	$75.00	$70.31
S9357	HIT enzyme replace diem	$93.75	$75.00	$70.31
S9359	HIT anti-TNF per diem	$79.50	$63.60	$59.63
S9361	HIT diuretic infus diem	$79.50	$63.60	$59.63
S9363	HIT anti-spasmotic diem	$93.75	$75.00	$70.31
S9365	HIT TPN 1 liter diem	$168.75	$135.00	$126.56
S9366	HIT TPN 2 liter diem	$172.50	$138.00	$129.38
S9367	HIT TPN 3 liter diem	$176.25	$141.00	$132.19
S9368	HIT TPN over 3 liters diem	$187.50	$150.00	$140.63

[6] Refer to your HCPCS book for a full description.

HCPCS code	Description[6]	Fee	Second Concurrent Infusion Therapy (Modifier SH)	Third Concurrent Infusion Therapy (Modifier SJ)
S9374	HIT hydra 1 liter diem	$25.50	$20.40	$19.13
S9375	HIT hydra 2 liter diem	$30.00	$24.00	$22.50
S9376	HIT hydra 3 liter diem	$34.50	$27.60	$25.88
S9377	HIT hydra over 3 liters diem	$45.00	$36.00	$33.75
S9490	HIT corticosteroid per diem	$93.75	$75.00	$70.31
S9497	HIT antibiotic Q3H diem	$112.50	$90.00	$84.38
S9500	HIT antibiotic Q24H diem	$93.75	$75.00	$70.31
S9501	HIT antibiotic Q12H diem	$105.00	$84.00	$78.75
S9502	HIT antibiotic Q8H diem	$105.00	$84.00	$78.75
S9503	HIT antibiotic Q6H diem	$112.50	$90.00	$84.38
S9504	HIT antibiotic Q4H diem	$112.50	$90.00	$84.38

Updated 01/06

Home Infusion Therapy TPL Avoidance Requests

Home infusion therapy may be covered by Medicare under the Medicare Part B Durable Medical Equipment benefit or a recipient's third party resource under HCPCS "A" and "E" codes, for example A4221, A4222, and E0781, or HCPCS "S" codes for home infusion therapy such as S9330.

Requests for third party liability avoidance for home infusion therapy must include

- number of requested nursing visits with procedure codes, number of requested home infusion therapy per diem services and HCPCS codes, drug, dose, number of doses, directions, route of administration, diagnosis code(s), and begin and end dates; and
- a current Region D DMERC Local Coverage Determination for Medicare covered external infusion pumps that is in effect for the requested dates of service; or
- a current copy of the health plan's coverage of home infusion therapy.

Updated 01/06

Home Infusion Therapy Prior Authorization

All home infusion therapy services require prior authorization and may be requested electronically or in writing on the certificate of medical necessity form.

The request must include

- written home health or hospice plan of care;
- number of requested nursing visits with procedure codes, number of requested home infusion therapy per diem services and HCPCS codes, drug dose, number of doses, directions, route of administration, diagnosis code(s), begin and end dates; and
- a current Region D DMERC Local Coverage Determination for Medicare covered external infusion pumps that is in effect for the requested dates of service, if applicable; or
- a current copy of the health plan's coverage of home infusion therapy, if applicable.

The written home health plan of care must include

- pertinent diagnoses, including mental status;
- types of services and equipment required;
- the frequency of visits;
- the prognosis for the recipient;
- an analysis of the recipient's rehabilitation potential;
- a description of the recipient's functional limitations;
- activities permitted to the recipient;
- the recipient's nutritional requirements;
- the recipient's medications and treatments;
- any safety measures to protect the recipient against injury; and
- instructions for a timely discharge and referral.

The written hospice plan of care must include

- an assessment of the recipient's needs; and
- a detailed statement of the scope and frequency of services needed to meet the recipient's and family's needs (including biologicals and drugs used primarily for the relief of pain and symptom control of the terminal illness).

Updated 01/06

Documentation Requirements

The department will pay an enrolled provider for medically necessary durable medical equipment and supplies or prosthetics and orthotics furnished to a Medicaid recipient, if the equipment or supplies are

- prescribed by the attending physician, physician assistant, or advanced nurse practitioner acting within the scope of that person's license who shall complete a certificate of medical necessity form provided by the department to prescribe the equipment or supplies for which a prior authorization is required; the form may also be used to document medical necessity.
- appropriate for use in the recipient's home, school, or community
- The provider furnishes orientation and training to the recipient regarding the proper use of the equipment or supplies, and includes proof of compliance with this paragraph in its records. The provider shall submit this proof to the department upon request.

A durable medical equipment and supplies, prosthetics, or orthotics provider must

- document a recipient's request for a 30-day refill
- accept returns from recipients of any substandard item[7]; and
- upon request, provide proof, in the form of copies of letters, logs, or signed notices, that it has provided Medicaid recipients with warranty information for Medicaid covered items.

Updated 01/06

[7] Substandard item means an item that does not function in a manner that meets the prescribed need or the specifications. See "Replacement of Items."

Prior Authorization

A provider seeking prior authorization must make a request electronically or in writing on a certificate of medical necessity. Prior authorization is required for

- the rental of durable medical equipment;
- medical supplies that exceed a 30-day limit set by the department; (The department will set the 30-day limit based on the 75th percentile of recipient use in calendar year 2004, and will review the limit at least biennially thereafter.)
- requests that exceed the maximum allowable payment for durable medical equipment, medical supplies, noncustomized-fabricated orthotics, prosthetics, or orthotics under 7 AAC 43.1920;
- customized durable medical equipment;
- the following incontinence supplies:
  - garments;
  - liners;
  - underpads;
  - nonsterile gloves;
  - diaper wipes;
  - disposable washcloths
- the following items:
  - skin sealant;
  - skin protectant;
  - skin moisturizer;
  - skin ointment;
  - skin cleansers;
  - skin sanitizers;
- items that are listed on the department's Durable Medical Equipment Prior Authorization List, dated August 2005, and adopted by reference;
- items that are identified as miscellaneous in the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) 2005;
- respiratory therapy assessment visits for ventilator-dependent recipients;
- home infusion therapy;
- enteral and oral nutritional products;
- the purchase of durable medical equipment for a recipient in a SNF or ICF as indicated in the discharge plan;
- continuous oxygen for a recipient in a skilled nursing facility or intermediate care facility; and
- the purchase of durable medical equipment if the charge to the department is over $1,000.

A request for prior authorization must include

- a certificate of medical necessity completed by the attending physician, physician assistant, or advanced nurse practitioner.
- a written statement by the person listed above or physical therapist, occupational therapist, or speech-language pathologist that the recipient's condition requires the more costly durable medical equipment, medical supply, noncustomized-fabricated orthotics, prosthetics, or orthotics if the request is for payment that exceeds the maximum allowable payment under 7 AAC 43.1920; and
- documentation by the person listed above that the item or service is necessary to treat, correct, or ameliorate a defect, condition, or physical or mental illness if the recipient is under 21 years of age.

In addition to the requirements of this section, a prior authorization request for the following durable medical equipment or medical supplies must include, if available for the item, manufacturer information, the item description or number, the global trade item number (GTIN), the suggested list price, the serial number, and the national drug code (NDC):

- items that are identified as miscellaneous in the HCPCS 2005, as amended from time to time and adopted by reference;
- customized durable medical equipment;
- requests that exceed the maximum allowable payment under 7 AAC 43.1920 for the item;
- the following items:
  - skin sealant;
  - skin protectant;
  - skin moisturizer;
  - skin ointment;
  - skin cleanser;
  - skin sanitizer.

Based on its review under this section, the department will give prior authorization if

- the documentation has been provided, as applicable;
- payment is appropriate; and
- the information reviewed otherwise supports approval of the request.

Updated 01/06

DME PA List

The following items require prior authorization:

- Adaptive Strollers
- Aerosol Delivery Devices
- Airway Clearance/High Frequency Chest Wall Oscillation Devices
- Apnea Monitors
- Augmentative and Alternative Communication Devices
- Bed Wetting Alarms

- Bone Growth Stimulators, Noninvasive
- Breast Pumps, Heavy Duty, Hospital Grade
- Cervical Traction Devices
- Commodes
- Compression Garments in the Treatment of Venous Stasis Ulcers
- Continuous Passive Motion Device (CPM), Knee
- Dorsal Column Stimulators/Spinal Cord Stimulators: Chronic Pain, Angina Pectoris
- Electrical Stimulation/Electromagnetic Therapy for the Treatment of Wounds, Chronic Stage III & IV Musculo-Cutaneous Ulcerations
- Electrogalvanic Simulators for Levator Syndrome
- Foot Orthotics, Therapeutic Shoes
- Gait Trainers
- Home Oxygen Therapy
- Hospital Beds
- Implanted Peripheral Electrical Nerve Stimulation
- Interferential/Inferential Current Stimulation
- Intrapulmonary Percussive Ventilator (IPV)
- Insulin Pump, Ambulatory
- Jobst Burn Garments
- Lymphedema Compression Devices
- Lymphedema Pump/Manual Lymph Drainage
- Manual Wheelchairs
- Mechanical In-Exsufflation/In-Exsufflator Devices
- Nebulizers
- Negative Pressure Wound Therapy Pump
- Neuromuscular Electrical Stimulation (NMES)
- Nonimplantable Pelvic Floor Electrical Stimulator
- Noninvasive Airway Assist Devices
- Patient Lifts
- Pediatric Bath Chairs
- Pediatric Beds
- Pediatric Transport Chair Trays
- Percutaneous Electrical Nerve Stimulation (PENS)
- Phototherapy for Neonatal Hyperbilirubinemia
- Pneumatic Compression Therapy, End Diastolic for Extremity Ulcers
- Positioning Devices, Including Tumbleform Items, Pediatric Corner Chairs, and Floor Bases
- Positioning Seats for Persons with Special Orthopedic Needs for Use in Vehicles

- Power Operated Vehicles (POV)
- Power Wheelchairs
- Prothrombin Time, Home Testing Systems
- Pulsed Electrical Stimulation for Osteoarthritis of the Knee
- Radiant Heat Wound Therapy Systems
- Respiratory Assist Devices
- Seat Lift Mechanism
- Secretion Clearance Devices
- Standers, Boards, and Tilt Tables
- Supplies, Form-Fitting Conductive Garment for Transcutaneous Electrical Nerve Stimulation or NMES
- Support Surfaces
- Surface Electrical Muscle Stimulation
- Therapeutic Electrical Stimulation (TES)
- Traction for Low Back Pain
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Treatment of Motor Function Disorders with Electric Nerve Stimulation
- Wheelchair Cushions/Seating System
- Wheelchair Trays
- Whirlpool, Portable (Overtub type)

Updated 01/06

Transferring Prior Authorizations

Any recipient requests to transfer an existing prior authorization from one provider to another must include the following items:

- A written request, signed by the recipient (or his/her legal guardian), stating the former medical supplier and the new supplier and authorizing a change in providers.
- A new or existing physician prescription for the durable medical equipment or supply that covers the period of time requested on the prior authorization request for the new provider.
- A requested effective date for the transfer
- If the item is SME, the recipient's care coordinator must send the request to DSDS.

The new provider of service must forward a copy of the recipient's request to the previous provider in addition to sending the request to First Health Services Corporation. First Health Services will coordinate an effective date for the transfer with both providers before finalizing any changes to the prior authorizations.

A transferred prior authorization is subject to all other criteria required for a new authorization. In addition, all policies, including not dispensing beyond the recipient's current medical need for the established benefit period, are in effect at the time a transfer is requested.

Updated 01/06

Prior Authorization and Certificate of Medical Necessity Form

Requests for prior authorization may be submitted electronically or in writing on the certificate of medical necessity form.

Requests for skin sealants, skin protectants, skin moisturizers, skin ointments, skin cleansers, and skin sanitizers must be accompanied by the specific national drug code (NDC) that describes the prescribed product and the requested quantity. The United States Food and Drug Administration, Center for Drug Evaluation and Research's national drug code compilation is available at the following Internet address: www.fda.gov/cder/ndc/index.htm.

First Health will enter the primary diagnosis code for the requested item or service into the prior authorization record in the Medicaid Management Information System (MMIS). Any corresponding claims must include the same primary diagnosis for the item or service.

The request must include the ordering provider's Alaska Medicaid ID# if s/he is an Alaska Medicaid enrolled provider.

Section A must be completed by the ordering provider and may not be completed by the provider in Section C.

Up to 18 PA lines, or segments, may be requested at one time. Additional information may be attached to the certificate of medical necessity form, as necessary.

Updated 04/06

First Health Services Corporation
Certificate of Medical Necessity Page 1 of 2

Submitted by:_____
Date:

Recipient Name: _____ Medicaid #: _____ Date of Birth: ___/___/___ Age:_____Sex: ____ (M or F)	Ordering Provider's Name: _____ Medicaid ID# or AK License #: _____ Telephone #: (___) _____-_____ Ext. _____
HT: _____ (inches) WT: _____ (lbs) Date of last visit: _____	Retrospective Review? _____ (Y/N)

SECTION A: CLINICAL INFORMATION

*(THIS SECTION **MUST** BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, OR AUDIOLOGIST.)*

DIAGNOSIS	ICD-9-CM

Est. Length of Need (# of Months): _____1 – 99 *(99 = Lifetime)*

SECTION B:

CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN: Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. *(THIS SECTION MAY BE COMPLETED BY THE ATTENDING SPECIALIST, INCLUDING THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH LANGUAGE PATHOLOGY THERAPIST, REGISTERED DIETITIAN, AUDIOLOGIST, OR OTHER ATTENDING SPECIALIST WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)*

PLAN: *The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.*

AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST ATTESTATION, SIGNATURE AND DATE (NOTE: *Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

A physician, nurse practitioner, physician assistant, audiologist, or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____
Signature of Specialist – Title Date
This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.

_____ _____
Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant Date
I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.

Revised 2/3/06

Figure I-1: Certificate of Medical Necessity Form - Page 1

First Health Services Corporation
Certificate of Medical Necessity Page 2 of 2

Submitted by:_____
Date:

Recipient Name: _____

Medicaid #: _____

Date of Birth: ___/___/___ Age:_____ Sex: ____ (M or F)

Ordering Provider's Name: _____

Medicaid ID# or AK License #: _____

Telephone #: (____) _____-_____ Ext. _____

SECTION C: REQUESTED SERVICES OR ITEMS –
(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)

Provider Name: _____

Address: _____

Provider Medicaid No.: _____

Requester Name: _____

Telephone #: (_____) _____ Ext. _____

Fax #: (_____) _____ Ext. _____

Dates of Need-Start Date: **End Date:**

First Health Services Corp – Use Only

Your request is:

☐ Approved as Requested

☐ Approved as modified
(Items marked as authorized may be claimed)

Prior Authorization Number:

From Date: Thru Date:

☐ Denied

Authorizing Agent Signature & Date:

Comments:

	Procedure Code	Mod.	Description	QTY (#)	Charges	Authorized Yes	Authorized No	Approved Qty	Approved Amount
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									

SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

_____ _____
Signature of Supplier Date

Revised 2/3/06

Figure I-2: Certificate of Medical Necessity Form - Page 2

Recipient Eligibility

Verification

Before rendering services, the provider is responsible for verifying the following:

- the age of the recipient
- that the recipient is Alaska Medical Assistance-eligible and also eligible for the specific services
- that the services are covered by Medical Assistance

The provider can verify the patient's age and eligibility by the following methods:

- Checking the patient's Medical Assistance identification card or coupon (refer to Section III for samples)
- Verifying age and eligibility by telephoning FHSC's automated **Eligibility Verification System (EVS)** at (800) 884-3223, described in Section III
- Sending a 270 HIPAA Eligibility Inquiry and receiving a 271 HIPAA Response. For assistance:
  - Refer to the Companion Guide
  - Refer to the ECCS Help Desk. See the *Telephone Inquiries* page for telephone numbers.
- Telephoning or faxing Provider Inquiry in FHSC's Provider Services Unit. See the *Telephone Inquiries* page for these telephone numbers.

Updated 01/06

Eligibility Codes

Recipients with the Medical Assistance eligibility codes shown in Table I-4 are eligible to receive approved DME, medical supplies, respiratory therapy assessment visits, home infusion therapy, SME, prosthetics and orthotics.

Table I-4. Eligibility Codes for DME, MS, Respiratory Therapy Assessment Visits, Home Infusion Therapy, SME, Prosthetics and Orthotics

Code	Category
10	Public Health Service (IHS, AANHS, and CHAMPUS)
11	Pregnant Woman (Alaska Healthy Baby Program)
20	No Other Eligibility Codes Apply
21	Chronic and Acute Medical Assistance Coverage Only (CAMA)
24	300% Institutionalized
30	Adult Disabled, Waiver Only
31	Adult Disabled, Waiver Medical
34	Adult Disabled, Waiver Adult Public Assistance (APA)/Qualified Medicare Beneficiary (QMB)
40	Older Alaskan, Waiver Only
41	Older Alaskan, Waiver Medical
44	Older Alaskan, Waiver APA/QMB
50	Under 21
51	Juvenile Court Ordered Custody of Health & Social Services
52	Transitional Medical Assistance
54	Disabled/Supplemental Security Income Child
69	APA/QMB) - (Dual Eligibility)
70	Mental Retardation and Developmental Disabilities, Waiver Only
71	Mental Retardation and Developmental Disabilities, Waiver Medical
74	Mental Retardation and Developmental Disabilities, Waiver APA and QMB
80	Children with Medically Complex Conditions, Waiver Only
81	Children with Medically Complex Conditions, Waiver Medical

Note: CAMA recipients are eligible for diabetic medical supplies only.

Note: Only recipients who have eligibility codes with the word “Waiver” in the description are eligible for SME items.

Updated 01/06

Reimbursement

General

Timely Filing

All claims must be filed within 12 months of the date services were provided to the recipient. The 12-month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier. In these cases, providers must bill Medical Assistance within 12 months of the service date and attach explanation of benefits documentation from the third-party carrier to the Medical Assistance claim.

"Timely filing" of claims is discussed in greater detail in Section III.

Updated 08/03

Billing Guidelines

A provider must bill Medical Assistance the provider's lowest charge (except as noted below) that is advertised, quoted, posted, or billed for that same procedure and unit of service and provided on the same day, regardless of the source or method of payment, including any discounted price offered to any other purchaser of services. Exceptions to this policy include:

Medicare Assignment. The Medicare exception applies when a provider accepts Medicare assignment, which requires billing Medicare at the Medicare fee schedule. Enrolled Medical Assistance providers are not required to bill Medical Assistance at the Medicare fee schedule.

Sliding Fee Schedule. The sliding fee schedule exception applies when a provider has a *written* policy that establishes a sliding fee schedule based on the federal poverty level for Alaska (families and individuals with income equal to or less than 250 percent of the federal poverty level). Enrolled Medical Assistance providers are not required to bill Medical Assistance at the sliding fee discounted rate.

Contract for Group Discounts. This exception applies when a provider executes or enters into a contract to provide health care services at a discounted rate for a specified group of patients. Enrolled Medical Assistance providers are not required to bill Medical Assistance at the discounted rate if the revenue from a single contract does not exceed 20 percent of the provider's annual gross income, or if the contract is with a state or federal agency.

Provider's Employee Benefits. The employee benefits exception applies when a provider offers a reduced rate for health care services to the provider's employees as part of an employment benefit package. Enrolled Medical Assistance providers are not required to bill Medical Assistance at that reduced rate.

Updated 04/03

Pricing Methodology

The department will pay an enrolled provider for durable medical equipment, supplies, enteral and oral nutritional products, prosthetics, and orthotics that are priced by CMS, based on 100 percent of the first quarter 2005 fee schedule established by CMS for durable medical equipment, supplies, prosthetics, and orthotics in this state.

The department will pay an enrolled provider for durable medical equipment, supplies, prosthetics, and orthotics that are not listed or priced by CMS. To be paid under this subsection, a billing must reflect a charge for the procedure that complies with the applicable standards in 7 AAC 43.040. The department will add new fees to the payment schedule under this subsection each time the department receives 10 claims for an item not already on the schedule. The department will pay for a covered item at 80 percent of billed charges from enrolled providers in this state for the first nine billings that reflect a charge for an item not already on the schedule. Thereafter, the fee will be established based on the 50th percentile of the first 10 billings.

The department will not pay an enrolled respiratory therapist or respiratory therapy technician separately for respiratory therapy assessment visits. If prior authorization has been obtained for the assessment visit, the department will pay an enrolled durable medical equipment provider $75 per hour for each assessment provided to a ventilator-dependent recipient by an enrolled respiratory therapist or a respiratory therapy technician during an assessment visit.

The department will pay an out-of-state provider at the lowest of the following:

- the amount normally charged the general public;
- the Medicaid rate established by the state in which the service is provided; or
- the maximum applicable rate set out in 7 AAC 43.1900 - 7 AAC 43.1980.

Updated 01/06

Rental Items

For a rental period that is 30 days or more, the department will pay, for rented durable medical equipment, a monthly rental fee that is 10 percent of the allowed purchase price under 7 AAC 43.1920. For a rental period that is less than 30 days, the department will pay an amount equal to 150 percent of the monthly fee, divided by the number of days in the month, times the number of days in the rental period. Payment may not exceed the monthly rate. Payment will be made by rental period. Payment will not be made for any item that exceeds 12 months of continuous use, except for an item that requires continuous rental including an apnea monitor, oxygen equipment, and an electric breast pump.

Updated 01/06

Skin Care Items

The department will not pay an enrolled provider more than the average wholesale price accepted monthly by the department from the American Druggist Blue Book, plus 10 percent of that amount, for the following items:

- skin sealants;
- skin protectants;
- skin moisturizers;
- skin ointments;
- skin cleansers;
- skin sanitizers.

The United States Food and Drug Administration, Center for Drug Evaluation and Research's national drug code compilation is available at the following Internet address: www.fda.gov/cder/ndc/index.htm.

Updated 01/06

Requests that Exceed the Maximum Allowable Payment

A request for prior authorization to exceed the listed maximum allowable payment amount must be completed by the attending physician, physician assistant, advanced nurse practitioner, physical therapist, occupational therapist, or speech-language pathologist and include

- a written statement that the recipient's condition requires the more costly durable medical equipment, medical supply, noncustomized-fabricated orthotics, prosthetics, or orthotics, and
- if available for the item, manufacturer information, the item description or number, the global trade item number (GTIN), the suggested list price, the serial number, and the national drug code (NDC).

Examples of items that might be requested to exceed the listed maximum allowable payment amounts are Mic-Key low profile feeding tubes, and Stockton and Monroe beds. If a prior authorization is obtained for items that exceed the maximum allowable payment amount, the provider must submit a **paper** claim with the PA number on it to ensure the claim is priced appropriately.

The department will pay a provider at 80 percent of billed charges from enrolled providers in this state for the first nine billings that reflect a charge for the item. The department will add new fees to the payment schedule each time the department receives 10 billings for the item. To be paid, a billing must reflect a charge that complies with the applicable standards in 7 AAC 43.040.

Updated 01/06

TPL (Third Party Liability)

Alaska Medical Assistance is the "payer of last resort." Providers who bill Alaska Medical Assistance are required to bill all third party resources (except IHS) prior to billing Alaska Medical Assistance. However, if the services provided fall under the Federal TPL Waiver, Alaska Medical Assistance will seek reimbursement from the third party.

Updated 04/03

Federal TPL Waiver

Alaska Medical Assistance has been granted a Federal TPL Waiver for certain providers that offer specific categories of service. At this time, providers who offer the services listed below are not required to bill third party resources:

- Dental services
- Transportation and accommodation services (*except* Air Ambulance and Ground Ambulance services)
- Home and Community Based Waiver provider services
- Personal Care Assistant services
- EPSDT screening services
- Prenatal Care services
- Preventive Pediatric services
- Eye wear (lenses/frames - This applies only to the contract supplier of eyewear.)

If you provide one (or more) of the services listed above, you are not required to bill a third party resource before you bill Alaska Medical Assistance. Alaska Medical Assistance will reimburse you up to the allowed amount and then seek reimbursement from the third party.

You may choose to bill the third party resource if the service provided is covered by that resource and the payment will exceed the expected Alaska Medical Assistance reimbursement amount.

Providers who offer services that are not listed above are required to

- bill all third party resources (except IHS) before billing Alaska Medical Assistance, and
- include all TPL resource payments on Alaska Medical Assistance claims.

Updated 06/05

Recipients with VA, Medicare, and Medicaid

Alaska Medical Assistance (Medicaid) is always the payer of last resort. Therefore, if a patient is eligible for VA, Medicare, and Medicaid, all VA and Medicare benefits must be exhausted or you must submit valid documentation of non-coverage from VA or Medicare before you bill Alaska Medical Assistance. Valid documentation may include an Explanation of Benefits showing non-coverage or a Medicaid Denial Letter from the Veteran's Administration (refer to "Obtaining a VA Medicaid Denial Letter" below for additional information).

A Medical Assistance recipient who is eligible for VA and Medicare can use either as his/her primary resource. However, the following conditions apply in regards to Alaska Medical Assistance paying anything for the claim:

- If VA is pursued as the recipient's primary payer (instead of Medicare), the claim is considered satisfied, and neither Medicare nor Medicaid will pay anything more.
- If Medicare is pursued as the recipient's primary payer (instead of VA),
    1. VA will not pay for anything over the amount paid by Medicare.
    2. Alaska Medical Assistance *may* pay the Medicare co-pay and/or deductible *if* the Medicare Remittance Notice (MRN) *and* the VA denial are attached to the claim.
    3. Alaska Medical Assistance may reimburse according to the applicable Alaska Medical Assistance rates *if* the services billed are non-covered Medicare services *and* a Medicaid Denial Letter from the VA is attached to the PA request and/or claim. (Refer to "Obtaining a VA Medicaid Denial Letter" below.)

Therefore, if a recipient is eligible for VA as indicated by a "N2" carrier ID code, Medicare, and Medicaid, Alaska Medical Assistance will not pay anything for the claim unless you have followed these steps:

1. Bill VA first and receive a formal denial (in writing) from VA or receive a Medicaid Denial Letter.

Note: If the recipient's carrier ID code is "N", you do not have to bill VA first. Also, if you have an applicable Medicaid Denial Letter from the VA, you do not have to bill VA first. Refer to "Obtaining a VA Medicaid Denial Letter" below.

2. Bill Medicare correctly.
3. Bill Alaska Medical Assistance correctly and attach the denial from VA and the Medicare Remittance Notice (MRN).

If these steps are followed and if the claim is billed correctly, Alaska Medical Assistance may pay the Medicare co-pay and/or deductible.

Explanation

VA is considered primary because they pay 100% of their allowed amount.

Medicare is considered secondary because they pay 80% of their allowed amount with a 20% co-pay, which Alaska Medical Assistance can cover under the correct billing process.

However, Alaska Medical Assistance will not use state funds for a 20% Medicare co-pay if the claim could have been satisfied with 100% federal funds (VA is federally funded).

Please refer to the back of the CMS-1500 claim form ("Refers to Government Programs Only") for rules and information related to billing multiple federally funded programs.

Updated 01/06

Obtaining a VA Medicaid Denial Letter

To provide freedom of choice for veterans with medical needs, the veteran can request a Medicaid Denial Letter from the Veteran's Administration. This letter, which is for specific services, can be submitted to the Alaska Medical Assistance program as an explanation of Veteran benefits. Therefore, if the veteran chooses ***not*** to use VA as his/her primary payer, you should attach a copy of this letter to any related prior authorization requests and/or claims sent to Alaska Medical Assistance.

Important: All other Medical Assistance billing requirements still apply to claims submitted with a Medicaid Denial Letter, including

- Timely filing of claims
- Exhaustion of all other benefit resources (including Medicare) before billing Medical Assistance

A Medicaid Denial Letter should be requested from the Anchorage office of the Veteran's Administration by the veteran.

Department of Veteran's Affairs
Alaska Healthcare System and Regional Office
2925 DeBarr Road
Anchorage, AK 99508-2989

(907) 257-6904
1-888-353-7574 ext. 6904

The VA Coordinated Care or Social Work department will mail the Medicaid Denial Letter to the veteran, any affected medical providers identified by the veteran, and Alaska Medical Assistance.

Updated 04/03

Providers Can Attach Other Insurance Benefit Booklet Pages

Providers are required to bill all applicable third party resources and insurance carriers prior to billing Medical Assistance.

If the service is not covered according to the third party resource or insurance carrier benefit booklet, providers may attach a copy of the benefit booklet page(s) to the claim submitted to Medical Assistance. The benefit booklet page(s) must specify the patient's benefit plan name and indicate that the service being billed to Medical Assistance is not covered. It may be necessary to copy the benefit booklet's cover page which identifies the benefit plan name as well as any page(s) within the booklet that describes the coverage or non-coverage of the specific service category being billed to Medical Assistance.

Providers may also use benefit booklet pages as specified above when requesting Third Party Liability (TPL) Avoidance. The TPL Avoidance process is explained on the following pages.

Updated 09/02

Third Party Liability (TPL) Avoidance

Medical Assistance and **First Health Services Corporation** have developed a process to assist providers with Medical Assistance claims for clients who have primary (third party) insurance coverage. The process may affect claims that the third party carrier has denied because

- The service is not covered by the benefit plan
- The recipient's yearly or lifetime maximum benefits for a service have been exhausted
- The servicing provider's credentials do not meet requirements for coverage by the insurance carrier

The Third Party Liability (TPL) Avoidance process allows the Medical Assistance claims payment system to bypass TPL editing when certain conditions are met. This procedure eliminates the need for providers to bill the primary insurance company for services that the insurance does not cover. The request for TPL Avoidance review must include documentation from the carrier specifically stating the services that are not covered and a valid reason for the denial. Services that were billed to the TPL carrier incorrectly or services for which required authorization was not received in advance are examples of conditions that would ***not*** qualify for TPL Avoidance. Other conditions may also apply. All requests for TPL Avoidance will be reviewed and if the request is approved, the requirement to bill the third party insurance will be waived.

Updated 09/02

Guidelines for Requesting TPL Avoidance and Criteria for Review

- TPL Avoidance is limited to ongoing services.

Example: If a recipient receives an influenza injection and the TPL carrier does not cover the service, this is a one-time event and is not considered ongoing. However, if a recipient is receiving medication management as a continuing service and the TPL carrier does not cover it, it is considered an ongoing service and is a candidate for a TPL Avoidance review.

- To request a review for TPL Avoidance for a specific recipient, complete the **TPL Avoidance Request Form** and attach the corresponding Explanation of Benefits (EOB), letter of explanation from the TPL carrier that specifically documents the reason for the non-payment of the service(s), or a copy of third-party resource benefit book page(s) that indicates the benefit plan name and that the service being billed is not covered. Both EOBs and denial letters must be specific to the recipient as well as the service rendered and must include a valid procedure code or ICD code and a valid reason for non-coverage.
- Recipients may exhaust maximum lifetime or yearly limitations for services that their TPL carrier will cover. When the maximum has been reached, attach the EOB reflecting this to the completed TPL Avoidance Request form and submit for TPL Avoidance review.

A request for TPL Avoidance review requires attached documentation that meets the guidelines stated above. Once a TPL Avoidance record is approved and on file, matching claims do not require an attachment and do not require TPL review before payment can be made.

Documentation will need to be updated periodically for continued TPL Avoidance.

Updated 04/02

Non-covered Medicare HCPCS Codes

Codes published in the HCPCS coding manual that are indicated to be non-covered by Medicare are included in the Alaska Medical Assistance TPL Avoidance file. This file is updated annually. When codes are added to the TPL Avoidance file, the claims processing system will not search for related third-party information (e.g., Medicare in this example) when processing a claim with those codes. Therefore, if you bill for one of these codes, the code will be recognized as a non-covered Medicare code and you will not be required to bill Medicare. Please note that even though you will not be required to bill Medicare, it is not guaranteed that Medical Assistance will cover the item or service provided.

Updated 08/03

All incontinence supplies listed in the HCPCS as “T” codes are included in the Alaska Medical Assistance TPL Avoidance files for all carriers.

Updated 01/06

ALASKA MEDICAID
TPL-AVOIDANCE REQUEST

Complete sections 1 and 2 - please print

Section 1.	**Provider Information**		
Today's Date:	Medicaid Provider Number:	Phone Number:	Fax Number:
Medicaid Provider Name:		Contact Name:	

Section 2.	**TPL-Avoidance Request Information**	
Recipient's Name:	Medicaid ID Number:	Resource Code*:

Do you have an attachment from the insurance company stating that this policy has terminated?: ☐ **- Yes** ☐ **- No**
If yes, please fax the attachment with this request.

↓ ***Please complete only fields that apply to this request*** ↓

Procedure Code(s):	Diagnostic Code(s):	Revenue Code(s):

LIFETIME
maximum exhausted? **Date Exhausted**: / /

YEARLY
maximum exhausted? **Date Exhausted**: / / **Date Renews**: / /

Additional/other related information to be considered for this TPL Avoidance request:

Please fax completed request with valid documentation to:

First Health Claims Operations
Fax: (907) 644-8122

Section 3. (Medicaid Use Only)	**Medicaid Determination**		
Request approved as follows: ☐	**Request Denied:** ☐ (see Comments)		
Recipient's Name:	Medicaid ID Number:	Resource Code:	
Medicaid Provider ID Number:	Type of Service:	Revenue Code:	Other (explain):

Start Date: / / (No end date for **LIFETIME** benefit maximum)

Start Date: / / End Date: / / (**YEARLY** benefit maximum)

Procedure Code(s):	Diagnosis Code(s):	Revenue Code(s):

Comments:

* The Resource Code identifies the insurance resource for which you are requesting TPL-Avoidance. You can find the code on the Medicaid coupon, DKC Card, or by calling the EVS system. If a recipient has more than one insurance, you may request TPL Avoidance for only ONE per form.

NOTE: Claims that are approved for TPL Avoidance will appear with one of the following messages on the Adjudicated Claims page of your Remittance Advice.
404 (TPL Avoidance Match – TPL Resource)
405 (TPL Avoidance Match – Medicare Resource)

07/04

Figure I-3: TPL Avoidance Request Form

Claims Billing Procedures

Claims: General Instructions

Claim forms are designed for computer processing. When completed, the forms contain information necessary to process claims for services rendered to Medical Assistance recipients. Adhere to the following instructions for claims to be processed efficiently. Accuracy, completeness, and clarity are important.

1. Do not fold or crease claims.
2. Fill in handwritten claims neatly and accurately.
3. Keep names, numbers, codes, etc., within the designated boxes and lines.
4. Make corrections carefully. Do not strike or write over errors to correct. Correction fluid or tape may be used as long as the corrected information is readable.
5. Include a return address on all claims and mailing envelopes.
6. Send only required attachments.

Updated 04/02

Claims: Specific Instructions

All charges for reimbursement must be billed on the Centers for Medicare and Medicaid Services (CMS-1500) health insurance claim form. The required information must be included in the appropriate field on the claim form. Instructions for completing the claim form can be found on subsequent pages in this section. DME providers can also bill electronically using PayerPath or National Standard Format, as described below.

When completing the claim form, the provider must supply the ICD-9 diagnosis code in Field 21 of the CMS-1500. (Refer to Section III for information about diagnosis codes.) In addition, the date(s) of service (Field 24A) must be the date that the recipient takes possession of the items.

Updated 01/06

Payerpath

Submit claims via the Internet with Payerpath, a free, Internet-based claims submission system. Payerpath's features include immediate claims editing, correction prior to submission, and patient re-bill demographics. In addition, providers can export files from their practice management systems to Payerpath, eliminating the need of "double entry."

Updated 01/06

X12N 837 Version 4010

Use existing practice management software to export files in a HIPAA compliant format and then submit the files to First Health Services electronically. The provider's practice management system vendor will know if the software can export an electronic file. To bill your claims correctly using this format, you will need the 837 Companion Guide for this claim type. These specifications can be obtained by accessing the First Health Services website at http://alaska.fhsc.com or by contacting FHSC's ECCS department.

To bill Medical Assistance claims electronically, you must complete the Provider Information Submission Agreement (PISA) form. This form is available from First Health Services via the website, Provider Enrollment Unit or ECCS department. Refer to "Telephone Inquiries" and "Addresses" in the front of this manual for contact information.

Updated 01/06

Electronic Transaction Information

If you would like more information about electronic transactions or to request electronic media specifications, call (907) 644-6800 or 1-800-770-5650 (toll-free in Alaska) and ask for the ECCS department.

Updated 01/06

Health Insurance Claim Form (CMS-1500) Instructions

Each number listed below refers to the field on the sample CMS-1500 claim form. Required fields when billing on a paper claim form are indicated with an asterisk (*); additional fields may be required for providers billing electronically in a HIPAA-compliant format.

Claim Field Identification		Explanations and Instructions
1.	Medicare/Medicaid/CHAMPUS/etc	Select Medicaid.
*1a.	Insured's I.D. Number	**Required.** Enter the patient's 10-digit Medical Assistance identification number as it appears on the eligibility coupon/label.
*2.	Patient's Name	**Required.** Enter the following information as it appears on the eligibility coupon: patient's first name, middle initial, and last name in full.
3.	Patient's Date of Birth/Sex	Optional. If used, enter patient's date of birth in MM/DD/YY format.
4.	Insured's Name	No entry needed.
5.	Patient's Address	Optional. If used, enter the following information: patient's full street address, city, state, and ZIP code.
6.	Patient's Relationship to Insured	Select Self.
7.	Insured's Address	No entry needed.
8.	Patient Status	Select the appropriate box.
*9. - 9d.	Other Insured's Name	**Required,** if the patient has other insurance, as indicated in field 11d. Enter the name of the policyholder, plan name and address, and policy number. **Note:** If an approved TPL avoidance record is on file, leave this field blank.
10.	Is Patient's Condition Related to A. Employment B. Auto Accident C. Other Accident	Optional. If used, select the appropriate box.
10d.	Reserved for Local Use	No entry needed.
11. - 11c.	Insured's Policy Group or FECA Number	No entry needed.
*11d.	Is There Another Health Benefit Plan	**Required.** Select the appropriate box. If "yes" is selected, complete fields 9 through 9d.

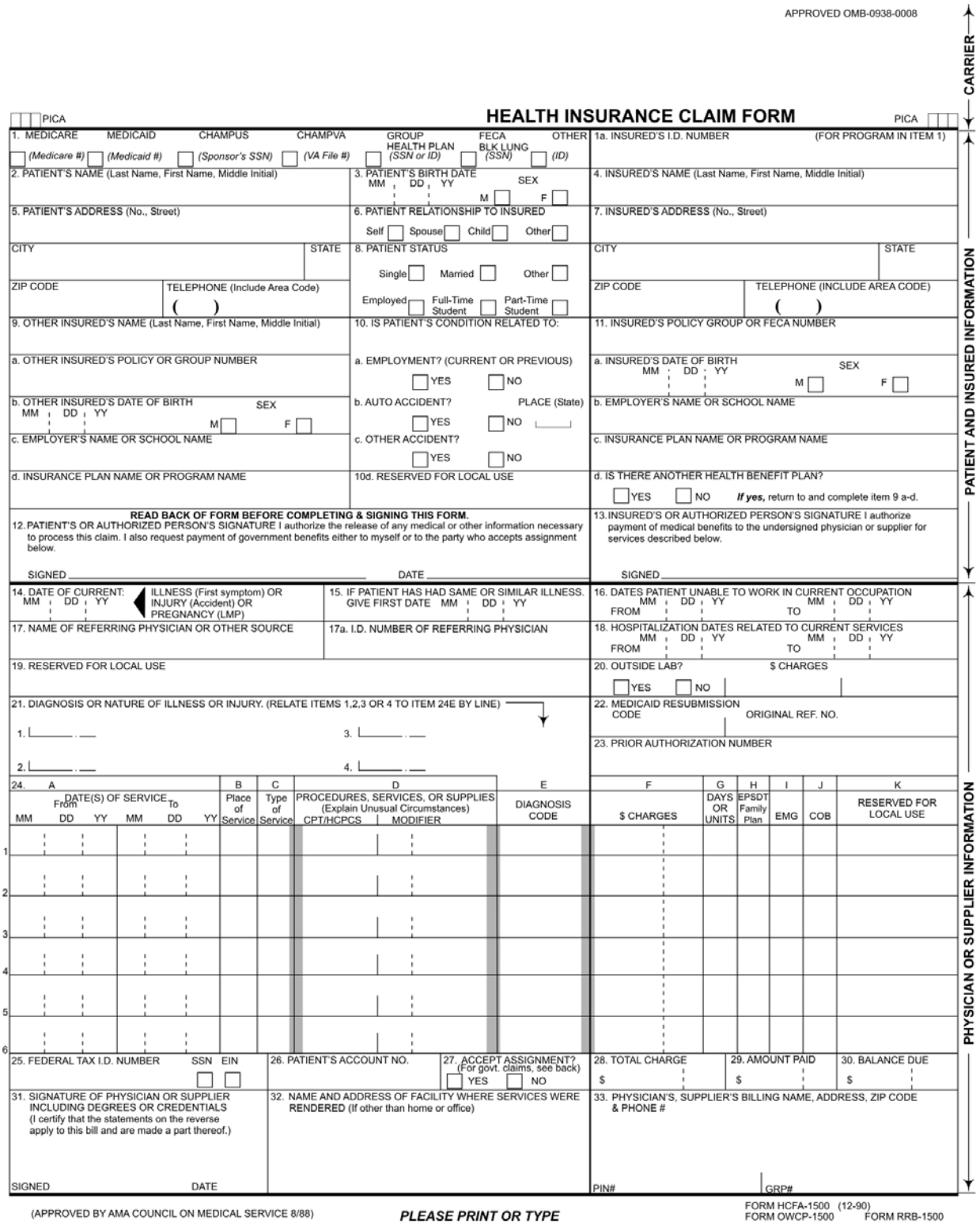
Claim Field Identification		Explanations and Instructions
12. - 13.	Signature	Have the form signed by the appropriate individuals or indicate if the signatures are on file
14.	Date of Current Illness or Injury or Pregnancy	Optional. If used, enter the date of the diagnosis.
15. -16	If Patient Has Had Same or Similar Illness, Give First Date/Dates Patient Unable to Work in Current Occupation	No entry needed.
17.	Name of Referring Physician or Other Source	Required. Enter the name of the provider who ordered the services or items.
17a.	I.D. Number of Referring Physician	Required, if enrolled in Alaska Medical Assistance. Enter the Medical Assistance provider ID number of the provider who ordered the services or items.
18.	Hospitalization Dates Related to Current Services	No entry needed.
*19.	Reserved for Local Use	**Required,** if applicable. If the provider performing the service is not the billing provider, enter the Medical Assistance provider number of the rendering provider. This applies to members of a group practice.
20.	Outside Lab?	No entry needed.
*21.	Diagnosis or Nature of Illness or Injury	**Required.** The diagnosis description and the ICD-9-CM diagnosis codes that describe the primary and secondary diagnoses must be entered.
		Note: The primary diagnosis on the claim must match the primary diagnosis in the recipient's clinical record and an approved PA.
22.	Medicaid Resubmission Code	No entry needed.
*23.	Prior Authorization Number	**Required** if any of the services being billed on the claim form have been prior authorized. Enter the 8-digit prior authorization number.
*24A.	Date(s) of Service (From/To)	**Required.** Enter the "from" and "to" date(s) that services were rendered, in MM/DD/YY format (e.g., January 15, 2001, would be 011501). Services must be billed with single dates of service. The "from" and "to" dates of service must match. Each service/procedure must be entered on a separate line with no more than six lines per claim form. Both a "from" and a "to" date of service are required.
		Note: The date that services were rendered is the date that the recipient takes possession of the items.

Claim Field Identification		Explanations and Instructions
*24B.	Place of Service	**Required.** Enter the appropriate two digit place of service code where the services occurred.
24C.	Type of Service	No entry needed.
*24D.	Procedures, Medical Services or Supplies	**Required.** Enter the appropriate procedure codes, modifiers, and descriptions of services.
		Modifier: Enter "RR" for rental of equipment. A written description is also required. **Note:** When billing for services that have been prior authorized, enter the procedure code and modifier (if applicable) that were approved. The code and modifier being billed must match those on the prior authorization. Remember to attach the NDC that describes the prescribed product and the requested quantity for prior authorized skin sealants, protectants, moisturizers, ointments, cleansers, and sanitizers.
*24E.	Diagnosis Code	**Required.** Enter the line number of the diagnosis code from Field 21 that applies to the procedure performed (e.g., "1" or "2"). Only the primary and secondary diagnoses are recognized.
		Note: The primary diagnosis on the claim must match the primary diagnosis in the recipient's clinical record and an approved PA.
*24F.	Charges	**Required.** Enter your actual fee for the services. If billing more than one unit of a service, the figure entered in this field reflects the total fee for all the units billed on this claim line.
*24G.	Days or Units	**Required.** Enter the number of units appropriate to the services rendered.
*24H.	EPSDT/Family Plan	**Required,** if applicable. Enter "1" if services rendered are related to family planning; "2" if related to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); and "3" if related to both. Leave blank if neither apply.
24I.	EMG	No entry needed.
24J.	COB	No entry needed.
24K.	Reserved for Local Use	No entry needed.
*25.	Federal Tax ID Number	**Required.** Enter the tax ID number for the billing provider.
26.	Your Patient's Account No.	Optional. This is for the convenience of the provider for identifying the claim on the Remittance Advice. Enter a maximum of 10 alpha or numeric characters.
*27.	Accept Assignment?	**Required** if applicable. Select the appropriate box.
*28.	Total Charge	**Required.** Enter the total for all charges listed in Column 24F.

Claim Field Identification		Explanations and Instructions
*29.	Amount Paid	**Required,** if applicable. Enter the amount paid by any insurance carrier or legal settlement. Attach the Explanation of Benefits (EOB) for the paid amount.
*30.	Balance Due	**Required,** if Field 29 is used. Enter the difference between Field 28 (Total Charge) and Field 29 (Amount Paid).
*31.	Signature of Physician or Supplier	**Required.** The claim must be signed and dated by the health care provider or an assigned representative. A facsimile signature is acceptable. The claim cannot be prepared and signed/dated prior to the date of services being rendered. The signature date becomes the billing date and must not be a future date nor a date before the latest date of service on the claim.
*32.	Name and Address of Facility Where Services Were Rendered	**Required** if different from the address in field 33. Enter the name and address of the location where services were provided.
*33.	Physician's, Supplier's Billing Name, Address, ZIP Code & Phone #	**Required.** Enter the following information as shown on your Medical Assistance provider agreement: name, street address, city/state, ZIP Code, and telephone number. Enter your Medical Assistance billing provider number in the GRP# section of this field.

Note: The Health Insurance Claim Form is a two-part form. Keep the bottom copy and mail the top copy to the appropriate claims address on Page vi.

Updated 01/06



APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

Figure I-4: Health Insurance Claim Form (CMS-1500)

Medicare/Medical Assistance Crossover Billing

When a recipient is covered by both the federal Medicare Program and Alaska Medical Assistance and benefits are payable through both Medicare and Medical Assistance, the "crossover billing" format is used. Recipients who have Medicare will have specific resource codes on their Medical Assistance identification card: "G," "H," or "J" (refer to "Resource Codes" in Section III).

Medical Assistance and Medicare cover many of the same services[8]. The crossover billing is intended to automatically cross over by tape submission from Medicare to Medical Assistance. Medicare establishes the allowed amount for the service, determines if the patient's deductible has been met, and pays the appropriate percent of the Medicare allowable amount after subtracting any unmet deductible. The provider will receive payment or denial of payment from Medicare, along with an Explanation of Medicare Benefits/Medicare Remittance Notice (EOMB/MRN). When the Medicare payment information has automatically crossed over, a statement similar to the following may appear on the EOMB/MRN:

"Medicare payment information has been forwarded to the supplemental insurer indicated on your claim."

If your crossover billing is not adjudicated by Medical Assistance within 45 days of your Medicare payment, submit a claim to Medical Assistance for the residual amount (deductible or coinsurance). ***Attach the EOMB/MRN.*** The Medicare non-allowed or disallowed charges shown on the EOMB/MRN are not included in the Medical Assistance balance due. Alaska Medical Assistance will pay only for the sum of the coinsurance and deductible, minus any third party insurance payment.

Updated 12/02

Billing Medical Assistance for Services Denied or Limited by Medicare

Services denied by Medicare because of non-coverage or exhausted benefits may be billed to Medical Assistance if the recipient is eligible for these Medical Assistance services. These claims must be prepared as a regular Medical Assistance claim, with the EOMB/MRN showing the denial attached behind the claim. **Do not use the crossover format.**

If services and supplies are listed as non-covered in "The Medicare Handbook" or other Medicare source, identify the source and attach a copy behind the Medical Assistance claim. This can be done in place of filing with Medicare for those services or supplies known to be non-covered, thus eliminating the wait for a denial on an EOMB/MRN.

Updated 12/02

Completing the Medicare/Medical Assistance Crossover Billing

To complete a Health Insurance Claim Form (CMS-1500) for Medicare/Medical Assistance crossover billing, follow the instructions below. Each number listed refers to the field on the sample claim form (Figure I-6). All fields listed are required in the format indicated.

Claim Field Identification		Explanations and Instructions
1a.	Insured's I.D. Number	**Required.** Enter the patient's 10-digit Medical Assistance identification number as it appears on the eligibility coupon/label.
2.	Patient's Name	**Required.** Enter the following information from the eligibility coupon: patient's first name, middle initial, and full last name.
24A.	Date of Service/Line 1 (From/To)	**Required.** Enter the "from" and "to" date(s) that services were rendered, in MMDDYY format (e.g., January 2, 2002, would be 010202). Dates must match dates of service on the Explanation of Medicare Benefits/Medicare Remittance Notice (EOMB/MRN).

[8] If you are billing a non-covered Medicare HCPCS code, you are not required to bill Medicare.

Claim Field Identification		Explanations and Instructions
24A.	Date of Service/Line 3	**Required.** Enter the date of the EOMB/MRN. If you are attaching more than one EOMB/MRN to your crossover claim, the date entered in this field is the most current EOMB/MRN date.
24D.	Procedures, Services or Supplies (Explain Unusual Circumstances)	**Required.** "Explain Unusual Circumstances." Enter the following words: Line 1 = "Medicare allowed amount" Line 2 = "Coinsurance" Line 3 = "Deductible" Line 4 = "Other third party payment"
24F.	Charges/Line 1	**Required.** Enter the total amount *allowed* by Medicare. If you are submitting multiple claims and EOMB/MRNs on this Medical Assistance recipient, enter the total of all allowed amounts from all EOMB/MRN pages. Attach the EOMB/MRNs behind each claim; if there is more than one page to an EOMB/MRN, be sure to attach a copy of all pages.
24F.	Charges/Line 2	**Required.** Enter the amount of *coinsurance* indicated on the EOMB/MRN. If you are submitting multiple claims or EOMB/MRNs on this Medical Assistance recipient, enter the total of all coinsurance amounts from all EOMB/MRN pages.
24F.	Charges/Line 3	**Required.** Enter the amount of *deductible* indicated on the EOMB. If you are submitting multiple EOMB/MRNs on this Medical Assistance recipient, enter the total of all deductible amounts from all EOMB/MRN pages.
24F.	Charges/Line 4	**Required,** if applicable. Enter any *third party insurance payment* and attach the EOB.
28.	Total Charge	**Required.** Enter the total charge billed to Medicare, as represented on the EOMB/MRN(s) you are attaching to the crossover claim.
29.	Amount Paid	**Required.** Enter the amount *paid by Medicare*.
30.	Balance Due	**Required.** Enter the amounts of coinsurance plus deductible less any third party payment received. This represents the portion Medical Assistance will pay for eligible recipients.
31.	Signature of Physician or Supplier	**Required.** The claim must be signed and dated by the provider or an assigned representative. A facsimile signature is acceptable. The claim cannot be prepared and signed/dated prior to any of the dates listed in Field 24A.
33.	Physician's, Supplier's Billing Name, Address, ZIP Code & Phone #	**Required.** Enter the following information as shown on your Medical Assistance provider agreement: name, street address, city/state, ZIP code, and telephone number. Enter the *Medical Assistance provider number i*n the GRP# section of this field.

Note: The Health Insurance Claim Form is a two-part form. Keep the bottom copy and mail the top copy to the appropriate claims address on Page vi.

The sample EOMB/MRN in Figure I-5 has circled numbers of the required items needed to complete the Medicare/Medical Assistance crossover billing. Figure I-6 shows the completed form with corresponding circled numbers. Remember that your EOMB/MRN ***must accompany your billing.***

Updated 04/04

MEDICARE Payment Report
For Health Insurance • Social Security Act

AK-RP-000123

Provider Number	Check Number	Statement Date (24a, line 3)	Page
X00X00X	01	01/31/01	1

Patient John Doe (2) **HIC** 123456789A **ICN** 1234567890111 **ACT** **EOB** **Offset** 0.00

MMDD-MMDDY (24A, line 1)	Pt	Proc Mods	Num	Billed	Allowed (24F, line 1)	AC	Deduct (24F, line 3)	Coinsur (24F, line 2)	Interest	Other (24F, line 4)	Pt Pd	Prov Pd (29)	Provider
0112 01121	1	99214	001	120.00	96.00	01	0.00	19.20	0.00	0.00	0.00	76.80	X00
0115 01151	1	99214	001	120.00	96.00	01	0.00	19.20	0.00	0.00	0.00	76.80	X00
		Claim Totals		240.00 (28)	192.00		0.00	38.40	0.00	0.00	0.00	153.60	

Figure I-5: Sample EOMB/MRN (Medicare Payment Report)

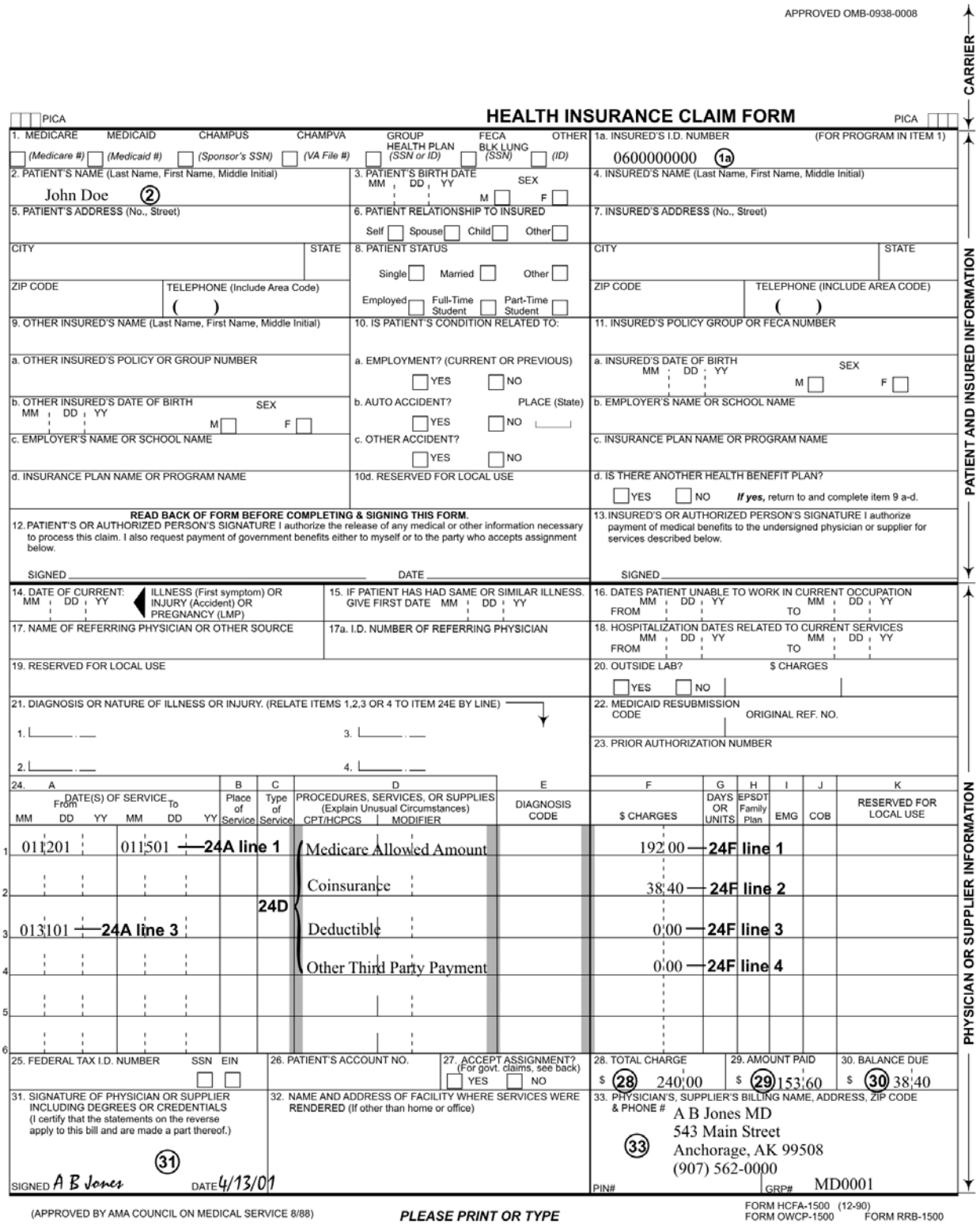


Figure I-6: Sample Completed Medicare/Medical Assistance Crossover Billing (CMS-1500)

Section II
Supplemental Documents and Instructions

Attachments to the Claim Form

Certain services billed on claim forms submitted to First Health Services require additional documentation for the provider to receive payment. The following attachments may be required.

Updated 04/04

Written Explanation

If a provider is unable to locate a code to explain the procedure or service rendered to the recipient, an *unlisted procedure code* may be used. A written explanation must be attached behind the provider's claim, which includes

- A description of the procedure or service rendered.
- The reason no other procedure was appropriate for the procedure or service rendered.

Updated 01/06

Proof of Timely Filing Documentation

Claims that are submitted after the timely filing period has expired will require that documentation is attached for review of timely filing.

The provider will be asked to attach proof of timely filing documentation showing that either the original claim was filed within the twelve month timely filing requirement or the claim met one of the conditions for timely filing extension.

Documentation for proof of timely filing and conditions for timely filing extension of claims are discussed in detail in Section III of this manual.

Updated 08/03

Electronic Claims Attachment Transmittal

When transmitting an electronic claim, complete the "First Health Services Corporation Electronic Claims Attachment Transmittal" (sample in Figure II-1) and fax with any required attachment ***on the same day that you transmit your electronic claim***. Include the unique attachment control number, recipient name, and Medical Assistance identification number ***on the attachment***. Use only the fax number for EDI attachments [(907) 644-8122 or (907) 644-8123], shown on the transmittal form and on the "Telephone Inquiries" page. For additional information, please refer to the "Alaska Trading Partner Companion Guide" located on the First Health Services website at http://alaska.fhsc.com/.

Updated 04/06

First Health Services Corporation®
A Coventry Health Care Company

ATTACHMENT FAX COVER SHEET
P.O. Box 240808 • ANCHORAGE, ALASKA 99524-0808
TELEPHONE: (907) 644-6800 or 1-800-770-5650
FAX (907) 644-8122/(907) 644-8123

To: _____ Date: _____

From: _____ Fax#: _____

Number of Pages: _____ Time: _____

Submitter Number: _____ MCN #: _____

Submission Date: _____ Provider #: _____

Indicate the Transaction Type:

☐ 837P(rofessional) ☐ 837I(nstitutional) ☐ 837D(ental)

☐ Transportation/Accommodation or Other Non-covered Entity
(Include the recipient ID number on each page faxed)

Unique Attachment Control Number(s):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Include the appropriate Attachment Control Number on each faxed page.

CONFIDENTIALITY NOTICE

This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution of this communication is expressly prohibited. If you are not the intended recipient, please notify the sender at the sender's fax number above and destroy any and all copies of the original message. Thank you.

Rev. 1/13/06

Figure II-1: Electronic Claims Attachment Transmittal

Insurance Explanation of Benefits (EOB)

If the Medical Assistance recipient has insurance coverage, attach a copy of the EOB from the insurance company, showing the payment or denial. Sample EOB is in Figure II-2.

If the service is not covered according to the third-party resource or insurance carrier benefit booklet, you may attach a copy of the benefit booklet page(s) to the claim. These pages must specify the patient's benefit plan name and must indicate that the service being billed to Alaska Medical Assistance is not covered. If you attach such pages, you do not have to bill that third-party resource or attach an EOB from that insurance company.

Updated 04/02

EXPLANATION OF BENEFIT PAYMENT

Administration Office: P.O. Box 1234 Seattle, WA 98123 (206) 281-0000

Benefits Provided Through: Alaska H&W Trust

Underwritten by: Aetna Life & Casualty

Date: 1/31/01
SS#: XXX-XX-XXXX
Type: Medical
For: John H. Doe
Plan #: 020304

John H. Doe
123 Side Street
Anytown, AK 99500

A. B. Jones, MD
543 Main Street
Anchorage, AK 99503

Provider: A. B. Jones

1/15/01 Office Visit **Charge:** $60.00
Total Allowed: $48.00 **Paid:** $48.00 **Patient Balance:** $12.00

If you need claim forms, please contact Alaska H&W Trust at Fourth and F, Anchorage, AK 99501. Telephone: (907) 561-0000

Figure II-2: Insurance Explanation of Benefits (EOB)

Explanation of Medicare Benefits/Medicare Remittance Notice (EOMB/MRN) or Medicare Payment Report

When filing a claim for the Medical Assistance portion of Medicare deductible or coinsurance, always attach the EOMB/MRN or Medicare Payment Report (sample in Figure II-3) behind your claim form. ***A claim without the EOMB/MRN attached will be denied.***

Updated 10/02

MEDICARE Payment Report
For Health Insurance • Social Security Act

AK-RP-000123

Provider Number	Check Number	Statement Date	Page
X00X00X	01	01/31/01	1

Patient John Doe **HIC** 123456789A **ICN** 1234567890111 **ACT** **EOB** **Offset** 0.00

MMDD-MMDDY		Pt	Proc Mods	Num	Billed	Allowed	AC	Deduct	Coinsur	Interest	Other	Pt Pd	Prov Pd	Provider
0112	01121	1	99214	001	120.00	96.00	01	0.00	19.20	0.00	0.00	0.00	76.80	X00
0115	01151	1	99214	001	120.00	96.00	01	0.00	19.20	0.00	0.00	0.00	76.80	X00
			Claim Totals		240.00	192.00		0.00	38.40	0.00	0.00	0.00	153.60	

Figure II-3: Explanation of Medicare Benefits/Medicare Remittance Notice (EOMB/MRN)/Medicare Payment Report

Transportation Authorization and Invoice (AK-04)

The Transportation Authorization and Invoice (AK-04) must be completed for Medical Assistance-covered travel and accommodation services.

All medically necessary non-emergency air, water, or ground transportation and all hotel and meals must be prior authorized on the AK-04 by calling the First Health Services' Prior Authorization (PA) Unit.

Updated 04/04

Requesting Transportation/Accommodation Services

Transportation/Accommodation requests may be obtained from First Health Services by Fax or by phone (refer to "Telephone Inquiries" on page v for phone numbers).

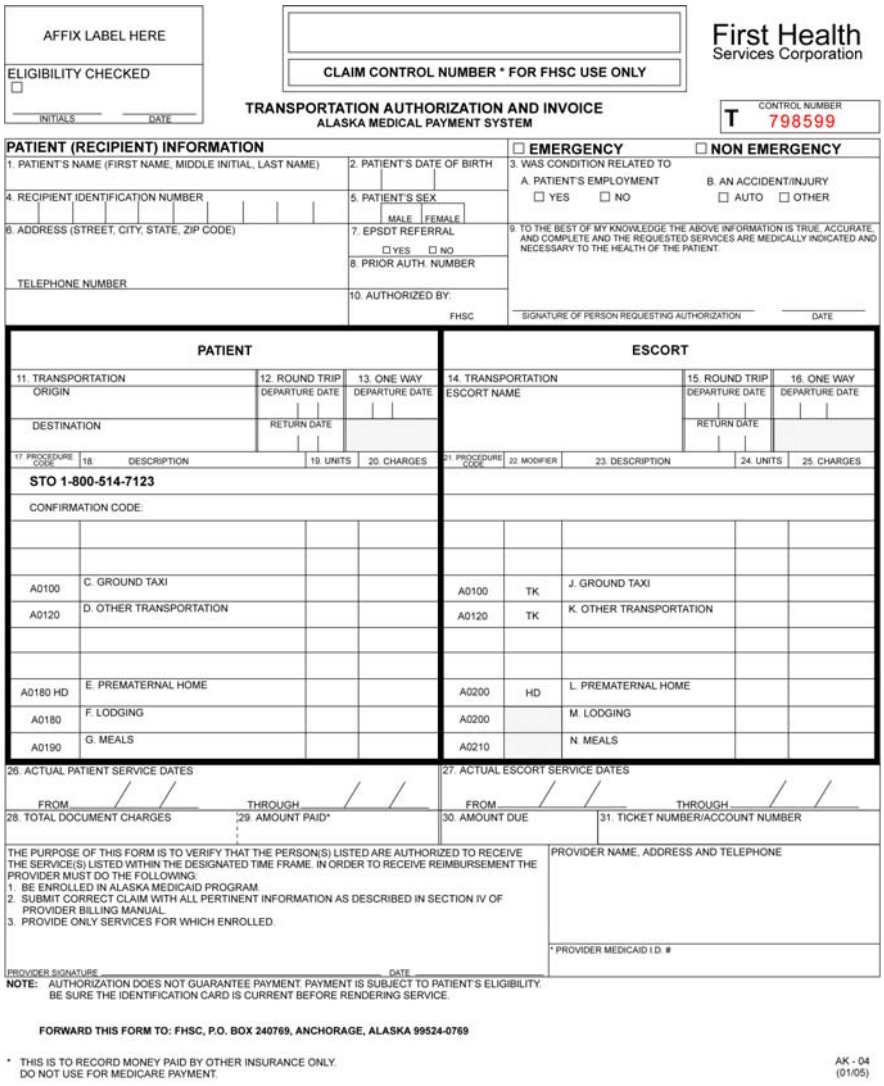
If requesting by Fax, make a photocopy of the Transportation Authorization and Invoice (AK-04) in Figure II-4 and complete the information indicated in the "Step by Step" instructions before sending the form to First Health Services. Be sure to list the number of units (Fields 19 and 24) you are requesting for travel, lodging, meals, and taxi. First Health Services will call you or fax to you the authorization number and authorizing agent's name. You can then enter this information on the appropriate forms.

If requesting by phone, prepare your AK-04 before placing the call by completing all the information shown in the "Step by Step" instructions. The First Health Services' PA Unit contact will give further instructions.

For more information about transportation and accommodation services, see Appendix E.

Updated 04/04

Step By Step



AFFIX LABEL HERE

ELIGIBILITY CHECKED ☐ INITIALS DATE

CLAIM CONTROL NUMBER * FOR FHSC USE ONLY

First Health Services Corporation

TRANSPORTATION AUTHORIZATION AND INVOICE
ALASKA MEDICAL PAYMENT SYSTEM

T CONTROL NUMBER 798599

PATIENT (RECIPIENT) INFORMATION

☐ EMERGENCY ☐ NON EMERGENCY

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)
2. PATIENT'S DATE OF BIRTH
3. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO
B. AN ACCIDENT/INJURY ☐ AUTO ☐ OTHER
4. RECIPIENT IDENTIFICATION NUMBER
5. PATIENT'S SEX MALE FEMALE
6. ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
7. EPSDT REFERRAL ☐ YES ☐ NO
8. PRIOR AUTH. NUMBER
10. AUTHORIZED BY: FHSC
9. TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
SIGNATURE OF PERSON REQUESTING AUTHORIZATION DATE

PATIENT

11. TRANSPORTATION ORIGIN
12. ROUND TRIP DEPARTURE DATE
13. ONE WAY DEPARTURE DATE
DESTINATION
RETURN DATE

17. PROCEDURE CODE	18. DESCRIPTION	19. UNITS	20. CHARGES
	STO 1-800-514-7123		
	CONFIRMATION CODE:		
A0100	C. GROUND TAXI		
A0120	D. OTHER TRANSPORTATION		
A0180 HD	E. PREMATERNAL HOME		
A0180	F. LODGING		
A0190	G. MEALS		

ESCORT

14. TRANSPORTATION ESCORT NAME
15. ROUND TRIP DEPARTURE DATE
16. ONE WAY DEPARTURE DATE
RETURN DATE

21. PROCEDURE CODE	22. MODIFIER	23. DESCRIPTION	24. UNITS	25. CHARGES
A0100	TK	J. GROUND TAXI		
A0120	TK	K. OTHER TRANSPORTATION		
A0200	HD	L. PREMATERNAL HOME		
A0200		M. LODGING		
A0210		N. MEALS		

26. ACTUAL PATIENT SERVICE DATES FROM THROUGH
27. ACTUAL ESCORT SERVICE DATES FROM THROUGH
28. TOTAL DOCUMENT CHARGES
29. AMOUNT PAID*
30. AMOUNT DUE
31. TICKET NUMBER/ACCOUNT NUMBER

THE PURPOSE OF THIS FORM IS TO VERIFY THAT THE PERSON(S) LISTED ARE AUTHORIZED TO RECEIVE THE SERVICE(S) LISTED WITHIN THE DESIGNATED TIME FRAME. IN ORDER TO RECEIVE REIMBURSEMENT THE PROVIDER MUST DO THE FOLLOWING:
1. BE ENROLLED IN ALASKA MEDICAID PROGRAM.
2. SUBMIT CORRECT CLAIM WITH ALL PERTINENT INFORMATION AS DESCRIBED IN SECTION IV OF PROVIDER BILLING MANUAL.
3. PROVIDE ONLY SERVICES FOR WHICH ENROLLED.

PROVIDER SIGNATURE DATE

PROVIDER NAME, ADDRESS AND TELEPHONE

* PROVIDER MEDICAID I.D. #

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.

FORWARD THIS FORM TO: FHSC, P.O. BOX 240769, ANCHORAGE, ALASKA 99524-0769

* THIS IS TO RECORD MONEY PAID BY OTHER INSURANCE ONLY. DO NOT USE FOR MEDICARE PAYMENT.

AK - 04 (01/05)

Complete Step A

(See next page)

DO NOT SEPARATE FORM

Complete Step B

(Fill out after Step A)

Prior Authorization will tell you when to separate the form. Complete one copy for each provider and one copy for each taxi ride.

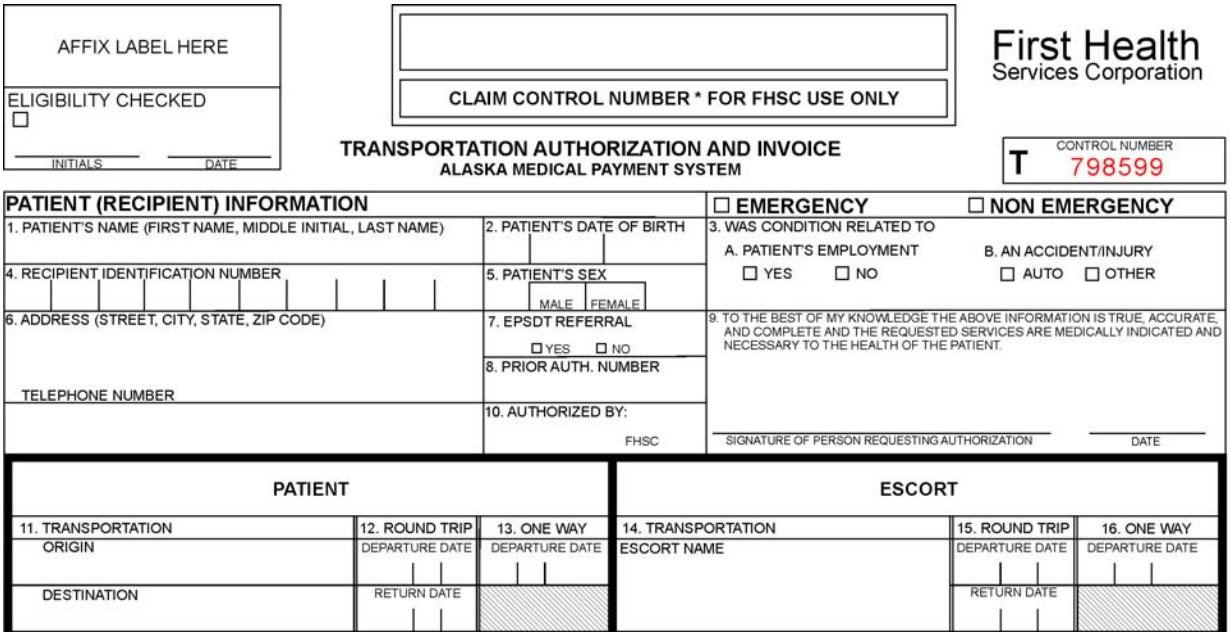
Step C

DO NOT FILL OUT THIS SECTION!

Figure II-4: Transportation Authorization and Invoice (AK-04)

Updated 03/05

Step A


AFFIX LABEL HERE

ELIGIBILITY CHECKED ☐

INITIALS DATE

CLAIM CONTROL NUMBER * FOR FHSC USE ONLY

First Health Services Corporation

TRANSPORTATION AUTHORIZATION AND INVOICE
ALASKA MEDICAL PAYMENT SYSTEM

T CONTROL NUMBER 798599

PATIENT (RECIPIENT) INFORMATION

☐ EMERGENCY ☐ NON EMERGENCY

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)
2. PATIENT'S DATE OF BIRTH
3. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO
B. AN ACCIDENT/INJURY ☐ AUTO ☐ OTHER
4. RECIPIENT IDENTIFICATION NUMBER
5. PATIENT'S SEX MALE FEMALE
6. ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NUMBER
7. EPSDT REFERRAL ☐ YES ☐ NO
8. PRIOR AUTH. NUMBER
9. TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.
10. AUTHORIZED BY: FHSC
SIGNATURE OF PERSON REQUESTING AUTHORIZATION
DATE

PATIENT

11. TRANSPORTATION
ORIGIN
DESTINATION
12. ROUND TRIP
DEPARTURE DATE
RETURN DATE
13. ONE WAY
DEPARTURE DATE

ESCORT

14. TRANSPORTATION
ESCORT NAME
15. ROUND TRIP
DEPARTURE DATE
RETURN DATE
16. ONE WAY
DEPARTURE DATE

Field		Explanation
	Eligibility Checked	Check the box, initial the line and enter the date after verifying eligibility.
	Emergency/Non-emergency	Check whichever applies.
1.	Patient's Name	Enter first name, middle initial, and last name (in that order).
2.	Patient's Date of Birth	Enter date in month/day/year order.
3.	Was Condition Related to Patient's Employment? An Accident or Injury?	Check whichever applies.
4.	Recipient Identification Number	Enter the recipient's (patient) 10-digit Medical Assistance identification number in the blocks provided.
7.	EPSDT Referral	If these travel arrangements are being made due to an EPSDT screening (Early and Periodic Screening, Diagnosis, and Treatment), mark the "yes" box.
9.	Signature of Person Requesting Authorization/Date	The person calling to get the authorization must sign and date the form here. Also enter phone number.
11.	Transportation (Patient)	Enter the name of the village or city where travel starts on the "origin" line, and the city the patient is going to on the "destination" line.
12.	Round Trip (Patient)	Enter the date the patient leaves and the date the patient returns if this is a round trip.
13.	One Way (Patient)	Enter the date the patient leaves if this is a one-way trip.

Field		Explanation
14.	Transportation (Escort)	Enter the first and last name of escort. Cross out escort portion of form if no escort is authorized and do not complete Fields 15, 16, and 24.
15.	Round Trip (Escort)	Enter the date the escort leaves and the date the escort returns if this is a round trip.
16.	One Way (Escort)	Enter the date the escort leaves if this is a one-way trip.

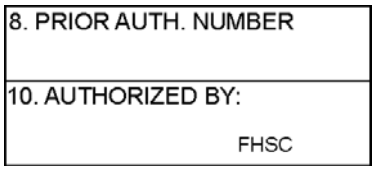
Updated 12/02

Step B

17. PROCEDURE CODE	18. DESCRIPTION	19. UNITS	20. CHARGES	21. PROCEDURE CODE	22. MODIFIER	23. DESCRIPTION	24. UNITS	25. CHARGES
STO 1-800-514-7123								
CONFIRMATION CODE:								
A0100	C. GROUND TAXI			A0100	TK	J. GROUND TAXI		
A0120	D. OTHER TRANSPORTATION			A0120	TK	K. OTHER TRANSPORTATION		
A0180 HD	E. PREMATERNAL HOME			A0200	HD	L. PREMATERNAL HOME		
A0180	F. LODGING			A0200		M. LODGING		
A0190	G. MEALS			A0210		N. MEALS		

Field		Explanation
17./18.	Procedure Code and Description (Patient)	Preprinted on form. If not preprinted on form, enter the code number on a blank line in Column 17 (Procedure Code) and the description on the same line in Column 18 (Description).
19.	Units (Patient)	Enter the number of units authorized by First Health Services (for example, 1 unit = 1-way airline trip). If code is not preprinted on form, enter units in Column 19 (Units) on the same line that you entered a code and description in Columns 17 and 18.
20.	Charges (Patient)	Do NOT fill in.
21.-23.	Procedure Code, Modifier, and Description (Escort)	Preprinted on form.
24.	Units (Escort)	Enter the number of units authorized by First Health Services.
25.	Charges (Escort)	Do NOT fill in.

After receiving the information for Fields 19 and 24, First Health Services will give you the information to place in Fields 8 and 10.



Field		Explanation
8.	Prior Auth. Number	Enter the 8-digit prior authorization number given to you over the phone by First Health Services for this service.
10.	Authorized By:	Enter the employee name of the First Health Services' staff member who gave you the prior authorization over the phone.

Updated 03/05

Remittance Advice

The Remittance Advice (RA) is a claim status report. It is produced for the Medical Assistance enrolled provider when there is claim activity to report, such as payment, denial, adjustment, pended claim, or claim requiring additional information. It tells the provider the status of each claim submitted for processing.

Following the cover page, an RA is organized into the following sections:

- Message Page(s)
- Adjudicated Claims (Paid and Denied Claims)
- Adjustment Claims
- Voided Claims
- In-Process Claims

Note: The Adjustment Claims, Voided Claims, and In-Process Claims sections are repeated as necessary to report all the types of claims a provider files; for example, your primary service, Medicare crossover claims, etc.

- Financial Transactions (refunds, for example)
- EOB Description Page
- Remittance Summary
- Resubmission Turnaround Document (RTD)

Sample sections of the RA are shown and explained on the following pages.

Updated 04/02

Cover Page

Used for mailing to the provider, the cover page contains the provider's Medical Assistance identification number, name, and address. See sample in Figure II-5.

Updated 04/02

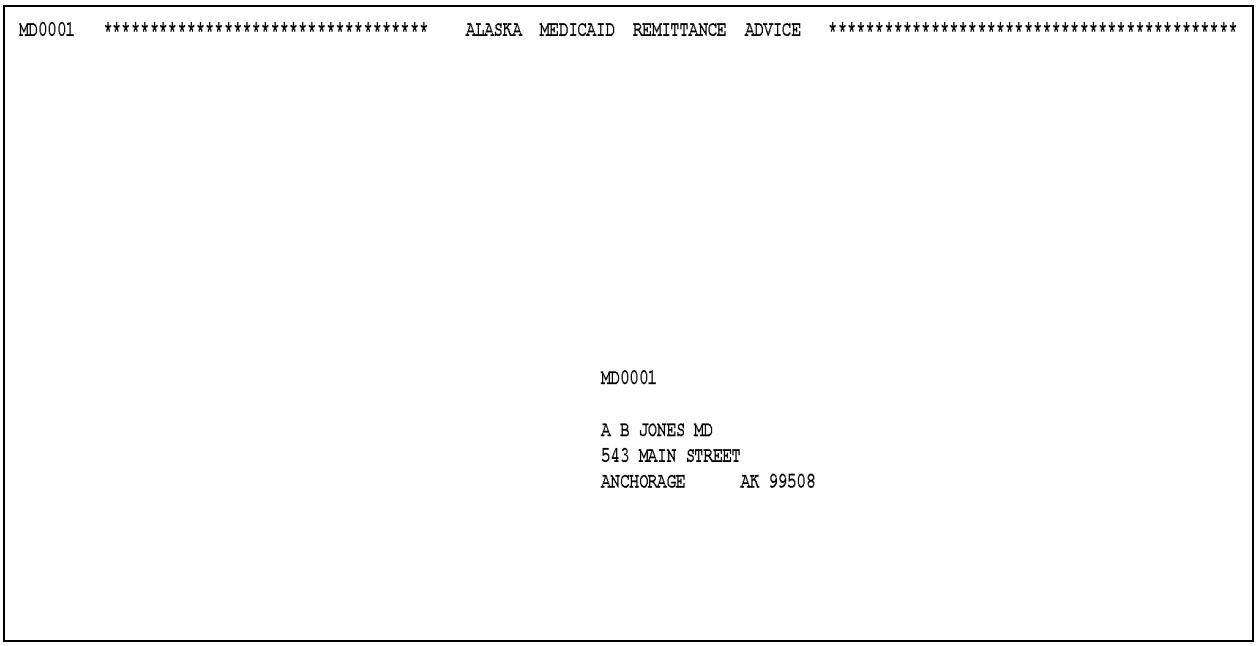
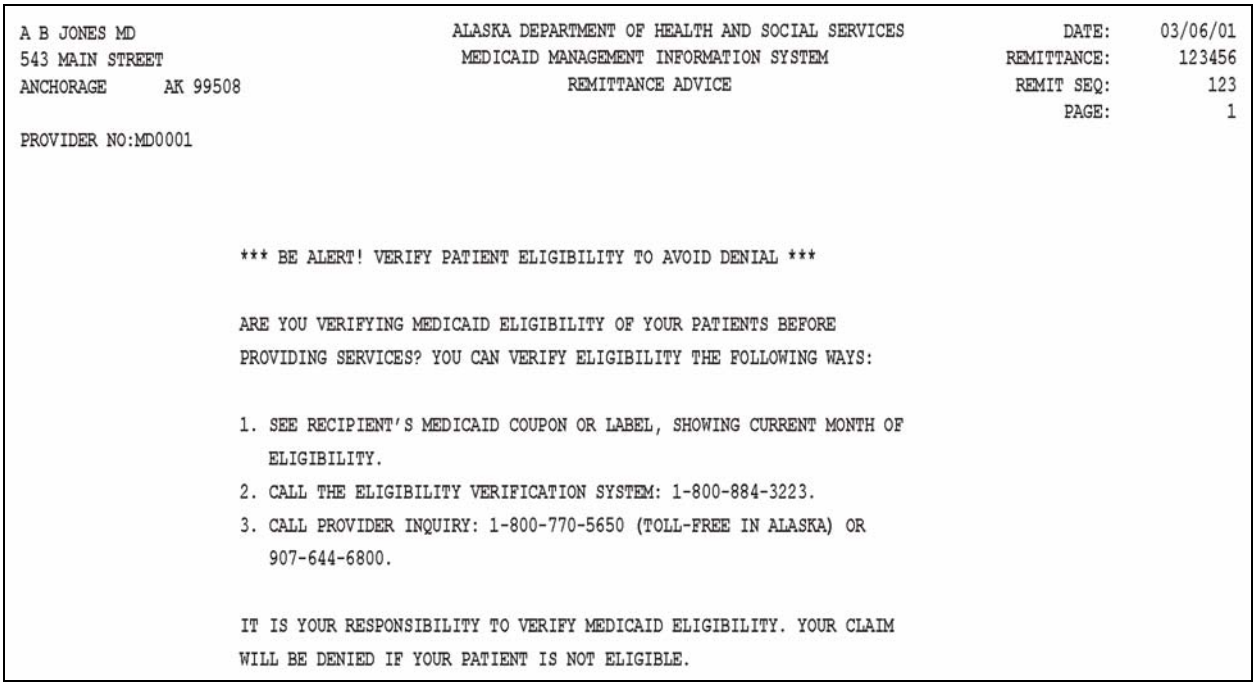


Figure II-5: Cover Page of the Remittance Advice

Message Page

The first section of the RA, following the cover page, is used to print messages from First Health Services to the provider. The message page is used to tell you about changes in billing procedures or program coverage. Careful attention to this information will aid your claims processing. A sample message page is in Figure II-6.

Updated 04/04



```
A B JONES MD                          ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES        DATE:      03/06/01
543 MAIN STREET                         MEDICAID MANAGEMENT INFORMATION SYSTEM          REMITTANCE:      123456
ANCHORAGE      AK 99508                           REMITTANCE ADVICE                     REMIT SEQ:          123
                                                                                           PAGE:            1
PROVIDER NO:MD0001


                    *** BE ALERT! VERIFY PATIENT ELIGIBILITY TO AVOID DENIAL ***

                    ARE YOU VERIFYING MEDICAID ELIGIBILITY OF YOUR PATIENTS BEFORE
                    PROVIDING SERVICES? YOU CAN VERIFY ELIGIBILITY THE FOLLOWING WAYS:

                    1. SEE RECIPIENT'S MEDICAID COUPON OR LABEL, SHOWING CURRENT MONTH OF
                       ELIGIBILITY.
                    2. CALL THE ELIGIBILITY VERIFICATION SYSTEM: 1-800-884-3223.
                    3. CALL PROVIDER INQUIRY: 1-800-770-5650 (TOLL-FREE IN ALASKA) OR
                       907-644-6800.

                    IT IS YOUR RESPONSIBILITY TO VERIFY MEDICAID ELIGIBILITY. YOUR CLAIM
                    WILL BE DENIED IF YOUR PATIENT IS NOT ELIGIBLE.
```

Figure II-6: Message Page of the Remittance Advice

Adjudicated Claims (Paid and Denied Claims)

Figure II-7 shows a sample RA page relating to adjudicated claims. To help you identify the information, note the circled number on the sample and refer to the corresponding explanation on the following pages.

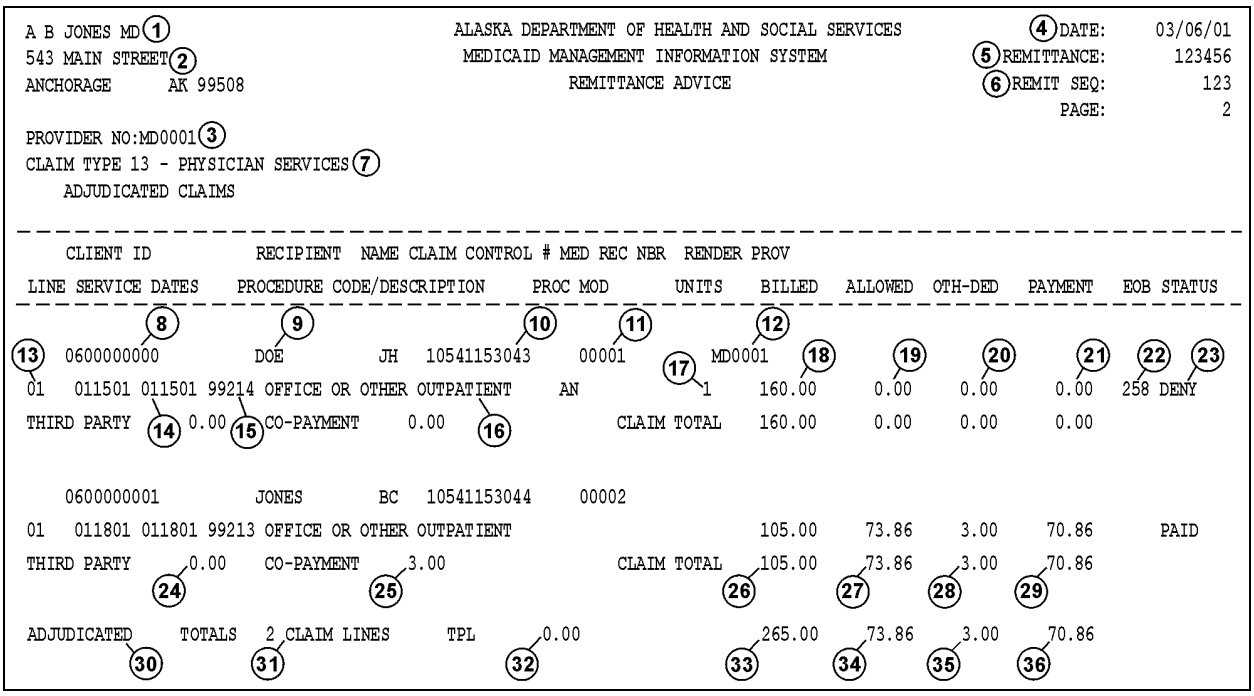


Figure II-7: Adjudicated Claim Page of the Remittance Advice

Circled Item	Adjudicated Claim Page Explanation
1.	**Provider Payee Name:** the name to which payment is made for services rendered.
2.	**Provider Payee Address:** the street, city, state, and zip code of the provider who is paid for the services.
3.	**Provider Number:** the Medical Assistance identification number of the billing provider.
4.	**Date:** the date the RA was created (the remittance cycle date).
5.	**Remittance:** a control number used by First Health Services in the production of RAs.
6.	**Remittance Sequence:** the identification number printed on the RA. The automated system maintains a count of RAs produced for each provider. This number helps individual providers make certain that all RAs are received and maintains a sequential file of the documents.
7.	**Claim Type:** identifies the type of claim filed by the provider.
8.	**Client ID:** the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).
9.	**Recipient Name:** the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file. If the claim is denied because the recipient number on the claim is invalid, no name will appear on the RA.
10.	**Claim Control Number:** the 11-digit number assigned to the claim by First Health Services for processing, based on the Julian Date calendar (see Appendix B).

Circled Item	Adjudicated Claim Page Explanation
11.	**Med Rec No. (Medical Record Number):** the number assigned to a recipient or a claim by the provider for reference purposes. If the provider has indicated a medical record number on the claim form, it is printed on the RA to help the provider identify the patient who received the services.
12.	**Rendering Provider:** the Medical Assistance identification number of the provider who rendered the services.
13.	**Line:** each line on the document is numbered and referenced here.
14.	**Service Dates:** the date or dates the services were performed.
15.	**Procedure Code:** the HCPCS or assigned code for the services or procedure rendered to the patient.
16.	**Description:** the description of the services rendered. This is printed on the RA as it is described in the Procedure Code File; therefore, it may not be the same as written on the claim when it was submitted.
17.	**Units:** the number of times/days that billed services were rendered.
18.	**Billed:** the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
19.	**Allowed:** the calculated claim payment amount before reduction due to third party liability (insurance), cutbacks, or denial.
20.	**Oth Ded (Other Deduction):** the portion of recipient cost sharing and third party reimbursement applied to this claim line.
21.	**Payment:** the amount calculated as due the provider for the service rendered after deductions.
22.	**EOB:** the principal explanation of benefits (EOB) code for the claim in its current status. Other EOB codes for each claim line are printed under the claim detail lines. The descriptions for these codes are listed on a separate page at the end of the RA. For a denied claim line, the EOB indicates the reason for the denial.
23.	**Status:** the disposition of each specific claim, e.g., paid, deny. ▪ **Paid.** Paid claim lines have passed final adjudication. They may be paid as submitted or at reduced amounts according to the program's reimbursement methodology. ▪ **Deny.** Denied claim lines represent those services that are unacceptable for payment. Denial may occur if claims information cannot be validated by First Health, if the billed service is not a program benefit, if line items fail the edit/audit process, or if the provider fails to return an RTD within the 90-day period. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within filing time limits.
24.	**Third Party:** the total amount paid by a third party resource on this claim.
25.	**Co-Payment:** the total amount of cost sharing paid by the recipient on this claim.
26.	**Claim Total Billed:** the total amount billed on this claim.
27.	**Claim Total Allowed:** the total amount allowed for this claim.

Circled Item	Adjudicated Claim Page Explanation
28.	**Claim Total Oth Ded:** the total amount of other deductions (third party reimbursement) for this claim.
29.	**Claim Total Payment:** the total amount of payment for this claim.
30.	**Claim Class Totals:** the name of each section of the RA that is being totaled (e.g., "adjudicated," "in-process," etc.).
31.	**Claim Lines:** the number of lines totaled for each section of the RA.
32.	**Total TPL:** the total amount paid by a third party resource for all claims in this section of the RA.
33.	**Total Billed:** the total amount billed for all claims in this section of the RA.
34.	**Total Allowed:** the total amount allowed for all claims in this section of the RA.
35.	**Total Oth Ded:** the total amount of third party reimbursement plus other deductions in this section of the RA.
36.	**Total Payment:** the total amount paid for all claims in this section of the RA.

Updated 06/02

Adjustment Claims

Previously paid claims may be adjusted if an error in billing or processing occurred. The provider must complete an Adjustment/Void Request Form (AK-05) within 60 days of the payment (or within 12 months of the date of service for services rendered 3/3/2001 and after) to adjust a previously paid claim. The procedure for adjusting a claim is discussed in "Adjustment/Void Request Form (AK-05)" later in this section. The use of the terms "Claim Control Number (CCN)" and "Identification Control Number (ICN)" are used interchangeably in the explanations that follow. The processed adjustment will appear in two parts on your Remittance Advice:

- **Credit.** Identified in the "Status" column, the credit lists the original CCN and reverses the original transaction. This is referred to on the adjustment claim page as "Adjust ICN." This portion adjusts the credits on the provider's 1099 by decreasing the amount.
- **Debit.** Identified in the "Status" column, the debit lists the new CCN and the corrected information and payment. It also lists the former CCN associated with the credit above. This is referred to on the adjustment claim page as "Former ICN." The date with the ICN is the date of the Remittance Advice on which original payment was made. If additional adjustments are necessary, use the debit CCN on your Adjustment/Void Request Form (AK-05).

Figure II-8 shows a sample adjustment claim page from an RA. The sample page identifies continuing processed adjustment requests. Note the circled numbers on the sample page and refer to the corresponding explanations after the sample page.

Updated 09/02

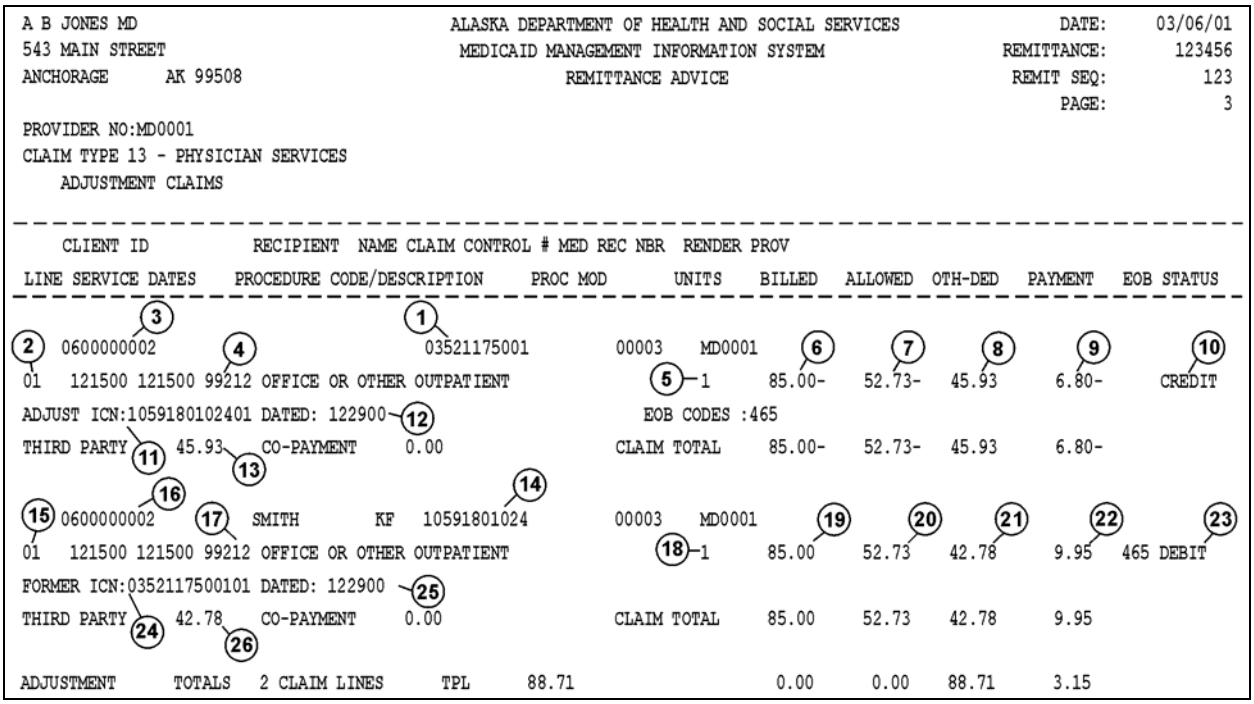


Figure II-8: Adjustment Claim Page of the Remittance Advice

Circled Item	Adjustment Claim Page Explanation
Credit	
1.	**Claim Control Number:** the CCN of the original claim being adjusted. This is the number you entered in Field 7A of the AK-05.
2.	**Line:** the specific line number of the original claim being adjusted.
3. - 9.	**Client ID/Procedure Code/Units/Billed/Allowed/Oth-Ded/Payment:** the information as it appeared when the original claim line processed.
10.	**Credit Status:** the credit portion of the adjustment, which adjusts the provider's 1099 by decreasing the amount. All dollar amounts therefore have minus signs ("-") associated with them.
11.	**Adjust ICN:** the CCN of the debit portion of the adjustment, which reflects the corrected information.
12.	**Dated:** the date of the RA on which the claim line originally processed.
13.	**Third Party:** the third-party payment information as it appeared when the original claim line processed.
Debit	
14.	**Claim Control Number:** the CCN of your adjustment request (from the "Adjust ICN," item 11). It contains the updated claim line information.
15.	**Line:** the line number of the adjustment request.
16.-22.	**Client ID/Procedure Code/Units/Billed/Allowed/Oth-Ded/Payment:** the updated changes you requested on the Adjustment/Void Request Form.
23.	**Debit Status:** the corrected data and payment for this claim line.

Circled Item	Adjustment Claim Page Explanation
24.	**Former ICN:** the CCN of the original claim being adjusted.
25.	**Dated:** the payment date of the original claim line now referenced as the credit.
26.	**Third Party:** the updated changes to third-party payment information you requested on the Adjustment/Void Request Form.

Updated 06/02

Voided Claims

A previously paid claim line can be voided and it is also deducted from the provider's 1099 total. An Adjustment/Void Request Form (AK-05) is used. Instructions for voiding a claim line are found in "Adjustment/Void Request Form (AK-05)" later in this section.

Figure II-9 shows the claim lines voided on the remittance cycle. Note the circled numbers on the sample page and refer to the corresponding explanations.

```
A B JONES MD                          ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES        DATE:      03/06/01
543 MAIN STREET                        MEDICAID MANAGEMENT INFORMATION SYSTEM            REMITTANCE:      123456
ANCHORAGE      AK 99508                          REMITTANCE ADVICE                      REMIT SEQ:          123
                                                                                            PAGE:            4

PROVIDER NO:MD0001
CLAIM TYPE 13 - PHYSICIAN SERVICES
    VOIDED CLAIMS

-------------------------------------------------------------------------------------------------------------
    CLIENT ID          RECIPIENT  NAME CLAIM CONTROL # MED REC NBR  RENDER PROV
LINE SERVICE DATES    PROCEDURE CODE/DESCRIPTION     PROC MOD      UNITS    BILLED   ALLOWED  OTH-DED   PAYMENT   EOB STATUS
-------------------------------------------------------------------------------------------------------------
                                                        (1)
    0600000002         SMITH        KF   10591800001    00003          MD0001                                  (2)
01   122800 122800 99212 OFFICE OR OTHER OUTPATIENT                      1      73.00-    52.91-    3.00     49.91-   462 VOID
VOID   ICN:1040115104601 DATED: 020901
THIRD PARTY      0.00  (3) CO-PAYMENT  (4) 3.00-               CLAIM TOTAL     73.00-    52.91-    3.00     49.91-

VOIDED CLAIM    TOTALS   1 CLAIM LINES      TPL       0.00                    73.00-    52.91-    3.00     49.91-
```

Figure II-9: Voided Claim Page of the Remittance Advice

Circled Item	Voided Claim Page Explanation
1.	**Claim Control Number:** the CCN of the void request document.
2.	**Void Status:** identifies this transaction as a void, removing the service and payment information from the history files.
3.	**Void ICN:** the CCN of the original claim line being voided.
4.	**Dated:** the date of payment of the claim line being voided.

Updated 04/02

In-Process Claims

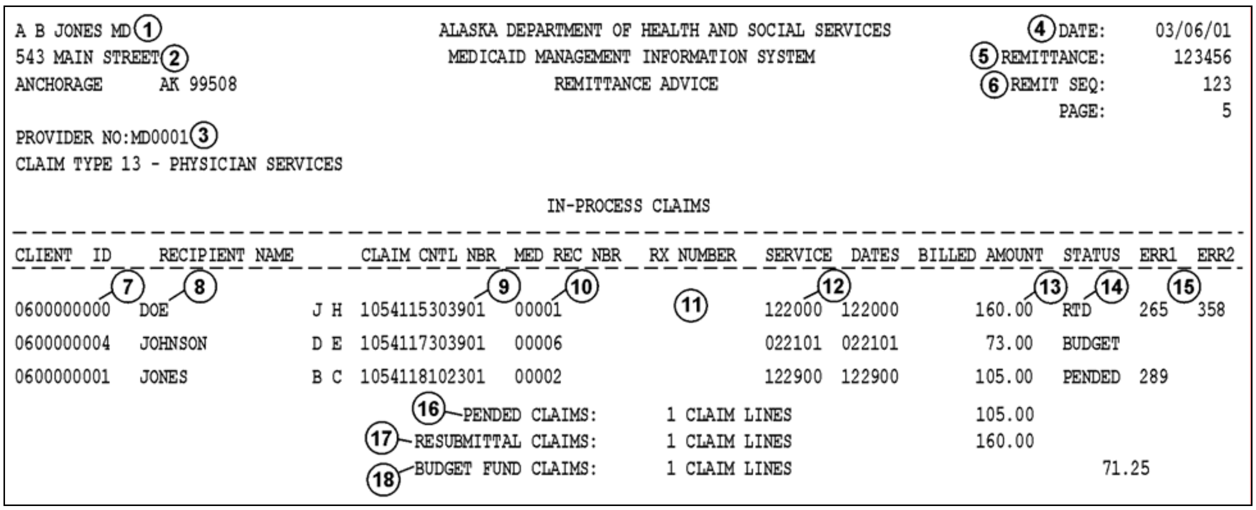
When a claim needs special handling in processing its status is said to be “in-process.”

If a claim is in-process due to an error that can only be corrected by the provider, the automated system prints a Resubmission Turnaround Document (RTD). The provider can then fill in the needed information on the RTD or attach the needed documentation. This type of claim is shown in the Status column of the In-process Claim Page as “RTD.”

If an in-process claim requires internal review by a First Health Services or DHCS claims examiner, its processing is suspended. For example, a claim may exceed timely filing or have attached documentation that requires manual pricing. An in-process claim that is suspended is said to be “pended.” This type of claim is identified in the Status column as “Pended.” No action is required by the provider while a claim is pended; however, an RTD may be sent to the provider as a result of the internal review. RTDs are discussed in “Resubmission Turnaround Document” later in this section.

A sample RA page showing in-process claims is in Figure II-10. Explanation of circled items follows below.

Updated 04/04



```
A B JONES MD (1)                 ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES   (4)DATE:        03/06/01
543 MAIN STREET(2)                 MEDICAID MANAGEMENT INFORMATION SYSTEM         (5)REMITTANCE:    123456
ANCHORAGE     AK 99508                      REMITTANCE ADVICE                     (6)REMIT SEQ:        123
                                                                                     PAGE:               5
PROVIDER NO:MD0001(3)
CLAIM TYPE 13 - PHYSICIAN SERVICES

                                             IN-PROCESS CLAIMS
CLIENT  ID    RECIPIENT NAME      CLAIM CNTL NBR  MED REC NBR  RX NUMBER  SERVICE  DATES  BILLED AMOUNT  STATUS  ERR1  ERR2
        (7)      (8)                         (9)      (10)                    (12)               (13)  (14)    (15)
0600000000   DOE             J H  1054115303901    00001           (11)   122000  122000       160.00  RTD     265   358
0600000004   JOHNSON         D E  1054117303901    00006                  022101  022101        73.00  BUDGET
0600000001   JONES           B C  1054118102301    00002                  122900  122900       105.00  PENDED  289
                                (16)PENDED CLAIMS:       1 CLAIM LINES                         105.00
                              (17)RESUBMITTAL CLAIMS:    1 CLAIM LINES                         160.00
                              (18)BUDGET FUND CLAIMS:    1 CLAIM LINES                                       71.25
```

Figure II-10: In-process Claim Page of the Remittance Advice

Circled Item	In-Process Claim Page Explanation
1.	**Provider Payee Name:** the name of the billing provider.
2.	**Provider Payee Address:** the street, city, state, and zip code of the billing provider.
3.	**Provider No.:** the Medical Assistance identification number of the billing provider.
4.	**Date:** the date the RA was created (the remittance cycle date).
5.	**Remittance:** a control number used by First Health Services in the production of RAs.
6.	**Remittance Sequence:** the identification number printed on the RA. The automated system maintains a count of RAs produced for each provider. This number helps individual providers make certain that all RAs are received and maintains a sequential file of the documents.
7.	**Client ID:** the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).

Circled Item	In-Process Claim Page Explanation
8.	**Recipient Name:** the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file.
9.	**Claim Control Number:** the 13-digit number assigned to the claim by First Health Services for processing. This includes the 2-digit line number.
10.	**Medical Record Number:** the number assigned to a recipient or a claim by the provider for reference purposes. If the provider has indicated this number on the claim form, it is printed on the RA to help the provider identify the patient who received the services.
11.	**RX Number:** not applicable.
12.	**Service Dates:** the date or dates the services were performed.
13.	**Billed Amount:** the amount billed to Medical Assistance for the services rendered.
14.	**Status:** the disposition of each specific claim, e.g., pended, RTD, or budget funded. RTD status may not apply to all claim lines; those lines not in RTD status are actually pended until the RTD is processed.
15.	**Err1/Err2:** The code(s) that indicate the reason for the pend status or the information needing correction on the Resubmission Turnaround Document (RTD).
16.	**Pended Claims:** the total number of pended claim lines.
17.	**Resubmittal Claims:** the total number of returned claim lines.
18.	**Budget Fund Claims:** the total number of approved claim lines that have had payment withheld temporarily due to budget constraints.

Updated 04/04

Financial Transactions

This section of the RA may reflect any of the following financial transactions:

- Cost settlement with the provider.
- Recoupment of interim payments.
- Returned state-issued warrants or personal checks received from providers.
- Withholding against payments to providers according to state instructions.
- Payments to providers according to state instructions.
- Payments to providers to rectify over-collections.

Figure II-11 shows a financial transaction page ("Refunds and Voids") of the RA. The circled items on the sample page are explained below.

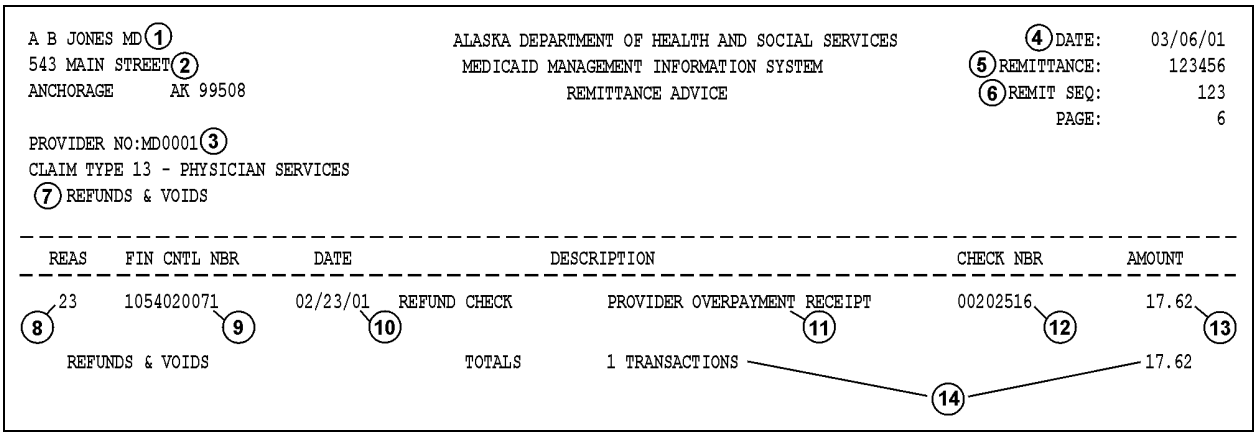


Figure II-11: Financial Transaction Page of the Remittance Advice

Circled Item	Financial Transaction Page Explanation
1.	**Provider Payee Name:** the name of the provider who is paid for the services.
2.	**Provider Payee Address:** the street, city, state, and ZIP code of the provider who is paid for the services.
3.	**Provider Number:** the Medical Assistance identification number of the provider who rendered the services.
4.	**Date:** the date the RA was created (the remittance cycle date).
5.	**Remittance:** a control number used by First Health Services in the production of RAs.
6.	**Remittance Sequence:** the identification number printed on the RA. The automated system counts all RAs produced for each provider. This helps the provider maintain a sequential file and make certain that all RAs are received.
7.	**Refunds & Voids:** the type of financial transaction shown on the next page.
8.	**Reason:** an internal code that indicates the reason for this financial transaction.
9.	**Financial Control Number:** an internal number to identify each financial transaction processed.
10.	**Date:** the date on which the financial transaction was submitted for processing.
11.	**Description:** a description of the reason for the financial transaction.

Circled Item	Financial Transaction Page Explanation
12.	**Check Number:** number of the check if one is being refunded or voided.
13.	**Amount:** the amount of the financial transaction.
14.	**Financial Type Total:** the number of transactions and the total amount of money for the transaction type.

Updated 04/04

EOB Description Page

This page lists all EOB (explanation of benefit) codes found on this RA and a brief description of each. The EOB codes and descriptions are furnished to help the provider understand the processed claims. This information is useful in correcting and rebilling denied claims. If further information is needed, the provider should contact First Health Services' Provider Inquiry (refer to "Telephone Inquiries" on page v).

A sample RA page with EOB codes and descriptions is in Figure II-12. See the explanations of the circled items below.

Updated 04/04

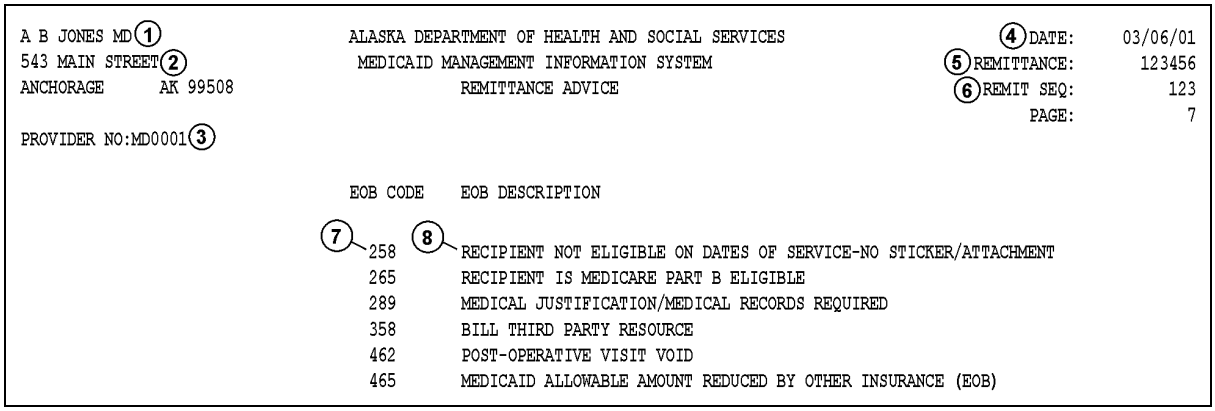


Figure II-12: Explanation of Benefits (EOB) Page of the Remittance Advice

Circled Item	EOB Page Explanation
1.	**Provider Payee Name:** the name of the provider who rendered the services.
2.	**Provider Payee Address:** the street, city, state, and ZIP code of the provider who rendered the services.
3.	**Provider Number:** the Medical Assistance identification number of the provider who rendered the services.
4.	**Date:** the date the RA was created (the remittance cycle date).
5.	**Remittance:** a control number used by First Health Services in the production of RAs.
6.	**Remittance Sequence:** the identification number printed on the RA. The automated system counts all RAs produced for each provider. This number helps the provider maintain a sequential file and make certain that all RAs are received.
7.	**EOB Code:** an explanation of benefits code that explains the disposition of a claim.
8.	**EOB Description:** a written message that explains the disposition of a claim.

Updated 04/04

Remittance Summary

The remittance summary shows the total weekly and year-to-date dollars paid to and collected from the provider. After the calendar year, First Health Services sends each provider a 1099 tax information statement, showing total Medical Assistance reimbursement payments made during the year. The same information is sent to the IRS. This information will match the year-to-date total paid amount shown on the last RA issued for the calendar year. If the totals disagree, contact First Health Services immediately. The explanations below correspond to the circled items on the sample remittance summary in Figure II-13.

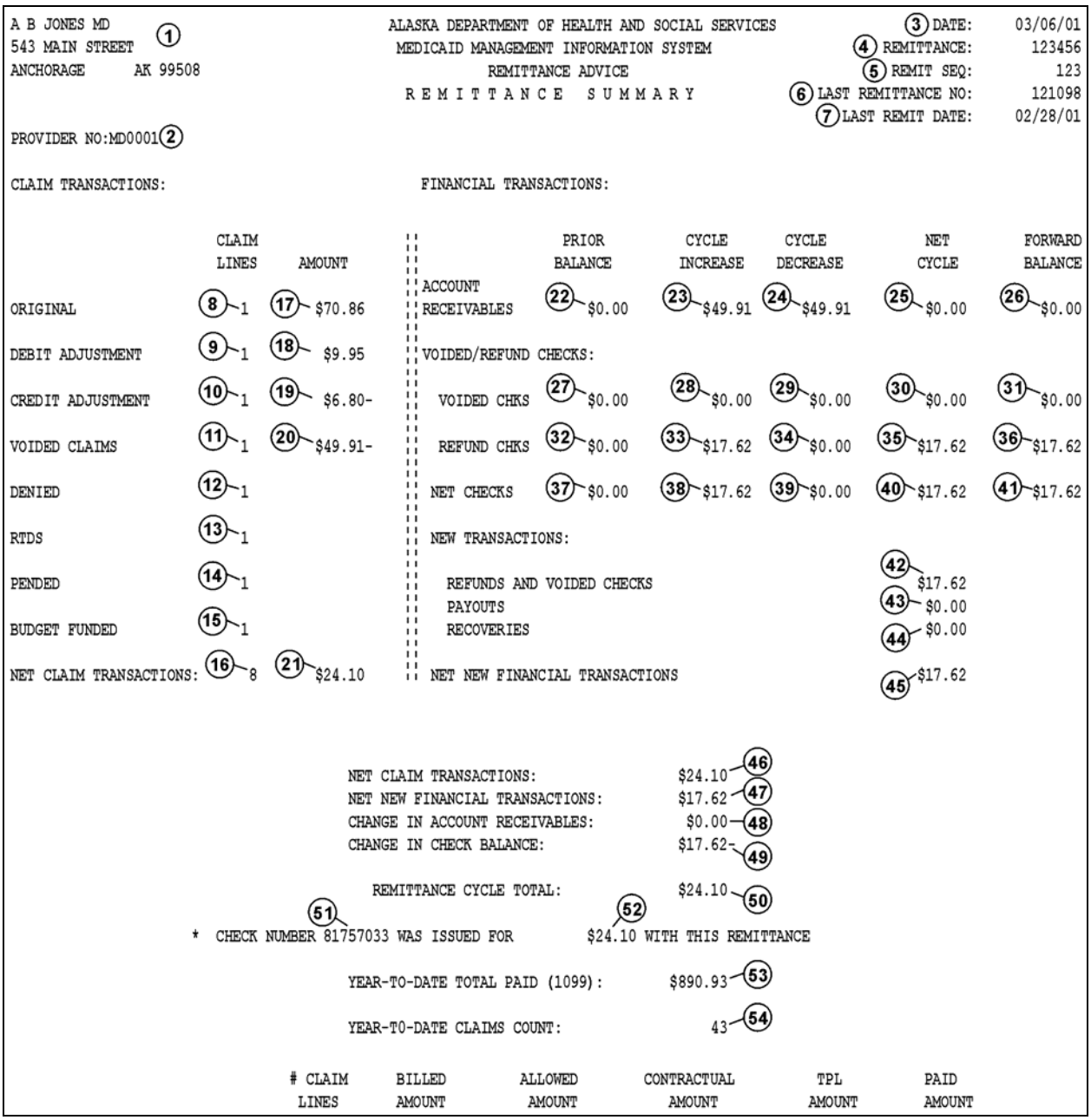


Figure II-13: Remittance Summary Page of the Remittance Advice

Circled Item	Remittance Summary Page Explanation
1.	**Provider Payee Name and Address:** name and address of the provider.
2.	**Provider Number:** Medical Assistance identification number of the provider who rendered the services.
3.	**Date:** date the RA was created (the remittance cycle date).
4.	**Remittance:** control number used by First Health Services in producing RAs.
5.	**Remittance Sequence:** identification number printed on the RA. The automated system counts all RAs produced for each provider. This number helps the provider maintain a sequential file and make certain that all RAs are received.
6.	**Last Remittance:** remittance number printed on the last RA.
7.	**Last Remit Date:** date that the last RA was issued to the provider.
Claim Transactions: Claim Lines	
8.	**Original:** total number of paid claim lines on this RA.
9.	**Debit Adjustment:** total number of debit adjustment claim lines on this RA.
10.	**Credit Adjustment:** total number of credit adjustment claim lines on this RA.
11.	**Voided Claims:** total number of voided claim lines on this RA.
12.	**Denied:** total number of denied claim lines on this RA.
13.	**Resubmitted (RTDs):** total number of claim lines on RTDs on this RA.
14.	**Pended:** total number of pended claim lines on this RA.
15.	**Budget Funded:** total claim lines in budget-funded status on this RA.
16.	**Net Claim Transactions:** total count of claim line transactions reported on this RA.
Claim Transactions: Amount	
17.	**Original:** total dollar amount of paid claim lines on this RA.
18.	**Debit Adjustment:** total dollar amount of debit adjustments on this RA.
19.	**Credit Adjustment:** total dollar amount of credit adjustments on this RA.
20.	**Voided Claims:** total dollar amount of voided claims on this RA.
21.	**Net Claim Transactions:** sum of the original and debit adjustment amounts (items 17 and 18) minus credit adjustment and voided claims amounts (items 19 and 20).
Financial Transactions: Account Receivables	
22.	**Account Receivables Prior Balance:** account receivable balance brought forward from previous cycle, indicating dollar amount yet to be received from the provider. Examples include the provider sending in an Adjustment/Void Request Form for an overpayment without sending a refund check or a financial transaction generated by the state. Providers are notified of all state-initiated financial transactions.
23.	**Account Receivable Cycle Increase:** dollar amount the account receivables increased by transactions on this RA.

Circled Item	Remittance Summary Page Explanation
24.	**Account Receivable Cycle Decrease:** dollar amount the account receivables decreased by transactions on this RA.
25.	**Account Receivable Net Cycle:** net difference in account receivable increase and decrease (items 23 and 24) reflected on this RA.
26.	**Account Receivable Forward Balance:** remaining account receivable balance after transactions from this remittance cycle have been applied. This will be the "account receivable prior balance" on next RA.
Financial Transactions: Voided Checks	
27.	**Voided Checks Prior Balance:** total dollar amount of checks voided that has not been applied to a claim/claim line.
28.	**Voided Checks Cycle Increase:** dollar amount of checks voided reflected on this RA.
29.	**Voided Checks Cycle Decrease:** dollar amount of checks applied to a claim/claim line on this RA.
30.	**Voided Checks Net Cycle:** net difference in voided checks cycle increase and decrease (items 28 and 29) reflected on this RA.
31.	**Voided Checks Forward Balance:** balance of voided checks that has not been applied to a claim/claim line. This will be the "voided checks prior balance" on next RA.
Financial Transactions: Refund Checks	
32.	**Refund Checks Prior Balance:** total dollar amount of checks refunded by the provider that has not been applied to a claim/claim line.
33.	**Refund Checks Cycle Increase:** dollar amount of checks refunded by the provider that is reflected on this RA.
34.	**Refund Checks Cycle Decrease:** dollar amount of checks refunded by the provider that has been applied to a claim/claim line on this RA.
35.	**Refund Checks Net Cycle:** net difference in the dollar amount of refund checks cycle increase and decrease (items 33 and 34) reflected on this RA.
36.	**Refund Checks Forward Balance:** balance of refunded checks from the provider that has not been applied to a claim/claim line. This will be the "refund checks prior balance" on the next RA.
Financial Transactions: Net Checks	
37.	**Net Checks Prior Balance:** sum of voided checks and refund checks prior balance.
38.	**Net Checks Cycle Increase:** sum of voided checks and refund checks that is reflected on this RA.
39.	**Net Checks Cycle Decrease:** sum of voided checks and refund checks that has been applied to a claim/claim line on this RA.
40.	**Net Checks Net Cycle:** sum of voided checks and refund checks net cycle reflected on this RA.
41.	**Net Checks Forward Balance:** sum of voided checks and refund checks forward balance. This will be the "net checks prior balance" on the next RA.

Circled Item	Remittance Summary Page Explanation
Financial Transactions: New Transactions	
42.	**Refunds and Voided Checks:** dollar amount of refund checks and voided checks listed on this RA.
43.	**Payouts:** dollar amount of money paid to the provider this cycle that is not reflected in net claim transactions (item 21).
44.	**Recoveries:** dollar amount of new account receivables recoupment processed this cycle.
45.	**Net New Financial Transactions:** positive or negative net amount of all new financial transactions processed this cycle.
Summary	
46.	**Net Claim Transactions:** net dollar amount of claim transactions reported on the RA (from item 21).
47.	**Net New Financial Transactions:** net dollar amount of all new financial transactions processed this cycle (from item 45).
48.	**Change in Account Receivables:** net effect dollar amount account receivables transactions on this RA (from item 25).
49.	**Change in Check Balance:** net effect dollar amount of financial transactions increasing or decreasing the dollar amount of the check issued to the provider with this RA.
50.	**Remittance Cycle Total:** positive or negative net amount as a result of claim transaction and financial transaction activity this cycle.
51.	**Check Number:** the number of the check issued to the provider associated with this RA.
52.	**Check Amount:** dollar amount of the check issued to the provider associated with this RA.
53.	**Year-to-date Total Paid (1099):** net amount paid to the provider by Alaska Medical Assistance for the tax year.
54.	**Year-to-date Claims Count:** total number of original, debit, credit, and voided claims paid for the tax year.

Updated 04/04

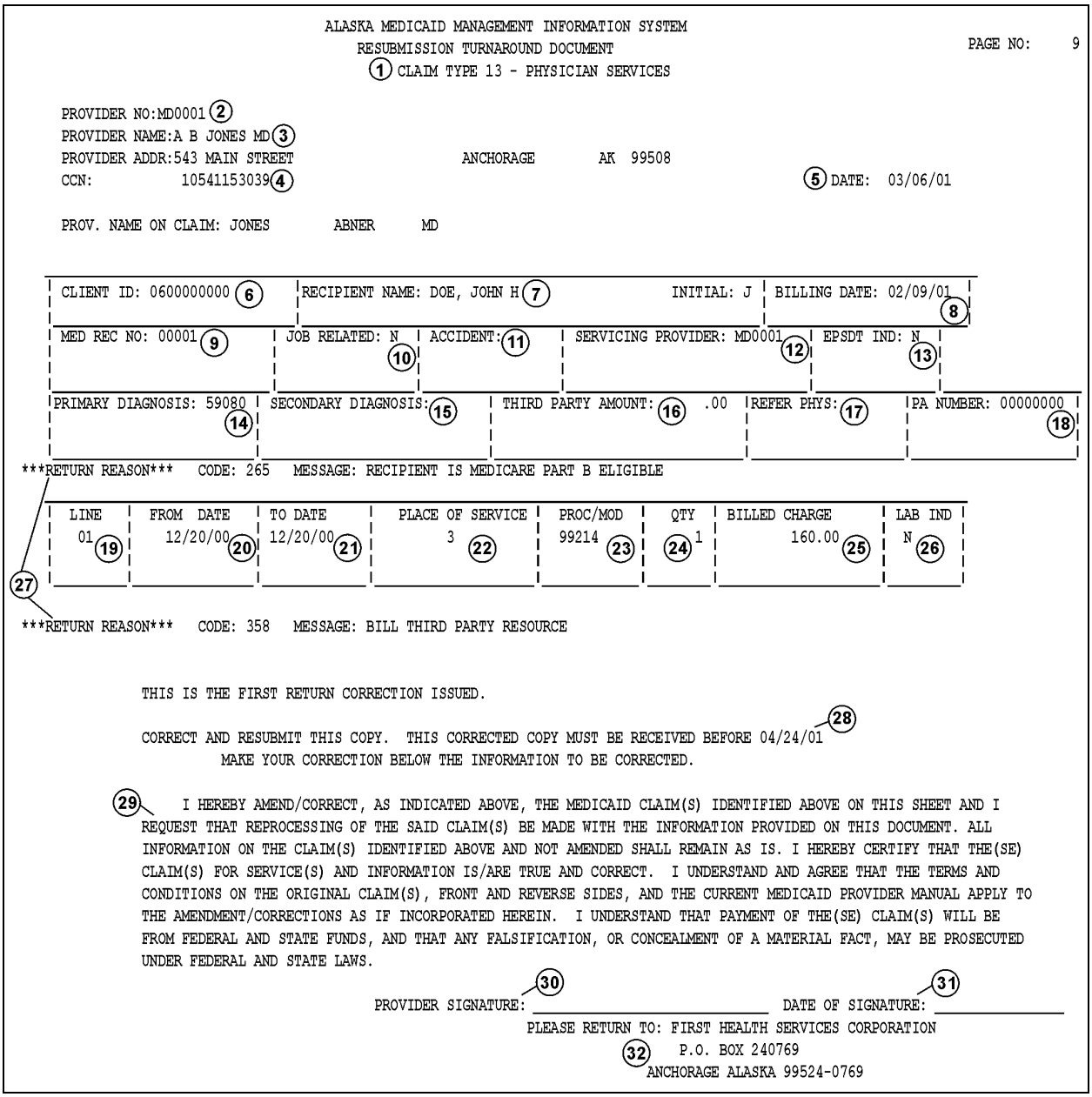
Resubmission Turnaround Document (RTD)

An RTD may accompany your RA, identifying errors on a claim. The RTD reports what was entered on the original claim form, what error occurred, and where. “Return reason” codes and messages are printed on the RTD after the claim information. The provider should read the messages, find the blocks on the RTD where the information is missing or incorrect, and enter the corrected information in the appropriate blocks.

A provider is allowed 90 days to correct errors without having to resubmit a claim form. The last date that the corrected RTD can be received at First Health Services is shown on the RTD (see circled item 28 on the sample RTD in Figure II-14). If the corrected RTD is not received after 60 days, a second RTD will automatically generate. The claim will be denied if corrections are not received within 30 days of the second notice.

The RTD must be signed by the provider or an assigned representative, since it is a supplement to the original claim. Return only the RTD, not the entire RA. Do not use the RTD to make an adjustment or add an additional claim line (refer to “Adjustment/Void Request Form (AK-05)” later in this section for information on making an adjustment to a claim).

A sample RTD is in Figure II-14. Circled items on the sample are explained below.



ALASKA MEDICAID MANAGEMENT INFORMATION SYSTEM
RESUBMISSION TURNAROUND DOCUMENT
PAGE NO: 9
(1) CLAIM TYPE 13 - PHYSICIAN SERVICES

PROVIDER NO:MD0001 (2)
PROVIDER NAME:A B JONES MD (3)
PROVIDER ADDR:543 MAIN STREET ANCHORAGE AK 99508
CCN: 10541153039 (4) (5) DATE: 03/06/01

PROV. NAME ON CLAIM: JONES ABNER MD

CLIENT ID: 0600000000 (6)	RECIPIENT NAME: DOE, JOHN H (7)	INITIAL: J	BILLING DATE: 02/09/01 (8)

MED REC NO: 00001 (9)	JOB RELATED: N (10)	ACCIDENT: (11)	SERVICING PROVIDER: MD0001 (12)	EPSDT IND: N (13)

PRIMARY DIAGNOSIS: 59080 (14)	SECONDARY DIAGNOSIS: (15)	THIRD PARTY AMOUNT: (16) .00	REFER PHYS: (17)	PA NUMBER: 00000000 (18)

RETURN REASON CODE: 265 MESSAGE: RECIPIENT IS MEDICARE PART B ELIGIBLE

LINE	FROM DATE	TO DATE	PLACE OF SERVICE	PROC/MOD	QTY	BILLED CHARGE	LAB IND
01 (19)	12/20/00 (20)	12/20/00 (21)	3 (22)	99214 (23)	1 (24)	160.00 (25)	N (26)

(27)

RETURN REASON CODE: 358 MESSAGE: BILL THIRD PARTY RESOURCE

THIS IS THE FIRST RETURN CORRECTION ISSUED.

CORRECT AND RESUBMIT THIS COPY. THIS CORRECTED COPY MUST BE RECEIVED BEFORE 04/24/01 (28)
MAKE YOUR CORRECTION BELOW THE INFORMATION TO BE CORRECTED.

(29) I HEREBY AMEND/CORRECT, AS INDICATED ABOVE, THE MEDICAID CLAIM(S) IDENTIFIED ABOVE ON THIS SHEET AND I REQUEST THAT REPROCESSING OF THE SAID CLAIM(S) BE MADE WITH THE INFORMATION PROVIDED ON THIS DOCUMENT. ALL INFORMATION ON THE CLAIM(S) IDENTIFIED ABOVE AND NOT AMENDED SHALL REMAIN AS IS. I HEREBY CERTIFY THAT THE(SE) CLAIM(S) FOR SERVICE(S) AND INFORMATION IS/ARE TRUE AND CORRECT. I UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS ON THE ORIGINAL CLAIM(S), FRONT AND REVERSE SIDES, AND THE CURRENT MEDICAID PROVIDER MANUAL APPLY TO THE AMENDMENT/CORRECTIONS AS IF INCORPORATED HEREIN. I UNDERSTAND THAT PAYMENT OF THE(SE) CLAIM(S) WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PROVIDER SIGNATURE: (30) _____ DATE OF SIGNATURE: (31) _____

PLEASE RETURN TO: FIRST HEALTH SERVICES CORPORATION
(32) P.O. BOX 240769
ANCHORAGE ALASKA 99524-0769

Figure II-14: Resubmission Turnaround Document (RTD) of the Remittance Advice

Circled Item	Resubmission Turnaround Document (RTD) Claim Page Explanation
1.	**Claim Type:** a code defining the type of claim filed by the provider.
2.	**Provider Number:** the Medical Assistance identification number of the billing provider.
3.	**Provider Name:** the name of the billing provider as entered on the claim form.
4.	**CCN (Claim Control Number):** the 11-digit number assigned to the claim by First Health for processing.
5.	**Date:** the date of this RA.

Circled Item	Resubmission Turnaround Document (RTD) Claim Page Explanation
6.	**Client ID:** the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).
7.	**Recipient Name:** the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file.
8.	**Billing Date:** the date the claim was signed.
9.	**Med Rec No (Medical Record Number):** the medical record number assigned to a claim by the provider for reference purposes.
10.	**Job Related:** indicates if the claim has been submitted for a condition related to the patient's employment and therefore may be subject to third party liability.
11.	**Accident:** indicates if the claim has been submitted for a condition related to an on-the-job injury, auto accident, or other accident and therefore may be subject to third party liability.
12.	**Servicing Provider:** the Medical Assistance identification number of the provider who rendered the services.
13.	**EPSDT Ind:** indicates if services rendered are related to an EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) referral.
14.	**Primary Diagnosis:** an ICD-9-CM code indicating the patient's primary diagnosis.
15.	**Secondary Diagnosis:** an ICD-9-CM code indicating the patient's secondary diagnosis.
16.	**Third Party Amount:** the amount of payment by a third party resource, which has been applied toward the services billed on the claim form.
17.	**Refer Phys:** the provider number or name of the physician or agency referring the recipient to this rendering provider.
18.	**PA Number:** the prior authorization number as it appeared on the claim submitted by the provider.
19.	**Line:** the claim line number as it appeared on the claim submitted by the provider.
20.	**From Date:** the beginning date on which the services were rendered.
21.	**To Date:** the ending date on which the services were rendered.
22.	**Place of Service:** a code indicating where the services were rendered.
23.	**Proc/Mod:** the HCPCS or assigned procedure code and any modifier for the services or procedure rendered to the patient.
24.	**Qty:** the units or number of times/days that billed services were rendered.
25.	**Billed Charge:** the amount billed to Medical Assistance for the services rendered.
26.	**Lab Ind:** indicates if lab work was performed outside of your office.
27.	**Return Reason Code and Message:** the code and description that indicate the information needing correction on the RTD. Enter the corrected information in block directly under the existing information.

Circled Item	Resubmission Turnaround Document (RTD) Claim Page Explanation
28.	**Received Before MM/DD/YY:** the date on which the claim line represented by the RTD will automatically deny if the RTD is not received by First Health. The RTD allows 90 days for the information to be provided and received by First Health. If not received after 60 days, a second RTD will automatically generate. The claim line(s) will be denied if the corrected RTD is not received within 30 days of this second notice.
29.	**I hereby amend...laws:** statement of certification.
30.	**Provider Signature:** the signature of the provider or authorized representative.
31.	**Date of Signature:** the date that the RTD was signed by the provider.
32.	**Please return to...:** address to which the corrected RTD should be returned.

Note: Steps to Remember When Completing the RTD

1. Read the "Return Reason" code and message (item 27).
2. Find the blocks on the RTD that need correcting.
3. Enter the corrected information in the appropriate blocks.
4. Sign and date the corrected RTD (items 30 and 31).
5. Return the ***corrected RTD so it is received by First Health before the date specified in item 28.***

Updated 06/02

Adjustment/Void Request Form (AK-05)

General Guidelines

The Adjustment/Void Request Form (AK-05) must be used to do any of the following:

- Change (i.e., "adjust") a paid claim line that was billed or processed incorrectly.
- Void a paid claim line.
- Repay an overpayment to Alaska Medical Assistance.

Each AK-05 submitted should have an attached copy of the claim and a copy of the page of the Remittance Advice (RA) indicating its paid status.

Note: Do not use the AK-05 if a claim line is denied.

When a claim line is denied, submit a new claim with corrected information in order to be reconsidered for payment. To determine what corrections to make, refer to the explanation of benefits (EOB) code associated with the denied claim line.

Updated 04/02

Adjustment

Submit an adjustment to correct a paid claim line only. For example, if a procedure or revenue code, charges, or units were billed or processed incorrectly, use the AK-05 to make a correction. If the adjustment is incorrect on the RA, submit another adjustment to correct it and enter the CCN of the debit portion of the adjustment in Field 7A.

Effective with dates of service on or after March 3, 2001, all adjustments must be submitted within 60 days from the payment date as indicated by the RA or within twelve months of the date of service when payment is owed to the provider (positive adjustment).

If the adjustment results in money being owed to Medical Assistance (negative adjustment), the 60-day filing limit does not apply.

Updated 09/02

Void

The AK-05 is also used to void a paid claim line. A void is needed when a provider is paid for a recipient who did not receive the services billed or when the claim had an incorrect rendering provider indicated (for those providers submitting claims with a group billing identification number).

A processed void request will result in a refund to Medical Assistance of the entire payment, reduction in the year-to-date dollar amount of claims paid to the provider, and deletion of the paid claim/claim line information from the recipient and provider history files. If a corrected claim is to be submitted that relates to the claim/claim line being voided, the voided claim must process before submitting your corrected claims. This will allow the corrected claim to process without being denied against the claim you plan to void as a duplicate payment. The 60-day filing limit does not apply to voids.

Updated 04/02

Overpayment/Refund

The AK-05 is used to refund an overpayment. Remember to attach a copy of the claim and the RA page showing the payment. There is no time limit associated with submitting an overpayment/refund. The provider can choose one of two refund methods:

- Submit the AK-05, complete Field 4, and include a check for the dollar amount of the refund made payable to the State of Alaska; or
- Submit the AK-05 without a refund check and allow the money to be automatically deducted from a subsequent Medical Assistance payment(s).

Note: Policy When Processing Refund Due to TPL Payment

- If the TPL payment exceeds the amount reimbursed by Medical Assistance, refund the total Medical Assistance payment.
- If the TPL payment is less than the amount reimbursed by Medical Assistance, refund Medical Assistance the amount equal to the TPL payment.
- In both cases, attach the TPL explanation of benefits (EOB) to the AK-05 and make the refund check payable to the "State of Alaska."

Updated 04/02

Completing the Adjustment/Void Request Form (AK-05)

Instructions for completing the AK-05 follow below. A sample AK-05 is in Figure II-15. Attach copies of the claim to be adjusted/voided and the RA page that shows the payment of the claim to be adjusted/voided.

Claim Field Identification		Explanations and Instructions
	Claim Control Number	Leave Blank. For First Health Services (FHSC) use only.
1.	Provider Name and Address	Enter the provider's complete name and address.
2.	Billing Provider Number	Enter the Medical Assistance provider identification number. If the claim was paid under an incorrect provider number, enter the incorrect provider identification number; that claim must be voided and a new claim submitted with the correct Medical Assistance provider identification number.
3.	Rendering Provider Number	Enter the rendering provider's Medical Assistance identification number if you bill with a group identification number (Field 2). If the rendering provider identification number is different from the information in Field 2, fill in Field 3. Otherwise, leave it blank.
4.	Overpayment	If an adjustment/void results in money owed to Medical Assistance, the provider may either refund the money or have it recovered from future payment of approved claims. If no check is enclosed, the money will be recovered from a future RA. If you attach a refund check to the AK-05, indicate the amount of the overpayment and your refund check number. Otherwise, leave Field 4 blank. Make the check payable to the State of Alaska.
5.	Recipient Name	Enter the recipient's name as it appears on the RA. If the payment was made for the wrong recipient, the paid claim must be voided and a new claim submitted.

Claim Field Identification		Explanations and Instructions
6.	Recipient Number	Enter the recipient's number as it appears on the RA. If the payment was made for the wrong recipient, the paid claim must be voided and a new claim submitted.
7A.	Claim Control Number	Enter the first 11 digits of the Claim Control Number (CCN) as it appears on the RA. If adjusting an adjustment, use the CCN that appears with the debit portion of the adjustment.
7B.	Line Number	Each line of the claim has its own number, and the claim line number appears in the far left column of the RA. If the wrong line number is recorded on the AK-05, the wrong line will be adjusted. Providers billing on the UB-92 claim form will only have line "01."
7C.	Reason for Adj/Void	Providers are to furnish sufficient information to properly process the AK-05 and attach documentation to support the request (copies of both the claim and the RA showing payment). **Example 1:** Line 03 was billed with a $10.00 charge for the service. Adjust the claim to reflect a $15.00 billed charge. **Example 2:** Payment was received for a service that was not rendered by this provider. Void the claim. **Example 3:** Third party insurance paid $15.00.
7D.	Comments	Add any additional comments that may aid the processing of the adjustment/void.
8.	Signature and Date	The signature of the original provider or representative goes here. Enter the date the adjustment/void is signed.

Note: The Adjustment/Void Request Form (AK-05) is a two-part form. Keep the "Retain for your Records" copy and submit the "Original Copy" to First Health Services at the address indicated in "Addresses" in the front of this manual.

Updated 08/04

CLAIM CONTROL NUMBER * FOR FHSC USE ONLY

ADJUSTMENT / VOID REQUEST FORM
ALASKA MEDICAL PAYMENT SYSTEM
(SEE BACK FOR INSTRUCTIONS)

MAIL TO: FIRST HEALTH SERVICES CORPORATION
P.O. BOX 240807
ANCHORAGE, ALASKA 99524-0807

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING: 1. COPY OF CLAIM. 2. COPY OF REMITTANCE ADVICE.

PART I PROVIDER INFORMATION

1. PROVIDER NAME AND ADDRESS

2. BILLING PROVIDER NUMBER

3. RENDERING PROVIDER NUMBER (IF DIFFERENT FROM #2)

4. OVERPAYMENT
(REFUND CHECK ATTACHED)

CHECK NO.

PART II CLAIM INFORMATION

5. RECIPIENT NAME

6. RECIPIENT NUMBER

7A. CLAIM CONTROL NUMBER

7B. LINE NUMBER		7C. REASON FOR ADJ/VOID

7D. COMMENTS:

I REQUEST THAT REPROCESSING OF THE CLAIM BE MADE WITH THE INFORMATION GIVEN ABOVE. THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, - STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. TO THE BEST OF MY KNOWLEDGE, NO OTHER RESOURCE EXISTS.

8. SIGNATURE

DATE

PART III FISCAL AGENT USE ONLY

A/V

A/V RES. CO.

CO. CD.

CT

DT KY

ADJUSTED DATA

REMARKS

ORIGINAL COPY

AK - 05 (1/88)

Figure II-15: Adjustment/Void Request Form (AK-05)

Claim Inquiry Form (AK-11)

General Guidelines

Use the Claim Inquiry Form (AK-11) when you want to know the status of a claim, clarification of an adjudicated claim (i.e., one that has paid, denied, adjusted, or voided) or an RTD return reason, etc. To file an appeal on a denied claim, see "Appeals Process" in section III and the Appeals form located at the end of section III. Claim inquiries will receive a written response by First Health Services.

In order to research your claim inquiry, certain basic information is required. This includes the recipient's name and Medical Assistance identification number, date(s) of service, procedure code and modifier, billed charges, and provider's Medical Assistance identification number. Please attach the following to your inquiry: 1) a copy of the claim, and 2) a copy of the page of the RA where the claim appears (applies only to a claim that has paid, denied, adjusted, voided, pended, or received an RTD).

Updated 04/04

Completing the Claim Inquiry Form (AK-11)

To ensure proper resolution of your inquiry, please complete the AK-11 as accurately and legibly as possible. A sample AK-11 is in Figure II-16.

Claim Field Identification		Explanations and Instructions
	Inquiry Control Number	Leave Blank. For First Health Services (FHSC) use only.
1.	Provider Name, Address, Telephone #:	Enter the provider's complete name, address, and telephone number. This is necessary to respond to your inquiry. A rubber stamp may be used.
2A.	HCP Billing Number	Enter your Medical Assistance billing provider identification number.
2B.	HCP Rendering Number	Enter your Medical Assistance provider identification number. If you bill as a group provider, enter the rendering provider's identification number here. Otherwise, leave it blank.
3.	Contact?	Enter the name of the person in your office who should be contacted about the inquiry.
4.	What is the nature of your inquiry?	Put an "X" in the space that best describes your inquiry. If none apply, explain as specifically as possible the nature of your inquiry. Include a copy of the claim and a copy of the page from the Remittance Advice (RA) that relates to it, if applicable.

Note: The Claim Inquiry Form (AK-11) is a two-part form. Please keep the "Retain for your Records" copy and submit the "Original" copy to First Health Services at the address indicated in "Addresses" in the front of this manual.

Updated 04/04

INQUIRY CONTROL NUMBER * FOR FHSC USE ONLY

MAIL TO: FIRST HEALTH SERVICES CORPORATION
P.O. BOX 240808
ANCHORAGE, AK 99524-0808

CLAIM INQUIRY FORM

(SEE REVERSE SIDE FOR INSTRUCTIONS)

ALASKA MEDICAL PAYMENT SYSTEM

(PLEASE ATTACH A COPY[IES] OF CLAIM FORM[S])

1. PROVIDER NAME, ADDRESS, TELEPHONE#:

2A. HCP BILLING NUMBER

2B. HCP RENDERING NUMBER

3. CONTACT?

4. WHAT IS THE NATURE OF YOUR INQUIRY? PLEASE PUT AN "X" ON THE APPROPRIATE LINE.

_____ NEED TO KNOW STATUS OF CLAIM

_____ WANT EXPLANATION OF A DENIED CLAIM

_____ OTHER (PLEASE EXPLAIN)

AUTHORIZED SIGNATURE

DATE

AK-11 (1/88)

ORIGINAL

Figure II-16: Claim Inquiry Form (AK-11)

Forms Order Request

Use the Forms Order Request to order necessary forms, manuals, and other documents. To be assured of meeting billing deadlines, providers should order a two-month supply of First Health Services forms.

Refer to the sample Forms Order Request on the following page and follow these steps:

1. Fill out the "Ship to:" block completely, since it will be used as a mailing label when First Health Services sends your order to you.
2. Be sure to include your Medical Assistance provider identification number (HCP #).
3. Mail your Forms Order Request to the Inquiries/Correspondence address of First Health Services' Provider Services Unit:

   First Health Services Corporation
   P.O. Box 240808
   Anchorage, AK 99524-0808
4. Allow approximately four weeks for delivery.

The AK-01 (UB-92 claim form for Inpatient/Outpatient, Home Health, Long-Term Care) and the AK-07 (ADA Dental Statement) are used to bill other insurance. Therefore, First Health Services must limit your request to the estimated usage for Alaska Medical Assistance billing when filling your requests. For additional supplies, First Health Services suggests that you contact commercial sources about availability in the State of Alaska.

A Forms Order Request will be included in each shipment of forms.

Updated 04/04

HEALTH CARE FORMS ORDER REQUEST

Please order a 2-month supply.

Mail to: **First Health** Services Corporation
P.O. Box 240808
Anchorage, AK 99524-0808

Allow approximately 4 weeks for delivery.

You must include your health care provider number (HCP #); for example, "MD0000", "HS00IP", "PH0000", etc.

Ship to: _____

_____

_____

Attention: _____

Phone Number: _____

HCP #: _____

Form Requested		Quantity				
Number	Description	25	50	100	300	Other
AK-01	UB-92 Claim Form					
AK-04	Transportation/Accommodation					
AK-05	Adjustment/Void					
AK-07	Dental					
AK-10	Child Health Screening					
AK-11	Claim Inquiry					
AK-PA	Prior Authorization					
AK-LTC-1	LTC Authorization					
CMS-1500	Health Insurance Claim Form					
Provider Billing Manual	Title of Manual or Provider Type (see reverse):					

_____ _____

Signature of Provider or Authorized Person *Date of Request*

For First Health Use Only

Comments: _____

Date Shipped: _____ Shipped By: _____

Rev. 2/04

Figure II-17: Forms Order Request (front)

PROVIDER BILLING MANUAL REQUESTS

Req. Date	Manual	Amount
	Advanced Nurse Practitioner/Nurse Midwife	
	Ambulatory Surgical Care Facility	
	Chiropractic	
	Dental	
	Direct Entry Midwife	
	Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, Orthotics, and Home Infusion Therapy	
	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	
	Family Planning Clinic	
	Federally Qualified Health Center (FQHC)/Rural Health Clinic Services	
	Hearing	
	Home & Community Based (HCB) Waiver Services: ☐ Care Coordination ☐ Environmental Modifications ☐ HCB Agency ☐ Residential Supported Living	
	Home Health	
	Hospice Care	
	Hospital: ☐ End Stage Renal Disease ☐ Inpatient/Outpatient ☐ Inpatient Psychiatric Services (Acute Care and Residential Psychiatric Treatment Center)	
	Indian Health Services (IHS) & Tribal Facility Services	
	Laboratory Services, Independent	
	Long Term Care Facility	
	Behavioral Health: ☐ Behavioral Health (Community Mental Health Clinics & Substance Abuse) ☐ Day Treatment Facility ☐ Mental Health Physician Clinic	
	Nutrition	
	Outpatient Therapy Center, Independent Physical Therapist, Certified Speech Pathologist, and Independent Occupational Therapist	
	Consumer Direct Personal Care Agency	
	Personal Care Agency	
	Pharmacy	
	Physician	
	Podiatry	
	Private Duty Nursing	
	School-based Services	
	Transportation & Accommodation	
	Vision	
	X-Ray	

(Rev. 01/06)

Figure II-18: Forms Order Request (back)

Section III
Alaska Medical Assistance Program
General Program Information

Program Introduction

Program Background

In July 1965, two major amendments to the Social Security Act greatly expanded the scope of medical coverage available to various segments of the population. One amendment, Title XVIII, established the Medicare program. The other, Title XIX, established the state-option medical assistance program known as Medicaid.

Medicaid provided federal matching funds to states implementing a single comprehensive medical care program. In September 1972, Alaska set in motion the Medicaid program through Chapter 43 of the Alaska Administrative Code.

In addition to the Medicaid coverage, Alaska provides Chronic and Acute Medical Assistance (CAMA) services, Denali KidCare services, and SeniorCare Rx, which are discussed later in this section. (CAMA, effective July 1, 1998, replaced the former General Relief Medical [GRM] Program that ended as of July 31, 1998; SeniorCare Rx sunsets on 12/31/05.)

Updated 05/05

Program Objectives

The Medical Assistance program strives to provide essential medical care and services to preserve health, alleviate sickness, and mitigate handicapping conditions for individuals or families on public assistance, or those whose income is insufficient to meet their individual health care needs.

Medical Assistance covered services are comprehensive, and recognized as standard medical services required in treating disease, disability, infirmity, or impairment. The major disciplines of health care are covered by Medical Assistance.

Updated 04/02

Program Fiscal Agent

In 1986, the State of Alaska released a Request for Proposal (RFP) to all interested vendors. The RFP was developed to fulfill the state's requirements for fiscal responsibilities and good administrative practice, and to develop a processing system that would meet federal requirements for a Medicaid Management Information System (MMIS). By meeting the federal requirements for a certified MMIS, the state would benefit by receiving increased federal matching funds. The federal funding matching rate would increase from 50% to 90% for development of a certified system and from 50% to 75% for ongoing operations.

The Virginia Computer Company (TVCC), later renamed **First Health** Services Corporation, responded to this RFP and was selected in November 1986 to process claims for Alaska Medical Assistance. **First Health** Services Corporation performs all MMIS claims processing functions at its office in Anchorage. This includes claims receipt, data entry, error corrections, and payments to providers of services. Prior authorization of services and Provider Services also operate out of the Anchorage office.

The Prior Authorization Unit (PA) authorizes transportation and accommodation required for non-emergency medical care as well as certain medical services, supplies and equipment in accordance with current policy. Those services or items requiring PA are indicated in Section I of this manual. Transportation/Accommodation PA requests are authorized by phone. All other authorization requests

must be submitted in writing on *Form AK-PA* to **First Health** Services Corporation, Prior Authorization (PA) Unit (address on page vi). PA procedures are discussed in Section II of this manual.

The Provider Services Unit has a number of distinct areas of responsibility. These include communications; provider enrollment; and provider education, training and assistance. Provider Services is also responsible for responding efficiently to the specific needs and inquiries of the health care community. It maintains an automated Eligibility Verification System (EVS) to help providers determine the eligibility of their patients. EVS is discussed in more detail on a following page in Section III.

Provider Services staff are able to quickly answer routine and uncomplicated inquiries. Immediate responses should be available in most cases on such matters as payment amounts, coverage of services, coding, and status of claims. Providers may be requested to direct more complex inquiries in writing to the Provider Services Unit (see page vi).

Personnel in both units have access to computerized information. Refer to page v of this manual for telephone service numbers. Guidelines to Efficient Telephone Inquiries are described in Table III-1.

Table III-1. Guidelines to Efficient Telephone Inquiries

1. Review the provider billing manual and bulletins before calling.
2. Have all material related to the call available for reference, such as Remittance Advice, claim forms, recipient's Medical Assistance identification number, etc. In addition, when calling the Prior Authorization Unit, be sure to have handy the dates of travel, Transportation and Authorization Invoice, and Prior Authorization number if calling for changes.
3. Have the provider's Medical Assistance identification number available.
4. Limit the length of the call. Provider Services personnel will help the provider until the problem is resolved or until it appears that a written inquiry is necessary to resolve the problem.
5. Note the name of the person who answered the call. This saves duplication if the provider needs to clarify a previous discussion or ask the status of a previous inquiry.

Updated 04/02

Provider Billing Information

Information about how to bill Alaska Medical Assistance for reimbursement of services rendered to Medical Assistance recipients is contained in this Provider Billing Manual. The weekly Remittance Advice (RA) Messages, other written correspondence and provider training sessions are also used to issue provider billing information, including new policy, clarifications and reminders.

For more information about this provider billing manual, see page iv. For more information about contacting the State of Alaska and **First Health** Services Corporation regarding Medical Assistance billing, see Appendix A of this manual.

Updated 04/02

Claims Processing Overview

First Health Services Corporation's primary task, as the Alaska Medical Assistance fiscal agent, is to process claims submitted by health care providers for services to Medical Assistance, Chronic and Acute Medical Assistance (CAMA), and SeniorCare Rx recipients. This claims processing is explained in the following paragraphs.

Updated 05/05

HCPCS Coding

The State of Alaska, in compliance with CMS's requirements, uses the HCPCS coding convention. All claims (originals and resubmittals), adjustments, and requests for prior authorization submitted for processing to Alaska Medical Assistance must therefore use HCPCS coding.

HCPCS coding has three levels. Each HCPCS procedure or service has a five-digit alpha-numeric code, with provision for a unique two-position modifier for each level of coding. The three levels are described below.

Level I: American Medical Association CPT-4 codes as found in the annual revision of the ***Physicians' Current Procedural Terminology***, Fourth Edition[1] (CPT-4).

Level II: CMS codes for physician and non-physician procedures and services not found in the CPT-4.

Level III: Eliminated.

Updated 01/06

Unlisted Codes

Unlisted procedure and service codes are to be used *only* when the provider is unable to locate a code listed in the most current CPT-4, HCPCS, the provider billing manual, or billing manual updates.

When using an unlisted procedure code, a written explanation with the following information must be included with your claim:

- A description of the procedure/service rendered.
- The reason no other procedure code was appropriate for the procedure/service rendered.

Any claim with an unlisted procedure code is "pended" for review. All other services billed on the same claim are also pended until the unlisted procedure code review has been completed. Before using an unlisted procedure code, carefully consider existing specific codes. Inappropriate use of unlisted codes will cause delay in processing submitted claims and the provider may be asked to rebill the procedure using an existing procedure code.

Updated 01/06

Diagnosis Codes

CMS requires that World Health Organization's *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis codes be provided on all claims that require a diagnosis. An ICD-9-CM diagnosis code is required on all of the following:

- Claims on UB-92 forms (used for hospital and home health agency charges).
- Claims for professional services *except* those of an optician or independent laboratory.
- Claims for *only* optometric refractions and visual examinations.
- Claims for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).
- Claims for portable X-ray for sonograms *only* (HCPCS procedure codes 76805, 76810, 76815, 76816, 76818, 76825, 76856, 76857).

ICD-9-CM diagnosis codes are *not* required on claims for optical, independent laboratory, personal care, dental, pharmacy, and transportation/accommodation services. Providers are responsible for accurately reflecting the patient's condition and for referring to the published ICD-9-CM volumes as required. To order an ICD-9-CM, see Appendix A for address.

Updated 08/03

[1] To order a current CPT-4, see Appendix A for address of the American Medical Association.

Coding Updates

First Health Services Corporation will update its claims processing code file with changes issued by the Alaska Department of Health and Social Services, as approved by CMS. Providers must ensure that current procedure and service codes are used when filing their Medical Assistance claims. Following the above guidelines will help reduce claims processing time.

Updated 08/03

Claims Submission

Claims can be submitted on paper or by electronic media. All incoming claim forms are received and sorted by type daily. Claims and attachments are microfilmed in the **First Health** Services Corporation mailroom and are assigned a Claim Control Number (CCN) for future identification. Each CCN is based upon the Julian Calendar. This is discussed in detail in Appendix B.

Electronic Data Interchange (EDI) transactions are submitted by enrolled EDI providers on diskette or over telephone lines by modem. The data is entered into **First Health** Services Corporation's computerized system and processed within 24 hours of receipt. This allows EDIs to be adjudicated a week or more before paper claims that are received on the same day. To receive more information on EDI submission, write to the Electronic Data Interchange (EDI) Department/Electronic Commerce Customer Support Department (ECCS), **First Health** Services Corporation, or call the EDI Coordinator/ECCS Coordinator (phone number and address on pages v and vi).

Table III-2. Advantages of EDI Transactions

1. Reduced claims processing time.
2. Reduced pended or denied claims.
3. Reduced data entry error.
4. Increased cash flow to the provider.

Updated 04/04

Computer Operations

Claims are transmitted to a data center where the information is checked against master files using "edits" and "audits" to determine, for example, some of the following:

- Compatibility of procedures and diagnoses
- Provider eligibility at the time of service
- Recipient eligibility at the time of service
- Third party liability
- Duplication of previously paid claims
- Valid "Prior Authorization" (PA) form on file, when required

Updated 04/99

Adjudication

When the computer finds claim information that fails the validation check, the claim is put into a "pended claim file" for review by a claims examiner. Claims examiners have access to computerized pend files. If data input errors are found, they are corrected and the claim is released from the pended claim file and recycled through the claims validation process.

If certain claim information fails an edit and *cannot* be corrected by a claims examiner, the computer prints a Resubmission Turnaround Document (RTD). The RTD is mailed to the provider to recheck the information that was submitted. This use of RTDs eliminates the need to return the original claim. RTDs are discussed further in Section II of this manual.

Updated 04/99

Payment

Claims that successfully pass the edits and audits are paid by Remittance Advice (RA) with an explanation of the financial transaction. The Medical Assistance check is printed, payable to the provider. **First Health** Services Corporation mails RAs and checks to providers each week. More information on RAs is contained in Section II.

Updated 04/02

Services

Medical Assistance Covered Services

Services for Children and Adults

Accommodations for non-emergency medical care

Advanced nurse practitioner services

Ambulance

Ambulatory surgical care

Dental care

Durable medical equipment

End Stage Renal Disease dialysis facility services

Family planning

Federally qualified health center

Hearing services

Home and community-based waiver services

Home health care

Hospice

Hospital inpatient and outpatient

Inpatient psychiatric services (recipients must be over 65 or under 21)

Intermediate care facility (ICF) services

Intermediate care facility for the mentally retarded (ICF/MR) services

Laboratory and X-ray

Mental health clinic services

Nurse midwife services

Nutrition services for pregnant women and children under 21

Occupational therapy

Personal care

Physical therapy

Physician services

Prescribed drugs

Prosthetic devices and medical supplies

Respiratory therapy

Rural health clinic services

Skilled nursing facility (SNF) services

Speech-language therapy

Substance abuse rehabilitative services

Transportation services for emergency and non-emergency medical care

Vision care

Updated 01/03

Services Only for Recipients Under 21 Years of Age

Chiropractic[2]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening

Podiatry[2]

Private duty nursing

School-based services

Updated 10/03

Chronic and Acute Medical Assistance (CAMA) Covered Services

The Chronic and Acute Medical Assistance (CAMA) program, unlike Medicaid, receives no federal funding. CAMA is an Alaska state-funded program that provides medical assistance for Alaska residents who do not qualify for Medicaid and do not have access to any other health care coverage. Eligibility is determined by the Division of Public Assistance (DPA).

To be eligible for CAMA, a person must have a diagnosis of a terminal illness, cancer requiring chemotherapy, diabetes, diabetes insipidus, chronic hypertension, chronic mental illness (as defined in 7 AAC 43.1990), or chronic seizure disorder. A CAMA recipient with one of the diagnoses listed above is considered to have a "CAMA covered medical condition." Alaska Medical Assistance will reimburse enrolled providers for the following services rendered to eligible CAMA recipients:

- Physician services for a CAMA covered medical condition. (Physician services provided in an inpatient hospital or nursing facility are *not* covered).
- Three (3) prescriptions filled or re-filled in a calendar month. Prescriptions cannot exceed a 30-day supply and must be prescribed for a CAMA covered medical condition.
- Limited medical supplies necessary for monitoring or treating a CAMA covered medical condition. No durable medical equipment (DME).
- Prior-authorized outpatient hospital radiation and chemotherapy services for cancer treatment.

Updated 09/03

[2] A Qualified Medicare Beneficiary (QMB) over 21 years of age is eligible only for payment of deductible and coinsurance of Medicare-covered services.

Denali KidCare

The Denali KidCare program provides comprehensive health care coverage to income-eligible children and youth through the age of 18, and to pregnant women who meet income guidelines.

Denali KidCare is a Medical Assistance expansion program administered by the Alaska Department of Health & Social Services. Denali KidCare covers the same services as Medical Assistance and claims are processed through the same system. Provider participation, prior authorization requirements, claims billing and follow-up procedures are the same as for Medical Assistance.

The only difference between Medical Assistance and the Denali KidCare program is how recipients demonstrate proof of eligibility.

Children from birth through age 18 and pregnant women in families with incomes at or below 200 percent of the Federal Poverty Level (FPL) are eligible for Denali KidCare. Children and youth through the age of 18 who have other health insurance may still be eligible if their family income is at or below 150 percent of the FPL. Income is the only determinant for eligibility; no other assets are considered.

Children eligible for Denali KidCare will receive a Denali KidCare Card. (See sample below.) The card is valid only for the person named on the card and is proof of eligibility only for the period shown on the card. The Denali KidCare Card displays the recipient's name, ID number, date of birth, eligibility code, coverage period, and resource code

- Children have continuous eligibility for six-month periods, regardless of changes in income or family composition.
- Disabled children and babies born to Medical Assistance enrolled women are eligible for one year.

Pregnant women eligible for Denali KidCare will receive eligibility coupons.

- Pregnant women are eligible through their pregnancy and two months following the end of the pregnancy.

Providers should use the same procedures to verify recipient's eligibility as with Medical Assistance. See page v for the Eligibility Verification System (EVS) phone number, and for numbers to call for other eligibility and billing questions. EVS is described in detail in "Eligible Recipients" on a following page in this section.

Updated 08/03

Figure III-1: Sample Denali KidCare Card (front and back)

SeniorCare Rx Program

The SeniorCare Rx Program bridges a gap for low-income Alaskan seniors until the full Medicare prescription drug coverage (Medicare Part D) begins in January 2006. Depending on income levels, qualifying seniors can receive a prescription drug subsidy of $1,000 to $1,600 per calendar year (amount will be pro-rated for partial calendar years).

To be eligible for the program, recipients must meet income requirements, be age 65 or older, and be eligible for Medicare (but not for Medicaid pharmacy coverage) when enrolling in the SeniorCare Rx program. Seniors eligible for the program will receive a SeniorCare Rx card (see sample below). The card is valid only for the person named on the card and is proof of eligibility only during the coverage period on the card.

Eligibility for the program is for one year; however, SeniorCare benefits cannot be used during a month that a recipient is eligible for Medicaid pharmacy benefits.

SeniorCare Rx coverage is modeled after Medicaid drug coverage, and all claims are processed using the same system. Therefore, providers should follow the same guidelines and procedures used for Medicaid pharmacy claims, including using the Preferred Drug List (PDL).

Note: Over-the-counter drugs and vitamins, except insulin, are not covered by the SeniorCare Rx program.

Updated 05/05

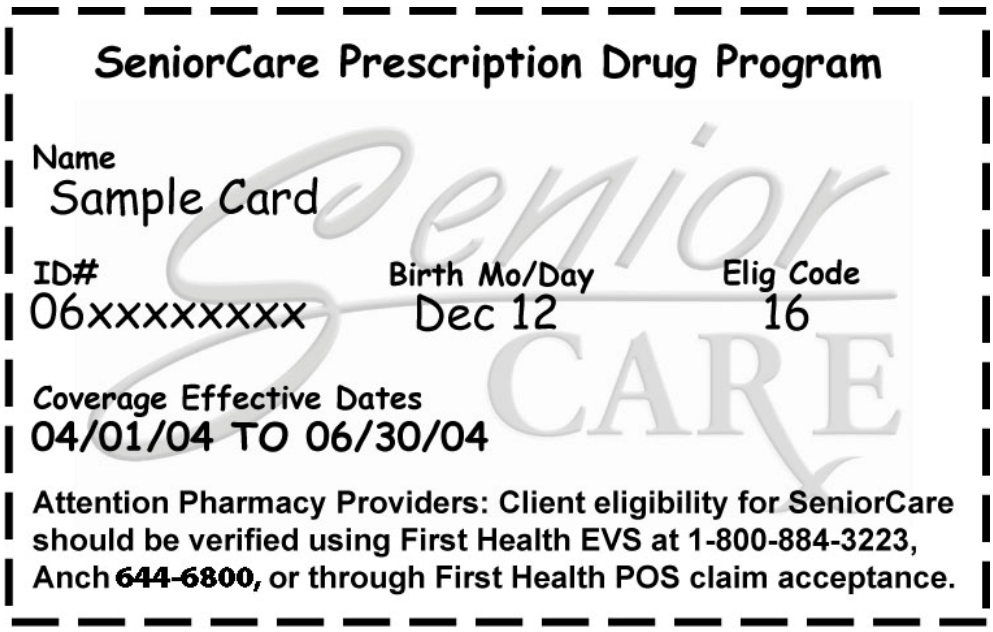


Figure III-2: Sample SeniorCare Rx Card

Out-of-State Services

Except in an emergency, reimbursement will not be made for out-of-state services that are available in Alaska unless the out-of-state provider has received prior authorization from **First Health** Services Corporation. Prior authorization is discussed on a previous page in this section. Emergency services should be authorized during **First Health** Services Corporation's normal working hours (page v). If services are necessary after hours, the provider must contact **First Health** Services Corporation or the Division of Health Care Services by the third working day following the emergency services.

Alaska medical assistance recipients may be eligible for payment of medical benefits while outside the state of Alaska. This eligibility exists when the individual is temporarily absent and intends to return to Alaska. Payment for services provided to Alaska medical assistance recipients outside the state of Alaska is limited to the lesser of: 1) the rate established by the Medicaid agency in the state where the services were provided; or, 2) the rate or payment methodology established by Alaska Medical Assistance.

Updated 08/03

Medically Necessary Services

Only medically necessary services should be provided to medical assistance recipients. Services may require prior authorization or written medical justification. Additional medical justification may be required for any services or procedures requested in order to determine that the requested services are medically necessary.

Updated 08/03

Medical Assistance Providers

The following information is not to be considered all inclusive, but is excerpted from Chapter 43 and Chapter 48 of the *State of Alaska Administrative Code*, the *State of Alaska Medicaid Manual*, and the *Medicaid Eligibility Manual* to give the provider a general overview of the public medical assistance program and related provisions.

Updated 08/03

Eligible Providers

The following providers are eligible to enroll in the Alaska Medical Assistance program, when enrollment criteria are met. Some restrictions may apply.

Updated 08/03

General Medical

Advanced nurse practitioner

Audiologist

Chiropractor, individual and group

Community health aide/practitioner

Dentist, individual and group

Dietitian

Direct entry midwife

Nurse midwife

Occupational therapist, independent

Optician/Optometrist/Vision group

Physical therapist, independent

Physician, individual and group

Podiatrist, individual and group

Respiratory therapist

Speech pathologist, independent

Updated 09/02

Home and Community-Based Waiver Services Providers

Care coordination agency

Environmental modification provider

Home and community-based agency

Residential supported living facility (adult foster care/adult residential care)

Updated 09/02

Hospitals

Administrative wait bed provider

Indian Health Service (IHS) inpatient/outpatient hospital

Inpatient acute care hospital

Inpatient psychiatric acute care hospital

Outpatient hospital

Swing bed provider

Updated 04/99

Long-Term Care Facilities

Intermediate care facility (ICF)

Intermediate care facility/Intermediate care facility for the mentally retarded (ICF/MRF)

Skilled nursing facility (SNF)

Updated 09/02

Other Facilities/Clinics

Community mental health center

Day treatment facility

End Stage Renal Disease (ESRD) dialysis facility

Federally qualified health center (FQHC)

Home health agency (includes RN, LPN, nurse aide, physical therapist, occupational therapist, and speech pathologist)

Hospice

Independent laboratory

Indian Health Service (IHS)/Tribal clinic

Mental health physician clinic

Outpatient physical therapy/Speech pathology center (includes occupational therapist, physical therapist, and speech pathologist)

Personal care agency

Private duty nursing agency (includes RN and LPN)

Rural health clinic

Substance abuse treatment center

Updated 04/04

Transportation/Accommodation Providers

Airline

Ambulance, air and ground

Ferry

Hotel/Motel with or without restaurant

Railroad

Taxi

Travel agency

Wheelchair van

Prematernal home

Updated 10/02

Other

Durable medical equipment (DME) supplier (includes respiratory therapist and respiratory therapy technician)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screener (includes public health agency, public health nurse, RN, and LPN)

Pharmacy

Portable X-ray provider

Prosthetics and orthotics supplier

School-based services

Updated 10/03

Non-Eligible Providers

The services of the following professionals are not currently covered under the Medical Assistance program in Alaska:

- Christian Science practitioner or theological healer
- Naturopath
- Any other licensed or unlicensed practitioner not otherwise specified.

Updated 04/02

Provider Enrollment Requirements

Providers must be enrolled in the Alaska Medical Assistance program to bill for reimbursement of health care services rendered to eligible Medical Assistance recipients. Out-of-state providers must be enrolled in the Medicaid program in their state in addition to the Alaska Medical Assistance program to bill for reimbursement of their services to Alaska recipients. To enroll, providers need to complete an *Alaska Medical Assistance Program Provider Enrollment Form (AK-22)* which includes a *Provider Agreement.*

Updated 08/03

Provider Agreement

The Provider Agreement is a contract between the provider and the State of Alaska. Signing the ***Provider Agreement*** and providing medical services or medically-related services to recipients and billing Alaska Medical Assistance for those services constitutes agreement by the provider:

- to follow policies and procedures in the current applicable provider billing manual;
- to comply with applicable state and federal law;
- to cooperate in reports, reviews, surveys, or audits conducted by the Department of Health and Social Services;
- to allow inspection of the provider's records, including desk and on-site review, by authorized representatives of state and federal Medicaid agencies;
- to retain records necessary to disclose fully to Medical Assistance representatives the extent of services provided to recipients (see "Provider Records Requirements and Retention," below); and
- to allow Alaska Medical Assistance to take action to recover an overpayment (discussed on a following page in this section).

Applications approved by the Alaska Division of Health Care Services will receive a provider identification number. Enrolled providers will receive a billing manual, an initial supply of claim forms, and a request form for reordering claim forms. The First Health Services Corporation's Provider Enrollment telephone number and address are on pages v and vi of this manual.

Changes in a provider's enrollment information *must be made in writing only* (faxing is acceptable). No changes will be made from verbal requests. This will ensure accuracy in completing changes as requested. **First Health** Services Corporation's Provider Enrollment must be notified within 30 days of any change in the following:

- Ownership
- Licensure, certification, or registration status
- Federal tax identification number
- Type of service or area of specialty
- Additions, deletions, or replacements in group membership

- Mailing address or phone number
- Participation in Alaska's medical assistance programs
- Medicare provider identification number

The provider is responsible for claims submitted or certified by an authorized representative. The provider or representative's endorsement of a check received from Alaska Medical Assistance certifies that the claim for which the check is payment is true and accurate unless written notice of an error is sent by the provider to Alaska Medical Assistance within 30 days after the date that the check is negotiated.

Updated 08/03

Provider Records Requirements and Retention

A provider shall maintain records necessary to support the care and services for which payment is requested, and to retain those records for **at least seven years** from the date services were provided. Records shall include:

- Patient information for each service provided, including the recipient receiving treatment; specific services provided; extent of service; date of each service; and individual who provided each service.
- Financial information for each service provided, including date of each service and charge; each payment source pursued; date and amount of all debit and credit billing actions; and amounts billed and paid.
- Clinical information pertinent to each service provided (according to applicable professional standards, applicable state and federal law, applicable Alaska Medical Assistance provider billing manuals, and any pertinent contracts) to a patient for which services have been billed to Medical Assistance, identifying the recipient's diagnosis; the medical need; each service, prescription, supply, or plan of care prescribed by the provider - including therapeutic services; and annotated case notes, dated and signed or initialed by the individual who provided each service.

Updated 04/02

Request for Records

At the request of a Department of Health and Social Services representative, an authorized federal representative, or another authorized representative, including an employee of the Department of Law, a provider shall provide records free of charge, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient. A provider who maintains records in an electronic format shall ensure that the data is readily accessible.

Updated 08/03

Eligible Recipients

The following general eligibility requirements apply to recipients of medical assistance in Alaska:

- Financially eligible to receive services.
- Resident of Alaska.
- U.S. citizen or an alien lawfully admitted for permanent residency or otherwise permanently residing in the United States under color of law.
- Not an inmate of a public institution except as a patient in a medical institution or an intermediate care facility.
- Eligible to receive benefits under one of the financial assistance programs named in Title 7.

Updated 04/99

Recipient Residency Requirements

Applicants for medical assistance in Alaska must be physically present in the state of Alaska. They must be living in Alaska voluntarily, with the intention of making Alaska their permanent home. There is no durational requirement of residency for medical assistance eligibility. An applicant is considered a resident of Alaska on the day of arrival if the person arrived voluntarily, is not here solely for vacation, and has no intention of leaving Alaska to establish residency elsewhere. Children for whom the applicant is applying are considered residents of the state if they are living in Alaska on other than a temporary basis. No consideration is given to their intentions or whether they are in the state of their own free will.

Updated 04/02

One-Day/One-Month Eligibility

A person who is eligible for medical assistance for any day of a month is eligible for the entire month, with the exception of certain alien groups. The month and year of eligibility is listed on the recipient's medical assistance card or coupon.

Updated 04/99

Eligibility Verification System (EVS)

The Eligibility Verification System (EVS) helps providers determine the eligibility of their patients. Each enrolled provider receives a unique identification number and instructions for using EVS. A provider with a touch-tone telephone can use EVS to verify patient eligibility 24 hours a day, seven days a week. Eligibility on as many as 30 individuals or dates of service can be verified per telephone call. EVS contains the most recent 12 months of eligibility history. The patient's Medical Assistance identification number or Social Security number and date of service in month/year format are required for each verification. Eligibility files are updated each Monday and Wednesday evening, with the updated eligibility files available Tuesday and Thursday. Eligibility for a new month is updated two days before the end of each month, and the new eligibility information is available on the first day of each month. If a provider dials EVS during this time, the system may be temporarily unavailable. A provider who does not have a touch-tone telephone can receive eligibility verification by contacting Provider Inquiry in the Provider Services Unit of **First Health** Services Corporation (see page v).

Table III-3. Advantages of EVS

1. Verifies recipient's month of eligibility.
2. Provides recipient's Medical Assistance identification number by use of recipient's Social Security number.
3. Identifies any third party liability (i.e., insurance).
4. Accessible 24 hours, 7 days a week.

Updated 04/02

Medical Authorization: ID Cards and Coupons

The Department of Health and Social Services (DHSS), Division of Public Assistance (DPA), produces and distributes medical assistance identification cards and medical coupons (samples are shown in Figures III-3 and III-4 in this section). These verify that a patient is eligible to receive Medical Assistance or CAMA services in a given month and contain the eligible recipient's name, identification number, date of birth, eligibility month and year, eligibility code, and up to four medical resource and coverage codes for each person listed. Each card has five coupons for each eligible recipient. If a recipient needs more than five coupons per month, additional labels must be requested from the local DPA office (addresses and phone numbers are listed in Appendix A). Providers may photocopy the recipient's coupon/card for proof of eligibility.

The medical identification card is not an authorization for payment of services that require prior authorization.

Temporary medical coupons may be issued when delay in obtaining the identification card would be harmful or when the authorization is limited to a pregnancy or incapacity determination, disability examination, or when the recipient is in the Care Management Program. These medical coupons (sometimes referred to as "medical manual coupons") are computer printed, typed, or handwritten. A sample medical manual coupon is shown in Figure III-5.

Table III-4. Codes on Recipient's Card or Coupon

When referring to the medical assistance identification card or coupon, providers should be aware of the following items, which are numbered in Figure III-3 to help you identify them:

1. Client (Recipient) I.D. Number. This is a 10-digit number that begins "0600XXXXXX."
2. Month and Year of Eligibility
3. Program Eligibility Codes
4. Resource Codes (other insurance)
5. Special Information or Authorization Statements (shown in Figures III-4 and III-5)

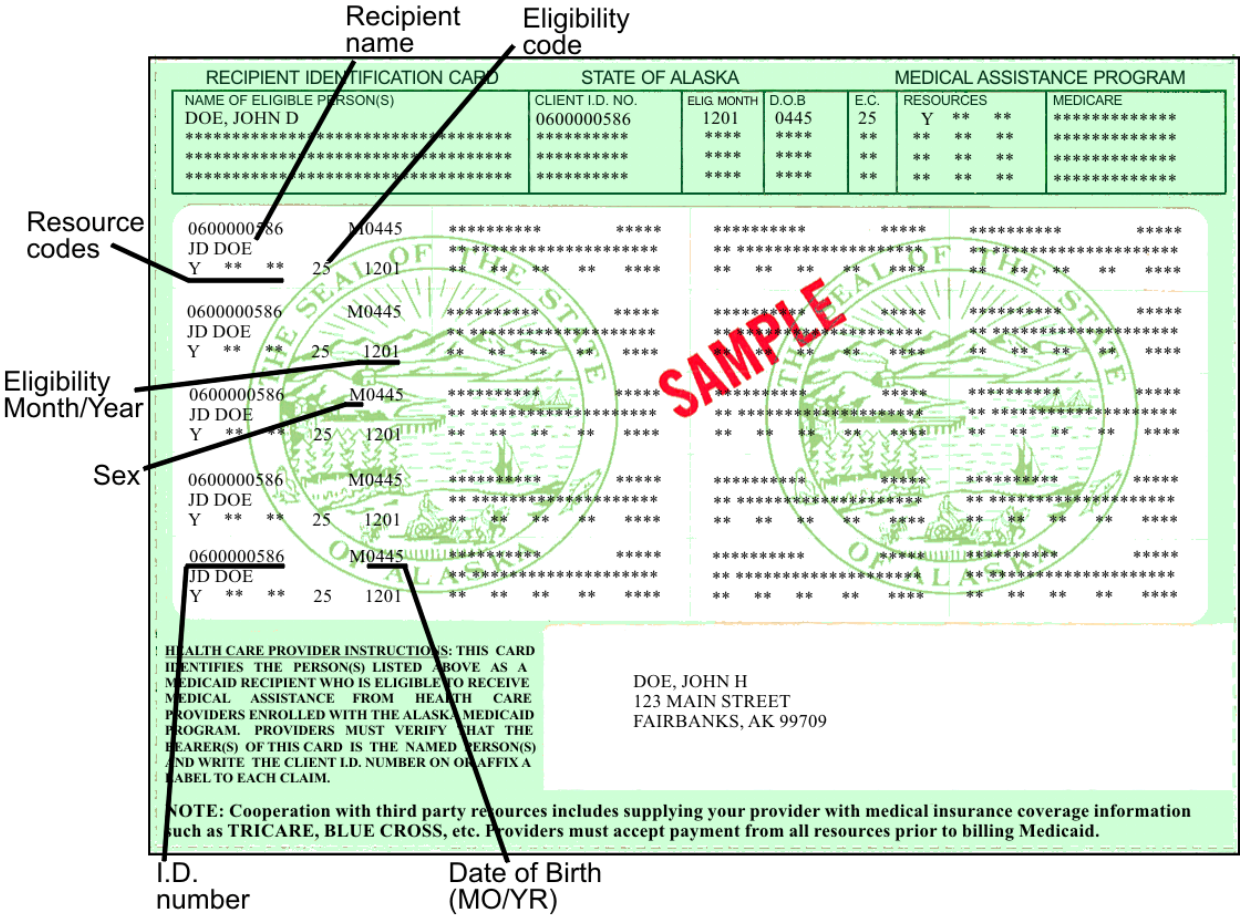


Figure III-3: Alaska Medical Assistance Recipient Identification Card

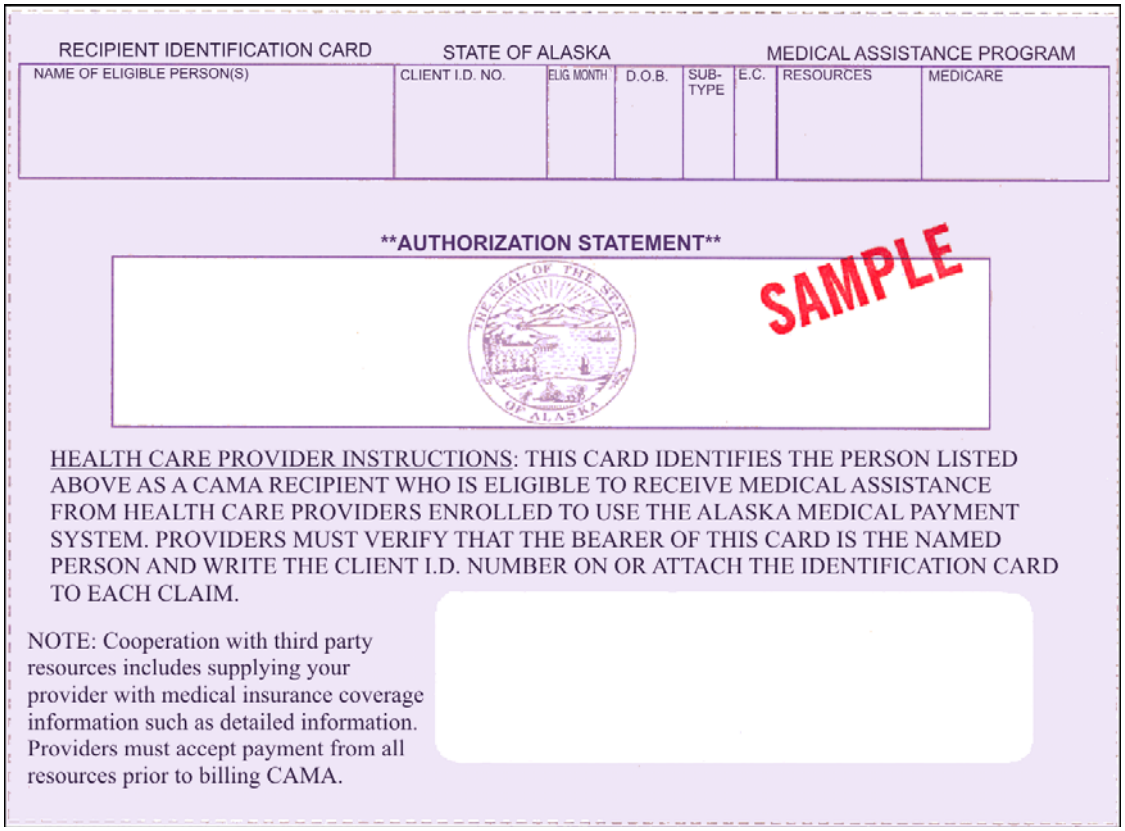


Figure III-4: Alaska Medical Assistance Identification Card for Non-standard Authorization

Providers must check all medical manual coupons for any special information or authorization statements. The coupons specify what services are eligible for Medical Assistance reimbursement. Special information statements most commonly found on the medical manual coupon are:

- "Not Valid for Medicaid Services. Valid Only for Deductible and Coinsurance Payments for Medicare Services."
- "Authorization Limited to Disability Exam by a Licensed Physician or Psychiatrist, Waiver Determination by Care Coordination Agency, and Related Transportation Approved by **First Health**."
- "Authorization Limited to Pregnancy Determination Only and Related Transportation as Approved by **First Health**."
- "Authorization Limited to Incapacity Determination Only and Related Transportation as Approved by **First Health**."
- "This Authorization is Valid Only for the State of Alaska to Pay the Above Person's Medicare Part A Premium. It is not Valid for Payment of any Medical Services."
- "Restricted." Except in a medical emergency, only a provider designated by the Department of Health and Social Services may provide medical services to a recipient whose identification card or medical coupon has this wording. Refer to Appendix C.
- "Authorization is Limited to a Non-Disability Waiver Determination Rendered by a Care Coordination Agency and Related Transportation Approved by **First Health**."

Updated 11/05

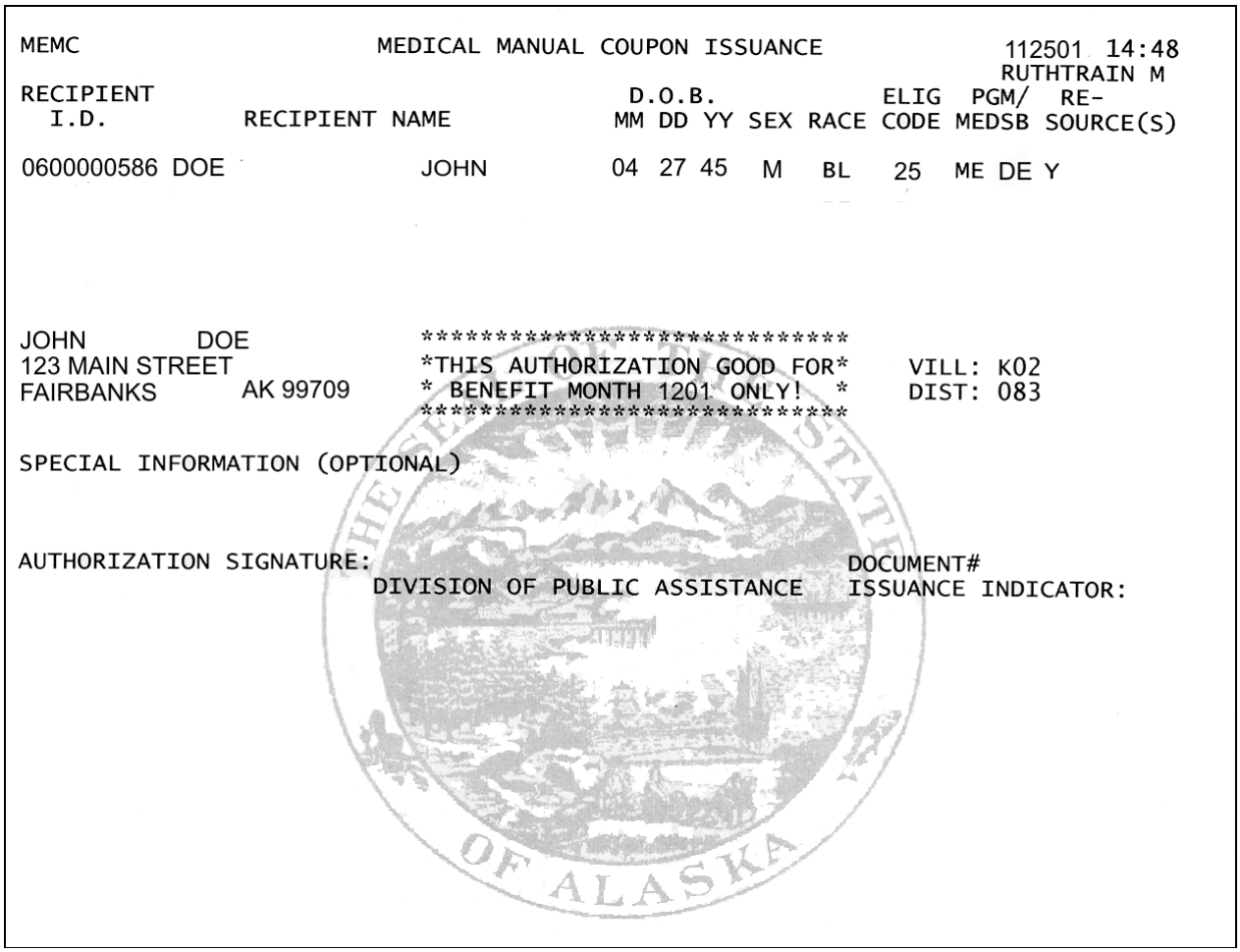


Figure III-5: Medical Manual Coupon Issuance

Medical Assistance Eligibility Codes

Table III-5. Medical Assistance Eligibility Codes

Code	Category
10	Public Health Service (IHS, AANHS, and CHAMPUS)
11	Pregnant Woman (Alaska Healthy Baby Program)
15	Incapacity/Pregnancy Determination
16	SeniorCare Pharmacy up to 135% FPL
17	SeniorCare Pharmacy 136-150% FPL
19	Waiver Determination
20	No Other Eligibility Codes Apply
21	Chronic and Acute Medical Assistance Coverage Only (CAMA)
24	300%/Institutionalized
25	Disability and Blindness Exams
30	Adult Disabled, Waiver Only

Code	Category
31	Adult Disabled, Waiver Medical
34	Adult Disabled, Waiver Adult Public Assistance/Qualified Medicare Beneficiary
40	Older Alaskan, Waiver Only
41	Older Alaskan, Waiver Medical
44	Older Alaskan, Waiver Adult Public Assistance/Qualified Medicare Beneficiary
50	Under 21
51	Juvenile Court Ordered Custody of Health and Social Services
52	Transitional Medical Assistance
53	Illegal Alien/Unqualified Alien Emergency Coverage
54	Disabled/Supplemental Security Income (SSI) Child
67	Qualified Medicare Beneficiary (QMB) Only - Eligible Only for Medical Assistance Payment of Medicare Deductible and Coinsurance for Medicare-covered Services
69	Adult Public Assistance (APA)/Qualified Medicare Beneficiary (QMB) - (Dual Eligibility)
70	Mental Retardation and Developmental Disabilities, Waiver Only
71	Mental Retardation and Developmental Disabilities, Waiver Medical
74	Mental Retardation and Development Disabilities, Waiver Adult Public Assistance and Qualified Medicare Beneficiary
80	Children with Medically Complex Conditions, Waiver Only
81	Children with Medically Complex Conditions, Waiver Medical

Updated 05/05

Chronic and Acute Medical Assistance (CAMA) Subtype

If the recipient's medical assistance eligibility code is 21 (Chronic and Acute Medical Assistance, or CAMA), the recipient's coupon will show the subtype GJ.

Table III-6. CAMA Eligibility Subtype

GJ	"Authorization limited to physician services, prior-authorized outpatient hospital radiation and chemotherapy, 3 prescriptions per month, and limited medical supplies."

Updated 09/03

Resource Codes

Many Medical Assistance recipients are also eligible for medical insurance programs, which will show on their Medical Assistance cards or coupons as "resource codes." Resource codes alert the Medical Assistance provider to bill the other program before billing Medical Assistance. If a recipient has more than one resource code, these codes will be listed on the recipient's eligibility card or coupon.

Updated 04/02

Federal Resource Codes

Some of the most common federal resource codes are as follows:

G	Medicare Part A
H	Medicare Part B
J	Medicare Parts A and B
M	CHAMPUS/TRICARE
N	Veterans Administration
P	AANHS (Alaska Area Native Health Service) (not primary to Medical Assistance)

Updated 04/02

G, H, J

Some Medical Assistance recipients, particularly those over 65, are also eligible for Medicare. Their eligibility is indicated by resource code "G," "H" or "J." Medical Assistance and Medicare cover many of the same services. *Medical Assistance providers must always bill Medicare before billing Medical Assistance for these recipients.*

Updated 04/02

M

Military personnel and their families are covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS/TRICARE). Their eligibility is indicated on the Medical Assistance card or coupon by resource code "M." Medical Assistance providers rendering services to Medical Assistance recipients who are covered by CHAMPUS/TRICARE must enroll as a CHAMPUS/TRICARE provider and always bill the appropriate participating claims processor before billing Medical Assistance for these recipients. Be sure to complete the fields on the appropriate *Health Care Financing Administration (HCFA)* insurance claim form (*CMS-1500* or *HCFA-1450*) that require CHAMPUS/TRICARE health insurance information on the insured. Also, you must accept assignment in order to be paid by CHAMPUS/TRICARE and to receive the explanation of benefits (EOB) showing the coinsurance and deductible amounts. On the CMS-1500, this means you must check "Yes" in box 27 ("Accept Assignment?"). Medical Assistance will reimburse you the CHAMPUS/TRICARE coinsurance and deductible amounts listed on the EOB, if they do not exceed the total Medical Assistance allowed amounts. Refer to the back of the HCFA form for further information about CHAMPUS/TRICARE billing.

Updated 04/04

N

Military personnel and veterans may also receive Veterans Administration (VA) health care benefits. VA eligibility is indicated by resource code "N" or "N2". If the recipient's carrier ID code is "N", you do not have to bill VA first.

When recipients have VA with "N2", Medicare, and Medical Assistance coverage, the providers must first bill VA, and then Medicare, before billing Medical Assistance. Since the VA payment is considered payment in full, and Medicare has a 20 percent coinsurance amount, VA is always considered the primary resource over Medicare.

Note: It is the veteran's responsibility to a) keep annual reviews current with the VA, b) provide the health care provider with the information about his or her VA coverage at the time of the appointment, c) follow all rules for using VA coverage before using Medicare or Medical Assistance. However, if the VA does not provide coverage for the medical service in "N2", the Medical Assistance recipient (veteran) is responsible for providing the denial, and must:

- Get a formal denial in writing from the VA stating why the services for the veteran's particular diagnosis and date of service are not available at the VA facility or at VA expense.
- Take a copy of the denial to the health care provider so the provider has an adequate and valid attachment for the provider's claim submission to Medical Assistance or crossover billing from Medicare.

Updated 01/06

P

Individuals who are part Alaska Native or American Indian are covered by Alaska Area Native Health Service (AANHS), a federal medical program. Those who are eligible for both AANHS and Medical Assistance can choose between AANHS and Medical Assistance enrolled health care providers for all services covered under Medical Assistance. Their resource code is "P." Providers may bill Medical Assistance first and are not required to bill AANHS.

Updated 04/02

No Other Insurance Available Resource

Providers may bill Medical Assistance.

Y

Individuals with no other insurance available have a resource code of "Y."

Updated 04/02

Commercial Insurance Resource Code

This insurance *must* be billed before Medical Assistance.

Any *two-character resource code* refers to a specific commercial insurance company, and that company must be billed before submitting a claim to Alaska Medical Assistance. (See "Third Party Payment" in this section for additional instructions). The list below is an example of commercial insurance resource codes used by First Health Services Corporation (FHSC). For a complete and current list of commercial insurance resource codes, call FHSC's Provider Services Unit (see page v), or visit the FHSC web site at http://alaska.fhsc.com.

Res. Code	Insurance Carrier Name	Insurance Carrier Address
RZ	Aetna	PO Box 91590; Arlington, TX 76015
RF	Blue Cross of Alaska	PO Box 240609; Anchorage, AK 99524
5D	Cigna	PO Box 188007; Chattanooga, TN 37422-8007
Q6	Mutual of Omaha	PO Box 668587; Charlotte, NC 28266-8587
NW	Prudential Insurance	PO Box 378710; Denver, CO 80237-8710

Updated 01/03

Eligible Medical Assistance Recipients

Medical Assistance *eligibles* are individuals who are eligible for Medical Assistance services under the state plan. Medical Assistance *recipients* are those eligible individuals who actually use Medical Assistance services. For purposes of this Alaska Medical Assistance Program Provider Billing Manual, the term "eligible recipients" is used to signify those individuals who receive Medical Assistance services.

Persons are automatically eligible for Medical Assistance if they receive financial assistance from Old Age Assistance (OAA), Aid to the Blind (AB), Aid to Disabled (AD), or Federal Supplemental Security Income (SSI); or are eligible to receive cash assistance from Adult Public Assistance (APA). Other eligible recipients are listed below.

- Certain low-income individuals under 21 years of age.
- Certain newborns of low-income women.
- Juveniles who are in the protective custody of the Department of Health and Social Services whose available financial resources do not exceed the Alaska Temporary Assistance Program (ATAP) need standard for a single person.
- Persons in health care facilities on an inpatient basis whose income does not exceed 300 percent of the current SSI payment standard.
- Individuals under 21 years of age who would be, except for age or school attendance requirements, dependent children under the ATAP program.
- Families who become ineligible for ATAP payments due to increased collection of child support. Post- ATAP Medical Assistance eligibility exists for four months after ATAP eligibility ceases, beginning with the month in which the family becomes ineligible for ATAP payments.
- Families who lose ATAP cash benefits due to increased earnings, increased hours of work, or loss of deductions. Transitional Medical Assistance may be approved for up to 12 months and is available only to those individuals who were included in the ATAP cash grant.

- Individuals under 21 years of age who are receiving active treatment in an inpatient psychiatric facility.
- Individuals under 21 years of age who are in an intermediate care facility for the mentally retarded, or individuals with related conditions.
- Individuals who meet the SSI eligibility requirements.
- Certain low-income pregnant women.
- Certain illegal or unqualified aliens.
- Certain children in subsidized adoptions by the Office of Children's Services.
- Certain aged, blind, and disabled individuals who are ineligible for cash payments due to cost of living increases.
- Certain Medicare eligible persons.
- Individuals approved for home and community-based waiver services.

Providers may request a Medical Assistance Eligibility Manual from the Division of Public Assistance for detailed information on recipient eligibility (see Appendix A). Eligibility of patients can also be verified through the Eligibility Verification System (EVS), described earlier in this section.

If recipients of health care services ask about eligibility, providers should refer them to the local Division of Public Assistance office, or call the Recipient Information Line at (907) 339-1932 (in Anchorage) or 1-800-780-9972 (outside of the Anchorage area). Applications can be made for deceased individuals.

Updated 04/04

Retroactive Eligibility for Eligible Medical Assistance Recipients

Medical assistance is available to applicants on a retroactive basis for three months prior to the month of application. When applying, the applicant must meet basic income and resource criteria for each month in which the retroactive eligibility is desired. An applicant may be eligible for one or more months during the three-month retroactive period.

When a provider renders services to a Medical Assistance recipient who is found to have retroactive coverage during a month in which a service was rendered, the recipient is liable for the cost of the service until the provider has been furnished proof of eligibility and agrees to accept payment by billing Medical Assistance for the service.

Updated 04/02

Eligible Chronic and Acute Medical Assistance (CAMA) Recipients

CAMA recipients must meet certain income and resource limits to qualify for the state-funded CAMA program (no federal funds are included). The Alaska Division of Public Assistance (DPA) determines eligibility by counting the income and resources of all the persons in one household who are related by blood or marriage and who do not receive assistance from Alaska Temporary Assistance Program, Adult Public Assistance, or Supplemental Security Income.

Income limits start at $300/month (after taxes) for one family member and go up $100/month for each additional family member. Resources are limited to $500. Resource limits are determined from cash, money in the bank, land, etc., but not from vehicles, a home, or property used to produce income.

Alaskans eligible for CAMA *must apply before receiving medical services* by contacting a DPA office or village fee agent; CAMA eligibility is not retroactive. Phone numbers and addresses are in Appendix A of this manual. Once accepted to receive CAMA services, the applicant receives a medical coupon showing the services covered.

Updated 08/03

Regulations and Restrictions

Discriminatory Practices

Federal laws prohibit discrimination against any person in the United States on the grounds of race, color, national origin, age, or handicap, which would deny that person participation in or benefits of any program or activity with federal financing. In addition, a provider must not discriminate against a person receiving Medical Assistance services who has a third party resource. Payments can only be made to providers who comply with federal laws. These federal requirements are stated in Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the 1975 Age Discrimination Act.

Billing for medical assistance services or supplies is considered evidence that the provider is complying with the Acts named above. Failure to comply may result in a determination by the Department of Health and Social Services that the provider is not qualified to participate in Alaska's medical assistance programs.

Updated 08/03

Surveillance and Utilization Review for Fraud, Waste, Abuse, or Misuse

As fiscal agent for the State of Alaska, First Health Services Corporation monitors and reviews services and claims to detect and prevent fraud, waste, abuse, and misuse of the Medicaid program by recipients and/or providers.

Fraud and abuse can be committed by either providers or recipients of services. Suspected fraud and/or abuse should be reported to Surveillance and Utilization Review (SUR) at First Health Services Corporation (see pages v and vi).

Persons knowingly assisting the recipient or the provider in committing fraud are generally considered as aiding in the commission of that act and may be held responsible. SUR is discussed in detail, along with sanctions that may be imposed by the State of Alaska, in Appendix C of this manual.

Updated 08/03

Medicaid Provider Fraud Control Unit

A Medicaid Provider Fraud Control Unit was established in 1992 by the Alaska Legislature and operates within the State Attorney General's Office. This Unit, under 42 CFR 431.107, is entitled to access all provider records and information necessary to fully disclose the extent of services or items furnished to Medical Assistance recipients. Accordingly, the Medicaid Provider Fraud Control Unit is an authorized representative of the Department of Health and Social Services (DHSS) for the purpose of investigating potential Medical Assistance fraud or patient abuse.

Pursuant to a Provider Agreement upon enrollment, and on file with DHSS, Medical Assistance providers must comply with this Medicaid Provider Fraud Control Unit's requests for records or information about claims submitted to Medical Assistance or services provided to Medical Assistance recipients.

Updated 08/03

Timely Filing of Claims

All claims must be filed within 12 months of the date services were provided to the patient. The 12 month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier. In these cases, providers must bill Medical Assistance within 12 months of the service date and attach explanation of benefits documentation from the third-party carrier to the Medical Assistance claim.

The timely filing limit may be extended under the following conditions:

1. **Court Orders or Administrative Hearings.** The timely filing limit can be extended and payment made by court order. If a provider had reason to believe that the recipient was ineligible at the time service was rendered, and the recipient is subsequently determined eligible by a court or hearing authority, the claim may be paid if it is filed within the above timely filing guidelines after the date of the court or administrative hearing authority's decision that the recipient was eligible [*AAC 43.025*]. A letter or document from the court or agency establishing the decision to make payment must accompany the claim.
2. **Good Cause.** The timely filing limit may be extended for "Good Cause." "Good Cause" exists when a claim has been previously filed timely and no record of that timely filing exists with either the provider or the Division of Health Care Services (DHCS). The provider must attest to the previous timely filing in an affidavit or other legally binding statement and attach it to his/her claim. "Good Cause" also exists when, through an "act of God" (fire, storm, earthquake, etc.), the provider was prevented from submitting the claim in a timely fashion due to loss or inaccessibility of records. "Good Cause" does *not* include errors that are due to the provider or provider's billing staff. "Good Cause" also does *not* include the recipient's failure to notify the provider of a court or administrative hearing authority's decision.

Updated 08/03

Proof of Timely Filing

Any time a claim is received by **First Health** Services Corporation after the timely filing period has expired, an attachment must accompany the claim to prove timely filing. Acceptable documentation must be dated within the timely filing period and must show that either the claim was previously received by **First Health** Services Corporation within the timely filing period or the claim met one of the conditions for timely filing extension.

Examples of acceptable documentation are:

- A copy of the Remittance Advice (RA) page showing claim denial
- A copy of a Resubmission Turnaround Document (RTD)
- A copy of the in-process claims page of an RA
- The Keymaster, Payerpath or other electronic claim submission transmission report
- Correspondence from **First Health** Services Corporation, the Division of Health Care Services (DHCS), or the Division of Public Assistance
- Court orders or Administrative Hearing documentation as outlined in #1 above

Updated 10/03

Filing Limits for Adjustments

Adjustment requests must be submitted within 60 days from the date of payment or within 12 months of the date of service if additional amounts are owed to the provider. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply.

Updated 08/03

Conditions for Payment

Providing services to medical assistance recipients and billing for those services signifies the provider's agreement and compliance with DHSS regulations and policies.

Updated 08/03

Full and Total Reimbursement

Payment less the amount of recipient cost sharing, if required by state regulation [*7 AAC 43.052*], represents full and total reimbursement for those covered services authorized under the Alaska Medical Assistance program.

Updated 08/03

Difference Between the Amounts Billed and Paid

Under federal regulations, recipients may not be charged for the difference between the amount billed and the amount received in payment for those covered services provided. If the billing is not made timely or appropriately, and the claim is denied, the recipient is not responsible for the charges.

Updated 04/99

Responsibility for Noncovered Services

Recipients are responsible for payment of all non-covered services (*and cost sharing amounts if required by 7 AAC 43.052*)**.** The provider should not accept a medical assistance coupon from the recipient if the service is not covered under the Alaska Medical Assistance program.

Updated 08/03

Prohibition Against Reassignment

Payment will not be made by DHCS for claims known by a provider to be covered by Medical Assistance when the claim has been assigned, sold, or otherwise transferred (including transfer through the use of power of attorney) to a collection agency, service bureau, or individual who advances money to a provider for his/her accounts receivable. The use of a billing agent or accounting firm that bills and receives payment in the name of the provider is permitted if payment for this service is not on a percentage or other basis related to the amount billed or collected.

Updated 08/03

Third Party Payment

By law, Medical Assistance funds are to be expended *only after all other available resources have been used*. This refers to third party resources that assume liability for payment when a person has received medical care and services. With some exceptions, the provider is required to bill third party resources before billing Medical Assistance. Medical Assistance is the "payer of last resort," except for U.S. Public Health Service (PHS) recipients.

If the provider is aware that the recipient is receiving treatment for injuries caused negligently or intentionally by another person, business, or organization, the provider should notify DHCS or First Health Services Corporation. If known, the provider can give an example to DHCS or First Health Services Corporation that proof of liability exists, and bill the responsible party. If liability is undetermined, notify DHCS or First Health Services Corporation of potential liability and bill Medical Assistance; payment will not be delayed.

By law, all third party resource benefits received by the provider for Medical Assistance covered services must be applied against the provider's charges for those services. This payment must be indicated on the claim submitted to Medical Assistance, with the third party's explanation of benefits (EOB) attached to the claim form. The resulting Medical Assistance payment for Medical Assistance covered services will be the amount remaining after the insurance payment is deducted from the Medical Assistance allowable amount. Providers will not be reimbursed by Medical Assistance when payment from a third party payer is equal to or exceeds the level of reimbursement allowed for the specific service. The provider may not bill the recipient for any unpaid balance of the total charge when the third party resource represents all or a portion of the Medical Assistance maximum allowable amount.

If the provider receives payment from the third party carrier(s) after receiving Medical Assistance reimbursement, the Medical Assistance payment must be refunded. This is done with an *Adjustment/Void Claim Form,* described in Section II.

Updated 08/03

Payment From Other Sources

Any payment received by a provider from any source for an authorized covered service that has been or will be paid by Alaska Medical Assistance must be refunded or credited to Alaska Medical Assistance up to the limit of the state's liability.

Updated 08/03

Recovery or Recoupment of an Overpayment

If Alaska Medical Assistance makes an overpayment to a provider, the overpayment will be recovered.

An overpayment may occur when a provider is reimbursed:

- for a noncovered service.
- for a service not authorized under the provider's current provider agreement.
- for a service without prior authorization when prior authorization is required.
- for a service paid for by another source or eligible for payment by another source.
- in an amount that exceeds the maximum allowable amount or units for a specific service.
- in an amount that the provider identifies as an overpayment.
- in an excessive amount as a result of automated claim processing error or omission.
- incorrectly for services not meeting established standards for reimbursement of services.

An overpayment is recovered through: 1) an arrangement of terms with the provider, or 2) through recoupment of the overpayment. Recoupment is the reduction of future payments to the provider until the amount of the overpayment has been offset.

The provider will be notified of recoupment by the provider's Remittance Advice when the action takes place within 120 days of the overpayment. If more than 120 days have passed since the overpayment, DHCS will notify the provider in writing at least 30 days before recoupment begins. The Remittance Advice or notice to the provider will identify:

a) the reason for the recoupment,

b) the amount of the overpayment to be recouped, and

c) the provider's right to obtain a review (see "Appeals Process" later in this section).

If a provider stops billing Alaska Medical Assistance for services after receiving notice of recoupment action, DHCS shall make written demand to the provider for repayment of the balance of the overpayment. Recovery of overpayment does not apply to probate collections, or to providers who are bankrupt, out-of-business, or under sanction actions.

Updated 08/03

Appeals Process

A provider may request review of a Medical Assistance claim if payment of an initial claim was denied or reduced, or if payment was reduced due to a recoupment action (recovery of an overpayment) by Medical Assistance. The appeals process is discussed below. In all cases, the provider must adhere to the timely filing requirements discussed on a previous page in this section.

Note: Before appealing a claim payment or denial of payment, the provider should try other methods to resolve the decision.

1. **Paid Claim.** Payment may be adjusted by submitting an ***Adjustment/Void Request Form (AK-05)***, correcting the information that was originally submitted, within the timely filing period for that date of service or within 60 days from the date of adjudication of the claim (Section II discusses form completion). The payment amount will be recalculated based upon the corrected claim information.
2. **Denied Claim.** If a claim is denied because the information on it is incorrect, resubmit the claim with the correct information within the timely filing period for that date of service.

Updated 04/02

Pre-Appeals Process

This process is available only for services that providers feel are exceptions to current Medical Assistance policies or editing which would normally be applied and result in denial or reduction of payment. To utilize this process, submit the claim with appropriate documentation that supports the exceptional circumstances to:

First Health Services Corporation
Attention: *Pre-Appeal Review*
Post Office Box 240808
Anchorage, AK 99524-0649

To ensure that it is not confused with routine correspondence, the claim and supporting documentation are to be submitted by mail with a cover sheet clearly marked "Pre-Appeal Review" or the provider may use the Provider Appeal form located on the following pages in Figure III-6.

Providers will be notified of the outcome in a future Remittance Advice statement after the claim is processed.

Updated 05/05

First Level Appeal

A provider may request a first level appeal if payment of an original claim was denied or reduced, or if payment was reduced due to a recoupment action. The provider is encouraged to use the Provider Appeal form located on the following pages in Figure III-6.

A first-level appeal may be filed with **First Health** Services Corporation. The following steps comprise a first level appeal.

1. First level appeals *must be in writing* and received within 60 days of the claim disposition date (the date of the Remittance Advice [RA]), or within the timely filing period for that date of service. Include a copy of the claim denial or payment notice (the RA), a copy of the original claim that was denied or reduced, and any supporting documentation considered relevant (i.e.,

chart notes, claim check audit report, etc.) A telephone call from the rendering provider does *not* serve as notification that a first level appeal is being made.

2. Providers should submit first level appeals with supporting documentation to Appeals, Provider Services Unit, **First Health** Services Corporation. (See page vi for address.)

3. Providers are notified in writing by **First Health** Services Corporation of the first level appeal results.

Updated 05/05

Second Level Appeal

A provider may request a second level appeal when they are not satisfied with the results of the first level appeal or when they are not satisfied with a denied enrollment or disenrollment or when they are not satisfied with a prior authorization decision. A second level appeal must be requested in writing to the Alaska Division of Health Care Services (DHCS). Second level appeal steps are as follows:

1. Second level appeals *must be in writing* and postmarked within 60 days of the date of the first level appeal decision by **First Health** Services Corporation or within 60 days of the adverse enrollment or prior authorization decision. Include a copy of the **First Health** Services Corporation first level appeal decision, or a copy of adverse enrollment or prior authorization decision, a copy of the claim denial or payment notice, a copy of the submitted claim, and supporting documentation considered relevant. A telephone call does *not* serve as notification that a second level appeal is being made.

2. Providers should submit second level appeals to DHCS. (See page vi for address.)

3. Providers will be notified in writing of the final decision by DHCS.

Updated 08/03

Final Level Appeal

Providers may appeal a previous decision to the Commissioner of the Alaska Department of Health and Social Services under the following circumstances:

- When they are not satisfied with the results of the second level appeal relating to denial of a claim for not meeting the timely filing requirement.

Final level appeal steps are as follows:

1. An appeal to the Commissioner must be in writing and postmarked no later than 60 days after the date of the second-level appeal decision by DHCS or the hospitalization decision. Include a clear description of the issue or decision being appealed and the reason for the appeal.

2. Providers should submit this appeal to:

   Commissioner, Department of Health and Social Services
   P.O. Box 110601
   Juneau, AK 99811-0601

Note: Reminder: Appeals must be in writing.

1. Send first level appeals to First Health Services Corporation.
2. Send second level appeals to Division of Health Care Services (DHCS).
3. Send final level appeals to Commissioner, Department of Health and Social Services.

Updated 08/03

P.O. Box 240808
Anchorage, AK 99524
(907) 644-6800
https://alaska.fhsc.com/

First Health Services Corporation
A Coventry Health Care Company

Provider Appeals Form

Pre-Appeal ☐ First Level Appeal ☐

Provider Information

Provider Name: _____

Provider ID No.: _____

Contact Name: _____

Contact Telephone No.: _____

Recipient Information

Recipient Name: _____

Recipient ID No.: _____

Date of Service Related to this Appeal: _____

Service(s) or Procedure(s) Related to this Appeal: _____

_____

Reason for Request (i.e., medical justification, timely filing, etc.)

_____

_____

_____

_____

_____

_____

_____

Figure III-6: Provider Appeals Form

Glossary

Terms and abbreviations commonly used in the Alaska Medical Assistance billing manual are defined below. The [1], [2], or [3] notation following each term refers to the source of definition:

[1] Alaska Administrative Code, Chapter 43

[2] Alaska Medicaid Manual

[3] Alaska MMIS Glossary

Adjudicated Claim

A claim that has reached final disposition, being either paid or denied. [3]

Updated 12/98

Adjustment

A transaction that changes any payment information on a claim that has been paid. [3]

Updated 12/98

AK-02

The State of Alaska's Health Insurance Claim Form used to bill Medical Assistance for specific health care services; used interchangeably with the HCFA-1500 claim form. The use of the Alaska unique AK-02 claim form was discontinued on 12/31/03 to comply with the HIPAA Act of 1996.

Updated 04/04

AK-PA

The Prior Authorization Request form used to authorize medical services in advance, when required.

Updated 12/98

Alaska MMIS

Alaska Medicaid Management Information System; claims processing. [3]

Updated 12/98

Appeal

An action taken by a provider who disagrees with the adjudicated result of a claim.

Updated 12/98

Beneficiary (more commonly called "recipient")

An individual eligible to receive medical services under Alaska statutes. [1]

Updated 12/98

CAMA (Chronic and Acute Medical Assistance)

See "Chronic and Acute Medical Assistance."

Updated 12/98

CCN (Claim Control Number)

An identification number assigned to each Medical Assistance claim submitted for processing, based upon the Julian Calendar. Also referred to as "ICN." [3]

Updated 04/02

Chronic and Acute Medical Assistance (CAMA)

A state-funded medical program that is designed to meet certain medical needs of low income Alaska residents who are ineligible for other Medical Assistance programs.

Updated 08/03

Claim Line

A line item of a claim form identifying the services and/or charges for service for a single recipient from a single provider. A UB-82 claim, which is processed as one claim line, is an exception.

Updated 12/98

CMS (Centers for Medicare & Medicaid Services)

Formerly HCFA (Health Care Financing Administration). Federal agency responsible for management of state-administered Medicaid programs, the fee-for-service Medicare program, and beneficiary information on Medicare and Medicare-related programs.

Updated 08/03

CMS-1500

Formerly HCFA-1500 (Health Care Financing Administration-1500). The Centers for Medicare and Medicaid Services' Claim Form used to bill Medical Assistance for specific health care services.

Updated 04/04

Cost Sharing

Co-payment. An established amount that is collected from the recipient by the provider of Medical Assistance services. Payment to the provider will be reduced by the cost sharing amount. [1]

Updated 08/03

CPT-4 (Current Procedural Terminology, Fourth Edition)

A listing of descriptive terms and identifying codes for reporting services and procedures performed by physicians. CPT-4 is revised and published annually by the American Medical Association.

Updated 08/03

Crossover Claim

A claim for services rendered to a recipient eligible for benefits under both Medical Assistance and Medicare programs. Medicare benefits must be processed prior to Medical Assistance benefits. [3]

Updated 04/02

Denali KidCare

A Medical Assistance expansion program providing medical assistance to eligible pregnant women, youth and infants.

Updated 04/02

Denied Claim

A claim for which no payment is made to the provider. [3]

Updated 05/99

Department of Health and Human Services (DHHS)

The department of the federal government that administers Medicare and Medicaid programs. Formerly called the Department of Health, Education and Welfare. [2]

Updated 05/99

Department of Health and Social Services (DHSS)

The State of Alaska department responsible for State administration of assistance programs. [2]

Updated 08/03

Division of Health Care Services (DHCS)

The division within the Alaska Department of Health and Social Services responsible for administering Alaska Medical Assistance and other medical assistance programs, including CAMA and Denali KidCare. [1] [7 AAC 43.709]

Updated 08/03

Division of Public Assistance (DPA)

The division within the Alaska Department of Health and Social Services responsible for determining eligibility for assistance programs.

Updated 08/03

ECCS

Electronic Commerce Customer Support. Customer support for providers who submit claims electronically.

Updated 04/04

EDI (Electronic Data Interchange) Transactions

Submission of Medical Assistance claims via BBS (Bulletin Board Service), diskette, or SSL FTP (Secure Socket Layer File Transfer Protocol) for processing.

Updated 04/04

Edit

Verification of appropriateness of claim data. [3]

Updated 05/99

Effective Date (of Payments)

The date on which a new or modified prospective payment rate is determined by the Department of Health and Social Services to be effective. [1] [7 AAC 43.709]

Updated 05/99

Eligibility Code

A category of eligibility assigned by the Alaska Division of Public Assistance to a recipient, determining the type of medical services the recipient is eligible to receive.

Updated 05/99

Eligible Recipient

See “recipient.”

Updated 05/99

EMC (Electronic Media Claim)

See “EDI”.

Updated 04/04

EOB (Explanation of Benefits)

1) A notice issued by an insurance company to the recipient or provider of Medical Assistance-covered services that explains the payment or non-payment of a specific claim processed. [3]

2) An explanation code appearing on the Medical Assistance Remittance Advice for those claim charges denied or returned for correction.

Updated 04/02

EOMB/MRN (Explanation of Medicare Benefits)

Same as EOB, except notice is issued by Medicare. [3]

Updated 01/03

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment)

A federally mandated program to prevent, or to identify early, and treat potentially disabling diseases and conditions in individuals under 21 years of age as a more cost-effective way to provide medical aid to eligible recipients. The program includes an outreach component to identify eligibles, match them with providers, and enroll them in the program. [3]

Updated 05/99

EVS (Eligibility Verification System)

An automated telephone system maintained by First Health to help providers determine the Medical Assistance eligibility of their patients.

Updated 04/02

Explanation of Benefits

See “EOB.”

Updated 05/99

Explanation of Medicare Benefits

See “EOMB.”

Updated 05/99

Facility

An acute care hospital, specialty hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric facility, home health agency, rural health clinic, or outpatient surgical clinic. [1] [7 AAC 43.709]

Updated 05/99

Family Planning (FP) Services

Those services and materials provided with the purpose of postponing, avoiding, or terminating pregnancy, including the dispensing of birth control drugs and devices for males and females, and the performance of vasectomies, sterilizations, and abortions for the purpose of avoiding or terminating pregnancy.[1] [7 AAC 43.835]

Updated 05/99

First Health Services Corporation (First Health)

See "fiscal agent."

Updated 05/99

Fiscal Agent

First Health Services Corporation (First Health). An organization that reviews, processes and pays provider claims on behalf of the Alaska Department of Health and Social Services for Medicaid and other medical assistance programs. [2]

Updated 08/03

FP (Family Planning)

See "family planning services."

Updated 05/99

HCFA (Health Care Financing Administration)

See "CMS."

Updated 08/03

HCFA-1500

The U.S. Health Care Financing Administration's Health Insurance Claim Form used to bill Medical Assistance for specific health care services; used interchangeably with the AK-02 claim form. (The AK-02 claim form was discontinued on 12/31/03 and the HCFA-1500 is now referred to as the CMS-1500.)

Updated 04/04

HCPCS

HCFA (Health Care Financing Administration) Common Procedure Coding System. [3]

Updated 05/99

Hospital

A facility licensed by the Alaska Department of Health and Social Services to provide inpatient and outpatient hospital services. [1] [7 AAC 43.090]

Updated 05/99

Hospital Inpatient Claim

The UB-82 claim form used to bill inpatient hospital services.

Updated 05/99

ICD (International Classification of Diseases)

A classification and coding structure of diseases, published by the World Health Organization and used by the health care community to describe a patient's condition and illness and to facilitate the collection of statistical and historical data. [3]

Updated 05/99

ICD-9-CM

International Classification of Diseases, Ninth Edition, Clinical Modification; the most recently published classification and coding structure of diseases used by the health care community. See "ICD." [3]

Updated 05/99

ICF (Intermediate Care Facility)

A licensed facility certified to deliver intermediate care services. These services are the observation, assessment, and treatment of a recipient with long-term illness or disability whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or care for a recipient nearing recovery and discharge whose condition is relatively stable but who continues to require professional medical or nursing supervision. [1] [7 AAC 43.185]

Updated 05/99

ICF-MR (Intermediate Care Facility for the Mentally Retarded)

A licensed facility certified as an intermediate care facility for the mentally retarded or persons with related conditions. [1] [7 AAC 43.090]

Updated 05/99

Institutional Claim

The UB-92 claim form used by institutional providers for inpatient and outpatient billing.

Updated 08/03

Interdisciplinary Team

A group of care providers involved in making decisions regarding the care of a specific child who has been identified by an EPSDT evaluation as needing psychological services. The team will include the child's family or legal guardian, the child's mental health provider, and the Alaska Division of Senior and Disabilities Services, and may also include other agencies and care providers involved with the care of the child. [1] [7 AAC 43.730]

Updated 08/03

Julian Date

The consecutively numbered day of the calendar year, which is used to assign a claim control number to each claim submitted for Medical Assistance processing.

Updated 04/02

Long-term Care Facility

Includes intermediate care facilities (ICF) and skilled nursing care facilities (SNF). [1] [7 AAC 43.709]

Updated 05/99

LTC (Long-term Care)

Medical care services performed in nursing homes. See "long-term care facility." [3]

Updated 05/99

Medicaid

A joint federal and state assistance program created by Title XIX of the Social Security Act designed to pay for necessary, covered medical care for certain needy people who meet the program's eligibility requirements. [2]

Updated 05/99

Medical Assistance Authorization

A medical assistance card or coupon issued by the Alaska Division of Public Assistance, which identifies a recipient as being eligible for Medicaid, CAMA or Denali KidCare coverage during a specific time period. [2]

Updated 08/03

MMIS (Medicaid Management Information System)

See "Alaska MMIS."

Updated 05/99

MRN

Medicare Remittance Notice.

Updated 12/02

NDC

National Drug Code.

Updated 05/99

Outpatient Care

Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient. [3]

Updated 05/99

Outpatient Surgical Clinic

An ambulatory surgical center that operates as a distinct entity exclusively for the purpose of providing surgical services to patients not requiring hospitalization. [1] [7 AAC 43.709]

Updated 06/98

PA (Prior Authorization)

Authorization granted for services or medical procedures requiring prior review and approval by State of Alaska medical professionals before such service can be performed and paid. [3]

Updated 08/03

Paid Claim

A claim that has been processed through the system and approved for payment. [3]

Updated 06/98

Patient Day

A calendar day of patient care. [1] [7 AAC 43.709]

Updated 06/98

Pended Claim

A claim that has failed to pass the system edits and requires manual intervention by State of Alaska or fiscal agent personnel before continuing in the processing cycle. [3]

Updated 08/03

Prevailing Charge

The 75th percentile of the charges made in the state for similar services during the computation period. [1] [7 AAC 43.103] Also, see “U & C.”

Updated 06/98

Pricing Methodology

The method for determining the allowable amount Medical Assistance will reimburse a provider for a specific service rendered to an eligible recipient.

Updated 04/02

Prior Authorization

See “PA.”

Updated 06/98

Prior Resource

An alternative resource available to provide or pay for a service, which must be fully utilized before payment will be made on behalf of an eligible recipient by Alaska Medical Assistance.

Updated 08/03

Procedure Code

A specific code number given to each individual service or procedure, which is entered on a Medical Assistance claim form by the provider to identify the services rendered to an eligible recipient.

Updated 04/02

Provider

A person, organization, or institution that provides health care related services. A provider must be approved by the State of Alaska for enrollment in the Medical Assistance program. [3]

Updated 08/03

Provider Relations

Communications between providers and the State of Alaska (or the State's fiscal agent) involving provider training, provider recruitment, problem resolution, and other provider inquiries. [3]

Updated 08/03

Psychiatric Facility

A facility or part of a facility licensed by the Alaska Department of Health and Social Services, which is primarily for the diagnosis and treatment of mental, emotional, or behavioral disorders. [1] [7 AAC 43.090]

Updated 08/03

RA (Remittance Advice)

The statement mailed to a provider detailing the charges pending, paid, denied, or returned. Explanation codes are included for those denied or returned for correction. [3]

Updated 06/98

Recipient

An individual eligible for medical assistance in accordance with Alaska statutes and certified as such by the State. [3]

Updated 08/03

Remittance Advice

See "RA."

Updated 06/98

Resource Code

Medical insurance coverage other than Medical Assistance, identified on the recipient's medical assistance authorization card or coupon.

Updated 04/02

Rolling Year

The 12-month period commencing with the date of the initial examination, visit, or treatment.

Updated 06/98

RTD (Resubmission Turnaround Document)

A page accompanying the Remittance Advice (RA) that allows the provider to correct certain errors on a claim form without having to resubmit the claim.

Updated 06/98

Rural Health Clinic

A facility that has filed an agreement with the Alaska Department of Health and Social Services to provide rural health clinic services under Medical Assistance. [1][7 AAC 43.709]

Updated 04/02

Rural Health Clinic Visit

A face-to-face encounter between a rural health clinic patient and any health care professional whose services are reimbursed by Alaska Medical Assistance; encounters with more than one health care professional, and multiple encounters with the same health care professional, regarding the same illness or injury, which take place on the same day and at a single location, constitute a single visit. [1] [7 AAC 43.709]

Updated 08/03

Sanction

A disciplinary action imposed on providers or recipients by the State of Alaska as a result of having committed an offense against the program as outlined in the Alaska Administrative Code. [3]

Updated 08/03

SNF (Skilled Nursing Facility)

A licensed facility certified to deliver skilled nursing care services to recipients on a 24-hour basis. [2]

Updated 06/98

State Medicaid Plan

The comprehensive written commitment by a Medicaid agency, submitted under Section 1903(a) of the Social Security Act, to administer or supervise the administration of a Medicaid program in accordance with federal and state requirements. [3]

Updated 08/03

SUR (Surveillance and Utilization Review)

Review that builds a statistical base for health care delivery and utilization pattern profiles for both providers and recipients and generates a listing of potential abuses for review by State personnel. [3]

Updated 08/03

Third Party Liability (TPL)

See "TPL."

Updated 05/99

Timely Filing

A requirement that all claims for reimbursement be filed promptly following the date of service. The timely filing period for a claim depends on the date of service of the claim, if a third party was billed for the service and whether or not the recipient received retroactive Medical Assistance eligibility. Timely filing is discussed in more detail in section I and/or section III of most Medical Assistance billing manuals. Generally, claims must be submitted within 12 months of the date of service.

Updated 08/03

Title XIX

Title Nineteen of the Social Security Act of 1965, which established Medicaid to provide medical assistance to certain low income needy individuals and families. [2]

Updated 05/99

TPL (Third Party Liability)

A situation in which a recipient has health insurance resources other than Medical Assistance or Medicare that are responsible for at least partial payment of a claim. [3]

Updated 04/02

U & C (Usual and Customary Charges)

The "usual charge" is the 75th percentile of the range of charges made for a specific service during the computation period. The "customary charge" in a region of the state is the 75th percentile of the range of charges made in that region for similar service codes during the computation period. [1] [7 AAC 43.101 - 7 AAC 43.102]

Updated 05/99

UB-92

The Uniform Bill (Form HCFA-1450) used by institutional providers for inpatient and outpatient billing. [3]

Updated 05/99

Unlisted Procedure Code

The use of an unlisted code on a claim form requires a written description by the provider of the service or procedure rendered to an eligible recipient and the reason no other procedure code was appropriate for the service or procedure rendered. This information is to be attached to the claim when submitted.

Updated 08/03

Verify

The process of checking the accuracy and correctness of data. [3]

Updated 05/99

Appendix A
Directory Assistance

Alaska Department of Health and Social Services

Office of the Commissioner

350 Main Street, Room 229 **(907) 465-3030**
P.O. Box 110611
Juneau, AK 99811-0601
http://www.hss.state.ak.us/commissioner/contacts/default.htm

Updated 08/03

Office of Children's Services

130 Seward Street, Room 4F **(907) 465-3170**
P.O. Box 110630
Juneau, AK 99811-0630
http://www.hss.state.ak.us/ocs

Infant Learning Program
http://www.hss.state.ak.us/ocs/InfantLearning/program/default.htm

WIC-Nutrition Services
http://www.hss.state.ak.us/ocs/nutri/WIC/about/default.htm

Updated 08/03

Division of Behavioral Health (Substance Abuse and Mental Health Services)

P.O. Box 110620 **(907) 465-3370**
Juneau, AK 99811
http://www.hss.state.ak.us/dbh/

Updated 08/03

Division of Health Care Services

P.O. Box 110660 **(907) 465-3355**
Juneau, AK 99811-0660
http://www.hss.state.ak.us/dhcs/contacts.htm

Medicaid, Denali KidCare, CAMA **(907) 334-2400**
4501 Business Park Boulevard, Suite 24
Anchorage, AK 99503-7167
http://www.hss.state.ak.us/dhcs/Medicaid/default.htm

Health Facilities Licensing and Certification **(907) 334-2483**
4730 Business Park Boulevard, Suite 18
Anchorage, AK 99503-7137
http://www.hss.state.ak.us/dhcs/HFLC/default.htm

Breast and Cervical Cancer Screening **1-800-410-6266**
http://www.hss.state.ak.us/dhcs/bchc/default.htm

Infant Screening and Testing Programs **(907) 269-3466**
http://www.hss.state.ak.us/dhcs/screening_testing.htm

Genetic and Specialty Clinics, Family Planning **(907) 269-3430**
http://www.hss.state.ak.us/dhcs/genetic_specialty.htm

Medical Care Advisory Committee **(907) 465-1164**
http://www.hss.state.ak.us/dhcs/mcac.htm

Nutrition Services Office **(907) 269-3459**

Early Screening Program **(907) 269-4575**
4501 Business Park Boulevard, Suite 24 **1-888-276-0606**
Anchorage, AK 99503-7167

Updated 12/04

Division of Public Assistance (DPA) District Offices

http://www.hss.state.ak.us/dpa

Bethel District Office **(907) 543-2686**
P. O. Box 365 **Toll Free 1-800-478-2686**
Bethel, AK 99559-0365

Dillingham Office **(907) 842-5135**
P.O. Box 1270 **Toll Free 1-800-478-4372**
Dillingham, AK 99576

Homer Office **(907) 235-6132**
601 East Pioneer Avenue, Suite 122
Homer, AK 99603

Juneau Office **(907) 465-3551**
10002 Glacier Highway, Suite 201 **Toll Free 1-800-478-3551**
Juneau, AK 99801

Kenai Office **(907) 283-2900**
11312 Kenai Spur Highway **Toll Free 1-800-478-9032**
Kenai, AK 99611

Southeast Regional Office **(907) 225-2137**
Ketchikan District Office **(907) 225-2135**
2030 Sea Level Drive, Suite 301 **Toll Free 1-800-478-2135**
Ketchikan, AK 99901

Kodiak Office **(907) 486-3783**
307 Center Street **Toll Free 1-888-480-3783**
Kodiak, AK 99615

Kotzebue Office **(907) 442-3451**
P.O. Box 1210
Kotzebue, AK 99752

Nome Office **(907) 443-2237**
P.O. Box 2110 **Toll Free 1-800-478-2236**
Nome, AK 99762

Sitka Office
201 Katlian Street, Suite 107
Sitka, AK 99835

(907) 747-8234
Toll Free 1-800-478-8234

Mat-Su District Office
855 W. Commercial Drive
Wasilla, AK 99654

(907) 376-3903
Toll Free 1-800-478-7778

Updated 08/03

Division of Public Assistance (DPA) Regional Offices

Central Office
P.O. Box 110640
Juneau, AK 99811-0640

(907) 465-3347

Central Region A Anchorage
Anchorage District Office
400 Gambell Street, Suite 101
Anchorage, AK 99501-2792

(907) 269-6599

Northern Regional Office (NRO)
Fairbanks District Office
675 - 7th Avenue, Section D
Fairbanks, AK 99701-4592

(907) 451-2850
Toll Free 1-800-478-2850

Coastal Region
3601 C Street, Suite 410
P.O. Box 240249
Anchorage, AK 99524-0249

(907) 269-8950
(907) 269-8960
Toll Free 1-800-478-4364
Toll Free 1-800-478-4372

Southeastern Regional Office (SERO)
2030 Sea Level Drive, Suite 301
Ketchikan, AK 99901

(907) 225-2137

Updated 12/98

Division of Public Health (DPH)

350 Main Street, Room 508
P.O. Box 110610
Juneau, AK 99811-0610
http://www.hss.state.ak.us/dph/director/contact.htm

(907) 465-3090

Community Health & EMS
http://www.hss.state.ak.us/dph/chems/default.htm

(907) 465-3027

Epidemiology
http://www.epi.hss.state.ak.us/deafult.jsp

(907) 269-8000

Laboratories
http://www.hss.state.ak.us/dph/labs/default.htm

(907) 334-2109

Public Health Nursing
http://www.hss.state.ak.us/dph/nursing/default.htm

(907) 465-3150

State Medical Examiner **(907) 334-2200**
http://www.hss.state.ak.us/dph/sme/default.htm

Vital Statistics **Juneau (907) 465-3391**
http://www.hss.state.ak.us/dph/bvs/default.htm **Anchorage (907) 269-0991**
Fairbanks (907) 452-4863
Updated 08/03

Division of Senior and Disabilities Services

3601 C Street, Suite 310 **(907) 269-3666**
Anchorage, AK 99503-5984 **(907) 269-3680**
http://www.hss.state.ak.us/dsds/

CHOICES Medicaid Waivers **(907) 269-3650**
http://www.hss.state.ak.us/dsds/choice.htm

Developmental Disabilities **Juneau (907) 465-2677**
http://www.hss.state.ak.us/dsds/dd/default.htm **Anchorage (907) 269-3600**
Fairbanks (907) 451-5045

Governor's Council on Disabilities and Special Education **(907) 269-8992**
http://www.hss.state.ak.us/gcdse

Home and Community Based Services **(907) 465-4798**
http://www.alaskaaging.org/hcb.html

Personal Care Assistant Program **(907) 269-3666**
http://www.hss.state.ak.us/dsds/pca/home.htm

Assisted Living Licensing **(907) 269-3666**
http://www.hss.state.ak.us/dsds/assist.htm

Alaska Medicare **(907) 269-3680**
http://www.hss.state.ak.us/dsds/medicare.htm **1-800-478-6065**

Adult Protective Services **(907) 269-3666**
http://www.hss.state.ak.us/dsds/aps.htm

Alaska Longevity Programs **(907) 465-4422**
http://www.hss.state.ak.us/dalp/

Updated 10/03

American Medical Association

Order Department **Toll Free 1-800-621-8335**
P.O. Box 10950
Chicago, IL 60610
http://www.ama-assn.org

Updated 04/03

American Society of Anesthesiologists Publications

520 Northwest Highway **(847) 825-5586**
Park Ridge, IL 60068-2573 **Fax: (847) 825-1692**
http://www.asahq.org/publicationsAndServices/general.htm

Updated 04/03

American Speech-Language-Hearing Association

10801 Rockville Pike **Professionals/Students 1-800-498-2071**
Rockville, MD 20852 **Public 1-800-638-8255**
e-mail: actioncenter@asha.org

Updated 10/03

Municipality of Anchorage Health and Human Services Commission

P.O. Box 196650 **(907) 343-4619**
Anchorage, AK 99519-6650
http://www.muni.org/health1/index.cfm

Updated 04/03

Commerce Clearing House, Inc.

4025 W. Peterson Avenue
Chicago, IL 60646-6085

Updated 12/98

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

Solucient, L.L.C. **Toll Free 1-800-568-3282**
Customer Service Department
5400 Data Ct. Suite 100
Ann Arbor, MI 48108-8935
http://www.solucient.com/solutions/ICD_9_CM.shtml

Updated 08/03

Appendix B
Julian Date Calendar

The Julian Date Calendar is useful in determining what day your claim was received by First Health Services Corporation for processing.

Each claim receives a Claim Control Number (CCN) with a portion of the CCN corresponding to the Julian Date on which the claim was received for processing. For example, a typical CCN would be "2 059 1 153 039 01," with the first digit, "2," representing the year (2002); the second, third, and fourth digits representing the Julian Date (059, for example, is February 28) of the year that the claim was received. For a Leap Year, one day must be added to the Julian Date number after February 28. The fifth through the thirteenth digits of the CCN are assigned by First Health Services Corporation to identify the type of claim (hospital, pharmacy, dental, etc.) and the number of the claim within the batch of claims being processed.

Day No.	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	--	88	119	149	180	210	241	272	302	333	363
30	30	--	89	120	150	181	211	242	273	303	334	364
31	31	--	90	---	151	---	212	243	---	304	---	365

For leap year, one day must be added to number of days after February 28.

Updated 04/02

Appendix C
Surveillance and Utilization Review

As fiscal agent for the State of Alaska, First Health Services monitors and reviews services and claims to detect and prevent fraud, waste, abuse, or misuse of the Medicaid program by recipients and/or providers and administers the Surveillance and Utilization Review Subsystem (SURS).

Updated 08/03

Surveillance and Utilization Review Subsystem

SURS is a federally required component for the Alaska Medical Assistance program. It originated as a required component for all certified Medicaid programs by the Health Care Financing Administration (HCFA) in 1973.

The goal of SURS is to provide a manageable approach to the process of aggregating and presenting medical care and service delivery data to meet two major concerns:

▪ **Surveillance**	The process of monitoring covered services and items by Medical Assistance participants. Surveillance includes use of itemized data for overall program management and use of statistics to establish norms of care in order to detect improper or illegal utilization practices
▪ **Utilization Review**	The process of analyzing and evaluating the delivery and utilization of apparently aberrant medical care on a case basis to safeguard quality of care and to guard against fraudulent or abusive use of the Medical Assistance program by either persons and/or institutions providing services or persons receiving them.

The principal functions performed in SURS are as follows:

- Develop comprehensive statistical profiles for revealing utilization patterns of health care delivery in the various categories of services authorized under the Alaska Medical Assistance program.
- Reveal possible instances of fraud and abuse by individual providers and recipients that will promote correction of such misutilization.
- Provide information indicating the existence of any potential deficiency or excess in the quantity and quality of services provided under the Alaska Medical Assistance program.

Alaska providers should be aware that all claims submitted to Medical Assistance will be subject to computerized analysis and case review. SURS will identify and report to the Division of Health Care Services occurrences of program misuse, suspected fraud, billing irregularities, and overutilization of services, with recommendations for potential sanctioning.

Updated 08/03

Fraud and Abuse

Fraud

Fraud is the misrepresentation of fact or omission of information with the intent to illegally obtain service, payment, or other gain. It can be committed by either the recipient or the provider.

Updated 06/98

Recipient

Recipient fraud is making false statements to eligibility workers or failing to reveal resources or income to obtain medical assistance.

The key factors in establishing recipient fraud are

- The fraudulent misrepresentation is represented as a statement of fact by the recipient.
- The fact misrepresented must be material; an incorrect age, for example, would not be critical except where age is a crucial factor in determining eligibility.
- The misrepresentation must be untrue, and the person making the misrepresentation must know or believe it to be untrue or make it with a reckless disregard of its truth or falsity.
- The misrepresentation must be made for the purpose of obtaining a benefit or a payment to which the individual is not entitled.

Updated 09/02

Provider

Provider fraud is knowingly and willingly billing for services not received by the recipient, double billing for a single service, or improperly billing to receive reimbursement that the provider was not entitled to.

The key factors in establishing provider fraud are

- The fraudulent misrepresentation is presented as a statement of fact by the provider.
- The fact misrepresented must be material; an incorrect diagnosis code, for example, would not be critical except when the diagnosis code is a crucial factor in determining reimbursement for procedures performed.
- The misrepresentation must be untrue, and the person making the misrepresentation must know or believe it to be untrue or make it with reckless disregard of its truth or falsity.

Updated 09/02

Abuse

Abuse is the overutilization of covered services, providing or receiving unnecessary covered services, and providing or receiving duplicate services. It can be committed by either the recipient or the provider.

Updated 06/98

Recipient

Recipient abuse occurs when the recipient utilizes medical personnel and facilities to meet non-medical needs, obtains duplicate services, or is uncooperative in accepting treatment plans.

Factors associated with recipient abuse include the following:

- Use of contacts with medical professionals and with persons in the waiting rooms of practitioners and outpatient facilities for essentially social purposes, relief of loneliness, reassurance, or as a substitute for more meaningful social activities.
- Recipient with impaired mental health (diagnosed or undiagnosed) inappropriately seeking care from physicians in general practice, which would more appropriately be provided by specialists or in mental health facilities.

- Recipient being inconvenienced or dissatisfied with medical care provided and seeking duplicate care in more congenial and convenient quarters.
- Negligence in caring for durable items (glasses, hearing aids, etc.) as well as desiring to keep up with fads of style.
- Manipulation of the program to acquire drugs or supplies for ineligible persons or to be sold for personal gain.
- Acquisition of drugs to support narcotics abuse.
- Gullibility in responding to promotional efforts or suggestions of practitioners that they receive care or supplies for which they previously had no desire and are unlikely to use.

Updated 06/98

Provider

Provider abuse occurs when the medical services provided are reimbursed in excess of those required, do not correspond with diagnosis, are insufficient to accomplish the purpose, or are otherwise of low quality.

Factors associated with provider abuse include the following:

- Inordinate referral to practitioners or facilities with whom or with which the referring practitioner has a financial arrangement or interest (e.g., ownership interest in institutional facilities, pharmacies, laboratories, etc.).
- Use of institutional facilities for care suitable to office treatment or other forms of ambulatory care.
- Promotional and sales efforts to provide services for which recipients felt no need and which they would be likely to use improperly (e.g., as sometimes happens with hearing aids and other prosthetic appliances.).
- An unstructured system for the delivery of medical care that results in duplicate or repetitive provision of services instead of transfer of medical records.
- Eccentric patterns of patient care (non-medically necessary services).
- Lack of sufficient medical resources (such as not having appropriate, less expensive alternative for medical care).

Updated 06/98

Fraud and Abuse Reporting

Recipients and providers should report any suspected fraud and/or abuse to SURS at First Health Services' toll-free Fraud Hotline, 1-800-256-0930. Reports made in writing should be submitted to:

First Health Services Corporation
Surveillance and Utilization Review
P.O. Box 240808
Anchorage, AK 99524-0808

The aforementioned method of reporting suspected fraud or abuse to First Health Services in no way restricts or relieves a citizen of the right and responsibility to report suspected criminal activity to the proper law enforcement authorities.

Persons knowingly assisting the recipient or the provider in committing fraud are generally considered as aiding in the commission of that act, and may be held responsible.

Updated 04/04

Restriction of Recipient's Choice of Providers

The Alaska Department of Health and Social Services will, at its discretion, restrict a recipient's choice of providers of items and services if the Department finds that the recipient has used an item or service paid for under Medical Assistance or Chronic and Acute Medical Assistance at a frequency or in an amount that is not medically necessary. The Department will notify the recipient of such a finding and request that the recipient choose a single provider to be the exclusive provider for the recipient of each item or service that the Department designates.

After designating a provider or providers, the Department will mark the identification card or medical coupons issued to the recipient with the word "RESTRICTED," and with the name of the designated provider or providers of restricted items or services.

Except in a medical emergency, only a provider designated by the Department may provide medical services to a recipient whose identification card or medical coupons are marked "RESTRICTED." In the event of a medical emergency, the recipient may choose a provider without restriction.

A medical emergency exists when a recipient has a severe, life-threatening or potentially disabling condition that requires intervention within minutes or hours.

For further information regarding restriction of recipient's choice of providers, refer to 7 AAC 43.027.

Updated 10/02

Sanctioning Providers

Grounds for Sanctioning Providers

As stated in 7 AAC 43.950, sanctions may be imposed for any one or more of the following reasons:

- Presenting or causing to be presented for payment any false or fraudulent claim for services or supplies.
- Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of a rate established by the Division or the provider's usual and customary charges.
- Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
- Failing to disclose or make available to the Division or its authorized agent records of services provided to Medical Assistance recipients and records of payments made for them.
- Failing to provide and maintain quality services to Medical Assistance recipients within accepted medical community standards as adjudged by a body of peers.
- Engaging in a course of conduct or performing an act considered improper or abusive of the Medical Assistance program or continuing that conduct following notification that it should cease.
- Breaching the terms of the Medical Assistance provider agreement or failing to comply with the terms of the provider certification on the Medical Assistance claim form.
- Overusing the Medical Assistance program by inducing or otherwise causing a recipient to receive services or supplies not required or requested by the recipient.
- Rebating or accepting a fee or portion of a fee or charge for a Medical Assistance recipient referral.
- Violating any provision of AS 47.07 or any regulation adopted under it.
- Submitting a false or fraudulent application for provider status.

- Violating any law, regulation, or code of ethics governing the conduct of occupations, professions or regulated industries.
- Being convicted of a criminal offense relating to performance of a provider agreement with the State of Alaska or relating to negligent practice resulting in death or injury to a patient.
- Failing to meet standards required by state or federal laws for participation, such as licensure.
- Being excluded from the Medicare program because of fraudulent or abusive practices.
- Following a documented practice of charging recipients for services an amount above payment made by Alaska Medical Assistance.
- Refusing to execute a new provider agreement when requested to so.
- Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies.
- Being formally reprimanded or censured by an association of the provider's peers for unethical practices.
- Being suspended or terminated from participation in another governmental medical program such as worker's compensation, crippled children's program, vocational rehabilitation services, and Medicare.
- Failing to repay or make arrangements for repaying identified overpayment or otherwise erroneous payment.
- Dispensing a lesser quantity of a drug than that prescribed in order to receive multiple dispensing fees for one prescription, unless the drug provider is reducing the prescribed amount in order to dispense no more than a 30-day supply.
- Billing for a drug other than the drug dispensed.
- Billing for an amount in excess of the normal charge to the typical walk-in, cash-paying customer.
- Billing for a prescription refill that was not authorized by the prescriber.
- Falsely submitting a bill specifying that a prescriber required a specific brand name drug rather than a less expensive generic equivalent.
- Supplying false information on a dispensing fee or drug cost survey initiated by the Department of Health and Social Services in order to establish or revise drug reimbursement rates.
- Failing to submit business records or other information determined to be necessary for the administration of the Medical Assistance program.
  (Effective 8/18/79, Reg. 71. Amended 2/1/89, Reg. 109, and 6/14/89, Reg. 110. Authority: AS 47.05.010, AS 47.07.050)

Updated 08/03

Types of Sanctions

The following sanctions may be invoked against providers, based on the grounds specified above:

- Termination from participation in the Medical Assistance program.
- Suspension from participation in the Medical Assistance program.
- Suspension or withholding of payments to a provider.
- Referral to peer review such as a professional association.
- Transfer to a closed-end provider agreement not to exceed 12 months or the shortening of an already existing closed-end provider agreement.

- Attendance at provider education sessions.
- Prior authorization of services.
- 100 percent review of the provider's claims before payment.
- Referral to the state licensing board for investigation.
  (Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)
- Recovery of funds from the provider.

Updated 04/02

Imposition of Sanction

The decision as to the sanction to be imposed will be at the discretion of the Director of the Division of Health Care Services, except as follows:

> If a provider has been convicted of defrauding the Medical Assistance program, or has been previously suspended due to program abuse, or has been terminated from the Medicare program for abuse, the Division of Health Care Services will institute proceedings to terminate the provider from the Medical Assistance program.

The following factors will be considered in determining the sanction to be imposed:

- Seriousness of the offense.
- Extent of violations.
- History of prior violations.
- Prior imposition of sanctions.
- Prior provision of provider education.
- Provider's willingness to obey program rules.
- Sufficiency of a lesser sanction to remedy the problem.
- Actions taken or recommended by peer review groups or licensing boards.
  (Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)

Updated 08/03

Scope of Sanction

A sanction may be applied to all known affiliates of a provider; however, each decision to include an affiliate must be made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where the conduct was accomplished within the course of his or her official duty or was effectuated by him or her with the knowledge or approval of the provider.

Suspension or termination from participation of any provider will preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association, to the Division of Health Care Services or its fiscal agents for any services or supplies provided after the suspension or termination.

A clinic, group, corporation, or other association that is a provider of services may not submit payment claims to the Division or its fiscal agents for any services or supplies provided by a person within that organization who has been suspended or terminated from participation in the Medical Assistance program, except for those services or supplies provided before the suspension or termination.

When provisions of the preceding paragraph are violated by a provider of services which is a clinic, group, corporation, or other association, the Division may suspend or terminate the organization or any individual person within it who is responsible for the violation, or both. *(Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)*

Updated 08/03

Notice of Sanction

When the Division intends to impose sanctions on a provider, written notice to the provider must be sent by certified mail. If suspension, termination, or withholding of payment is proposed, the provider must be permitted an appeal. Absent a request for appeal, the proposed sanction will become effective 30 days from the date of the notice.

The notice shall set forth:

- The nature of the discrepancies or violations.
- The dollar value of the discrepancies or violations.
- The method of computing the dollar value.
- Notification of further actions to be taken or sanctions to be imposed by the Division.
- Notification of any actions required of the provider and his or her right to a formal hearing.

The notice shall state whether or not the Division intends to withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question, or that the Division intends to suspend all payments to the provider.

When sanctions have been imposed on a provider, the Division will notify, as appropriate, the provider's professional societies, the Division of Occupational Licensing of the Alaska Department of Community and Economic Development, and any other interested federal or state agency of the findings made and the sanctions imposed.

If a provider's participation in the Medical Assistance program has been suspended or terminated, the Division will notify the recipients for whom the provider has submitted claims for services that the provider has been suspended or terminated. *(Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)*

Updated 08/03

Appeal of Sanction

Within 30 days after receipt of the notice of sanction, the provider may request a formal hearing. The request for appeal must be in writing and must contain a statement accompanied by supporting documents setting forth the asserted violations, discrepancies, or dollar amounts that the provider contends comply with regulations and the reasons for those contentions. The request for appeal must be sent to:

Director, Health Care Services, Department of Health and Social Services
Claims Appeal Section
4501 Business Park Boulevard, Suite 24
Anchorage, AK 99503

Upon receipt of the request for appeal, the withholding or suspension of payment may continue until a final determination is made regarding the appropriateness of the sanction. Unless a timely and proper request for appeal is received by the Division, the findings of the notice of sanction are considered a final and binding administrative determination. No formal review will be granted if the basis for termination is a failure to meet standards (including licensure or registration) required by federal or state law for participation in the Medical Assistance program.

Upon receipt of the request for appeal, a hearing must be scheduled to be held within 30 days of receipt of the request. Notice of the date, time, and place of the hearing must be sent to the provider and his or her attorney or representative. Any party may appear and be heard at any proceeding through an attorney at law or a designated representative. The hearing will be conducted by the Director of the Division of Health Care Services or designee. The Director of the Division shall render a written decision that will constitute final administrative action. *(Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)*

Updated 08/03

Appendix D
Forms

This appendix includes the forms listed below.

Note: This appendix includes forms that may or may not be applicable for your provider type.

- Adjustment/Void Request (AK-05)
- Air Ambulance Flight Summary
- Certificate of Medical Necessity
- Certificate to Request Federal Funds for Abortion
- Charter Flight Attachment Sheet
- Claim Inquiry
- Electronic Claims Attachment Transmittal
- Forms Order Request
- Hysterectomy Consent
- Medicaid Naltrexone Prior Authorization Certification
- Optical Contractor Order Form
- Prior Authorization (AK-PA) Request
- Provider Appeals
- Sterilization Consent
- TPL Avoidance Request

Updated 01/06

CLAIM CONTROL NUMBER * FOR FHSC USE ONLY

ADJUSTMENT / VOID REQUEST FORM
ALASKA MEDICAL PAYMENT SYSTEM
(SEE BACK FOR INSTRUCTIONS)

MAIL TO: FIRST HEALTH SERVICES CORPORATION
P.O. BOX 240807
ANCHORAGE, ALASKA 99524-0807

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING: 1. COPY OF CLAIM. 2. COPY OF REMITTANCE ADVICE.

PART I PROVIDER INFORMATION

1. PROVIDER NAME AND ADDRESS

2. BILLING PROVIDER NUMBER

3. RENDERING PROVIDER NUMBER (IF DIFFERENT FROM #2)

4. OVERPAYMENT (REFUND CHECK ATTACHED)

CHECK NO.

PART II CLAIM INFORMATION

5. RECIPIENT NAME

6. RECIPIENT NUMBER

7A. CLAIM CONTROL NUMBER

7B. LINE NUMBER

7C. REASON FOR ADJ/VOID

7D. COMMENTS:

I REQUEST THAT REPROCESSING OF THE CLAIM BE MADE WITH THE INFORMATION GIVEN ABOVE. THIS IS TO CERTIFY THAT THE FOREGOING IS TRUE, ACCURATE, AND COMPLETE AND IS IN COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 WHICH PRECLUDES EXCLUSION OR DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, OR NATIONAL ORIGIN. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, - STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. TO THE BEST OF MY KNOWLEDGE, NO OTHER RESOURCE EXISTS.

8. SIGNATURE

DATE

PART III FISCAL AGENT USE ONLY

A/V

A/V RES. CO.

CO. CD.

CT

DT KY

ADJUSTED DATA

REMARKS

ORIGINAL COPY

AK - 05 (1/88)

Figure D-1: Adjustment/Void Request Form (AK-05)

ALASKA DIVISION

OF HEALTH CARE SERVICES

AIR AMBULANCE FLIGHT SUMMARY

Provider Name: _____ Patient Name: _____

Provider ID Number: _____ Patient ID Number: _____

Flight Date: _____ Aircraft Type: Rotary: ____

Fixed Wing: ____

Total Number of
Patients On Flight: _____

Number of Attendants: _____

Referring Physician: _____

Receiving Physician: _____

Transported From: _____

Transported To: _____

Patient Loaded Statute Miles: _____

Diagnosis: _____

Rationale: _____

Flight Expenses:

Lift-Off Fee: _____ Total Mileage Fee: _____ Total Charge: _____

Signature (required): _____
Medical Director/Referring or Receiving Physician/Air Ambulance Director

Prior Authorization #:_____

AK-AAv.1

First Health Services Corporation
Certificate of Medical Necessity Page 1 of 2

Submitted by:_____
Date:

Recipient Name: _____ Medicaid #: _____ Date of Birth: ___/___/___ Age:_____Sex: _____ (M or F)	Ordering Provider's Name: _____ Medicaid ID# or AK License #: _____ Telephone #: (____) _____-_____ Ext. _____
HT: _____ (inches) WT: _____ (lbs) Date of last visit: _____	Retrospective Review? _____ (Y/N)

SECTION A: CLINICAL INFORMATION

*(THIS SECTION **MUST** BE COMPLETED BY THE ATTENDING PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, OR AUDIOLOGIST.)*

DIAGNOSIS	ICD-9-CM

Est. Length of Need (# of Months): _____1 – 99 *(99 = Lifetime)*

SECTION B:

CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICES OR ITEM(S) AND PLAN: Record information indicating the medical necessity of the requested services or items. Attach any additional information pertinent to the necessity of the requested equipment. *(THIS SECTION MAY BE COMPLETED BY THE ATTENDING SPECIALIST, INCLUDING THE PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH LANGUAGE PATHOLOGY THERAPIST, REGISTERED DIETITIAN, AUDIOLOGIST, OR OTHER ATTENDING SPECIALIST WITHIN THE SCOPE OF HIS OR HER SPECIALTY.)*

PLAN: *The plan should list each service or item specifically needed for the treatment of the recipient. Additional information may be attached to this form.*

AUDIOLOGIST/PHYSICIAN/NURSE PRACTITIONER/PHYSICIAN ASSISTANT AND SPECIALIST ATTESTATION, SIGNATURE AND DATE (NOTE: *Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)

A physician, nurse practitioner, physician assistant, audiologist, or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.

_____ _____
Signature of Specialist – Title Date
This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.

_____ _____
Signature of Audiologist / Physician / Nurse Practitioner / Physician Assistant Date
I hereby certify that I am the ordering audiologist/physician/nurse practitioner/physician assistant identified in this form.

Revised 2/3/06

Figure D-2: Certificate of Medical Necessity Form - Page 1

First Health Services Corporation
Certificate of Medical Necessity Page 2 of 2

Submitted by:_____
Date:

Recipient Name: _____

Medicaid #: _____

Date of Birth: ___/___/___ Age:_____Sex: ____ (M or F)

Ordering Provider's Name: _____

Medicaid ID# or AK License #: _____

Telephone #: (____) _____-_____ Ext. _____

SECTION C: REQUESTED SERVICES OR ITEMS –
(To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)

Provider Name: _____

Address: _____

Provider Medicaid No.: _____

Requester Name: _____

Telephone #: (_____) _____ Ext. _____

Fax #: (_____) _____ Ext. _____

Dates of Need-Start Date: **End Date:**

First Health Services Corp – Use Only

Your request is:

☐ Approved as Requested

☐ Approved as modified
(Items marked as authorized may be claimed)

Prior Authorization Number:

From Date: Thru Date:

☐ Denied

Authorizing Agent Signature & Date:

Comments:

	Procedure Code	Mod.	Description	QTY (#)	Charges	Authorized Yes	Authorized No	Approved Qty	Approved Amount
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									

SECTION D: SUPPLIER ATTESTATION, SIGNATURE AND DATE

I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering audiologist/physician/nurse practitioner/physician assistant specified in this form, and that these exact services or items listed in this form will be supplied to the specified recipient. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

_____ _____
Signature of Supplier Date

Revised 2/3/06

Figure D-3: Certificate of Medical Necessity Form - Page 2

CERTIFICATE TO REQUEST FEDERAL (MEDICAID) FUNDS FOR ABORTION

Effective November 13, 1997, Congress passed another revision of the Hyde Amendment pertaining to federally funded Medicaid abortions. The provision states that federal funds are available for an abortion only "(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."

_____ _____

(Recipient's Full Name) *(Recipient's Medicaid Identification Number)*

had an abortion procedure performed on _____/_____/_____ .
(Mo. / Day /Year)

Indicate the circumstance that applies below:

☐ I certify that prior to performing the abortion procedure on the above patient to terminate her pregnancy, I obtained a non-notarized signed statement from the patient that her pregnancy was the result of an act of ☐ rape or ☐ incest. That statement is now part of the patient's medical record.

☐ I certify that in my professional judgement, the abortion procedure on the above patient was performed due to physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed, based on full consideration of all factors as described in the attached operative report.

_____ M.D.
D.O._____/_____/_____

(Signature of Recipient's Attending Physician) *(Month / Day / Year)*
(Date of Physician's Signature)

This certificate to request federal (Medicaid) funds for an abortion must be personally signed and dated by the recipient's attending physician. A facsimile signature or signature of the physician's authorized representative is not acceptable. Each provider submitting a claim for abortion services (e.g., physician, inpatient hospital, outpatient hospital) must attach a completed certificate bearing an original signature of the recipient's attending physician. The signature requirement will not be waived for resubmission.

Rev. 10/98

Figure D-4: Certificate to Request Federal (Medicaid) Funds for Abortion

ALASKA DIVISION

OF HEALTH CARE SERVICES

CHARTER FLIGHT ATTACHMENT SHEET

Provider Name: _____ Patient Name: _____

Provider ID Number: _____ Patient ID Number: _____

Flight Date: _____ Aircraft Type: _____

Passenger Loaded Statute Miles: _____

Total number of Passengers: _____

Origin of Flight: _____

Destination of Flight: _____

Total Cost for Charter Flight: _____

Cost per Passenger: _____ (Total Cost/Total # of Passengers)

Prior Authorization #: _____

AK-CFv.1

INQUIRY CONTROL NUMBER * FOR FHSC USE ONLY

MAIL TO: FIRST HEALTH SERVICES CORPORATION
P.O. BOX 240808
ANCHORAGE, AK 99524-0808

CLAIM INQUIRY FORM

(SEE REVERSE SIDE FOR INSTRUCTIONS)

ALASKA MEDICAL PAYMENT SYSTEM

(PLEASE ATTACH A COPY[IES] OF CLAIM FORM[S])

1. PROVIDER NAME, ADDRESS, TELEPHONE#:

2A. HCP BILLING NUMBER

2B. HCP RENDERING NUMBER

3. CONTACT?

4. WHAT IS THE NATURE OF YOUR INQUIRY? PLEASE PUT AN "X" ON THE APPROPRIATE LINE.

_____ NEED TO KNOW STATUS OF CLAIM

_____ WANT EXPLANATION OF A DENIED CLAIM

_____ OTHER (PLEASE EXPLAIN)

AUTHORIZED SIGNATURE

DATE

AK-11 (1/88)

ORIGINAL

Figure D-5: Claim Inquiry Form (AK-11)

ATTACHMENT FAX COVER SHEET
P.O. Box 240808 • ANCHORAGE, ALASKA 99524-0808
TELEPHONE: (907) 644-6800 or 1-800-770-5650
FAX (907) 644-8122/(907) 644-8123

To: _____ Date: _____

From: _____ Fax#: _____

Number of Pages: _____ Time: _____

Submitter Number: _____ MCN #: _____

Submission Date: _____ Provider #: _____

Indicate the Transaction Type:

☐ 837P(rofessional) ☐ 837I(nstitutional) ☐ 837D(ental)

☐ Transportation/Accommodation or Other Non-covered Entity
(Include the recipient ID number on each page faxed)

Unique Attachment Control Number(s):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Include the appropriate Attachment Control Number on each faxed page.

CONFIDENTIALITY NOTICE

This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution of this communication is expressly prohibited. If you are not the intended recipient, please notify the sender at the sender's fax number above and destroy any and all copies of the original message. Thank you.

Rev. 1/13/06

Figure D-6: Electronic Claims Attachment Transmittal

HEALTH CARE FORMS ORDER REQUEST

Please order a 2-month supply.

Mail to: **First Health** Services Corporation
P.O. Box 240808
Anchorage, AK 99524-0808

Allow approximately 4 weeks for delivery.

You must include your health care provider number (HCP #); for example, "MD0000", "HS00IP", "PH0000", etc.

Ship to: _____

_____

_____

Attention: _____

Phone Number: _____

HCP #: _____

Form Requested		Quantity				
Number	Description	25	50	100	300	Other
AK-01	UB-92 Claim Form					
AK-04	Transportation/Accommodation					
AK-05	Adjustment/Void					
AK-07	Dental					
AK-10	Child Health Screening					
AK-11	Claim Inquiry					
AK-PA	Prior Authorization					
AK-LTC-1	LTC Authorization					
CMS-1500	Health Insurance Claim Form					
Provider Billing Manual	Title of Manual or Provider Type (see reverse):					

_____ _____

Signature of Provider or Authorized Person *Date of Request*

For First Health Use Only

Comments: _____

Date Shipped: _____ Shipped By: _____

Rev. 2/04

Figure D-7: Forms Order Request (front)

PROVIDER BILLING MANUAL REQUESTS

Req. Date	Manual	Amount
	Advanced Nurse Practitioner/Nurse Midwife	
	Ambulatory Surgical Care Facility	
	Chiropractic	
	Dental	
	Direct Entry Midwife	
	Durable Medical Equipment, Medical Supplies, Respiratory Therapy Assessment Visits, Prosthetics, Orthotics, and Home Infusion Therapy	
	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	
	Family Planning Clinic	
	Federally Qualified Health Center (FQHC)/Rural Health Clinic Services	
	Hearing	
	Home & Community Based (HCB) Waiver Services: ☐ Care Coordination ☐ Environmental Modifications ☐ HCB Agency ☐ Residential Supported Living	
	Home Health	
	Hospice Care	
	Hospital: ☐ End Stage Renal Disease ☐ Inpatient/Outpatient ☐ Inpatient Psychiatric Services (Acute Care and Residential Psychiatric Treatment Center)	
	Indian Health Services (IHS) & Tribal Facility Services	
	Laboratory Services, Independent	
	Long Term Care Facility	
	Behavioral Health: ☐ Behavioral Health (Community Mental Health Clinics & Substance Abuse) ☐ Day Treatment Facility ☐ Mental Health Physician Clinic	
	Nutrition	
	Outpatient Therapy Center, Independent Physical Therapist, Certified Speech Pathologist, and Independent Occupational Therapist	
	Consumer Direct Personal Care Agency	
	Personal Care Agency	
	Pharmacy	
	Physician	
	Podiatry	
	Private Duty Nursing	
	School-based Services	
	Transportation & Accommodation	
	Vision	
	X-Ray	

(Rev. 01/06)

Figure D-8: Forms Order Request (back)

PART I

This hysterectomy (is not being) (was not) performed solely for the purpose of rendering _____ permanently incapable of reproducing, and
(patient's name)
this hysterectomy (would be) (would have been) performed even without the purpose of rendering _____ permanently incapable of reproducing
(patient's name)
because of: _____.

_____
Physician's Signature

_____
Date

A hysterectomy consent form was not obtained because:

1. The patient _____ was sterile before this procedure because of:
(patient's name)

_____.

2. It was a life-threatening emergency and prior acknowledgement could not be obtained.

The emergency was: _____.

_____
Physician's Signature

_____
Date

PART II

I told _____ and her representative _____ both
(patient's name) (if one is present)
orally and in writing, that a hysterectomy will render her permanently incapable of reproducing.

Signature: _____
Person Obtaining Surgical Consent

_____
Date

PART III

I have received and understood both oral and written information explaining that a woman undergoing a hysterectomy will be permanently incapable of having children after the operation.
I was informed of this before my surgery was performed.

Signature: _____
Patient

_____
Date

Figure D-9: Hysterectomy Consent Form

DIVISION OF BEHAVIORAL HEALTH (DBH)
MEDICAID NALTREXONE PRIOR-AUTHORIZATION

AGENCY SECTION (TO BE COMPLETED BY THE COUNSELOR)	
SUBSTANCE ABUSE COUNSELOR (PRINT NAME AND SIGN):	CERTIFICATION NUMBER AND EXP. DATE

The certified treatment counselor listed above certifies that the patient listed below is 18 years of age or older, is alcohol or opiate dependent, with alcohol or opiate dependence as the primary addiction; has been admitted to and is currently in a Substance Abuse treatment program, funded and approved by the Division of Behavioral Health; and that Substance Abuse treatment is scheduled to be provided for a maximum of sixteen (16) weeks.

PATIENT SECTION (TO BE COMPLETED BY THE PATIENT)

PATIENT NAME	PATIENT MEDICAID ID#	ADMISSION DATE	DEPENDENCY ☐ALCOHOL ☐OPIATE

PATIENT AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION (TO BE COMPLETED BY PATIENT)

I, _____, authorize the certified substance abuse counselor indicated above to disclose patient identifying information, my status as a patient and their treatment recommendation to my physician and the pharmacy indicated below for the purpose of acquiring a prescription for naltrexone.

Physician: _____

Pharmacy: _____

I understand that my records are protected under Federal Confidentiality Regulations (42 CFR, Part 2) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent shall expire 90 days from the date signed. I further acknowledge that the information to be released was fully explained to me and that this consent is given of my own free will.

PATIENT'S SIGNATURE:_____ **DATE:** _____

PHARMACY SECTION (TO BE COMPLETED BY THE PHARMACY)

I have received a prescription for naltrexone for the patient named above from the patient's prescriber and have filled the prescription as authorized. I understand that reimbursement from Alaska Medical Assistance for naltrexone shall only be made under the following condition:

1. The recipient is Medicaid eligible,
2. The medication is provided as part of a comprehensive treatment program as verified by the certified Substance Abuse Counselor above,
3. Payment for the medication is limited to 16 weeks of continuous use. The medication is limited to a 30 day supply on each fill, not to exceed four fills,
4. The pharmacy shall include the prescribing physician's Medicaid Prescriber ID Number on the Medicaid claim,
5. The pharmacy must obtain prior-authorization from the First Health Pro-DUR Help Desk prior to each fill,
6. Record of the certification shall be kept on file at the pharmacy for Medicaid audit purposes. Prescriptions reimbursed by Alaska Medical Assistance for naltrexone without this certification record on file will be considered overpayment.

PHARMACIST'S SIGNATURE: _____ **DATE:** _____

Figure D-10: Medicaid Naltrexone Prior Authorization Certification Form

Rochester Optical
1260 Lyell Avenue
Rochester, New York 14606

Phone (585) 254-0029 Fax (585) 254-0132 www.rochesteroptical.com

Alaska Medicaid Program

Recipient Name ***(please print)*** Last First MI

Address Street City State Zip

Recipient I.D. Number | Date of Birth MM DD YY | Sex | Date of Order MM DD YY

Provider Name | Provider I.D. No.

Material	Exception	Special Instructions
☐ Glass ☐ Plastic ☐ Antiscratch ☐ Polycarb	☐ EPSDT ☐ Other Prior Authorization No.	

	SPHERE	CYLINDER	AXIS	PRISM In	PRISM Out	PRISM Up	PRISM Down	MULTIFOCAL TYPE
R								
L								

	ADD	SEG HGT	LAB	DIST	PD	NEAR	LAB	TINT
R								
L								

Frame: Manufacturer | Name | 1st Choice | Color | 2nd Choice

Eye Size | Bridge Size | Temple | Lab | B. | ED.

FTC | Supply | Enclosed

Chem Temp | Heat Temp | Date Rec'd | Date Comp.

Cat	Code	Cost	Ship To:
RL			
LL			
PR			
Metal			
ZYL			
Misc. #1			
Misc. #2			
NP A			
NP FF			

Notice: Edged or edged and mounted lenses are treated for impact resistance to meet FDA requirements.
Retain **Yellow** copy for your records

Figure D-11: Optical Contractor Order Form

AFFIX LABEL HERE

AFFIX LABEL HERE

CONTROL NUMBER * FOR FHSC USE ONLY

First Health
Services Corporation

STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DO NOT USE THIS FORM TO REQUEST LONG TERM CARE PLACEMENT

PRIOR AUTHORIZATION REQUEST

SEQUENCE NUMBER
P 33026

(PLEASE TYPE) FOR HEALTH CARE PROFESSIONAL (HCP) USE

1. HCP PHONE NO. ( )
2. HCP IDENTIFICATION NO.
3. REQUEST IS RETROACTIVE? ☐ YES ☐ NO

4. HCP NAME AND ADDRESS

PLEASE TYPE YOUR NAME AND ADDRESS HERE

5. RECIPIENT NAME (LAST, FIRST, MI)
6. RECIPIENT ID NO.
7. STREET ADDRESS
8. SEX
9. DATE OF BIRTH
10. AGE
11. CITY, STATE, ZIP CODE
12. PHONE NUMBER ( )
13. DIAGNOSIS AND MEDICAL JUSTIFICATION:
14. PRIMARY ICD-9-CM DIAGNOSIS CODE

FOR FHSC USE

20. HCP: YOUR REQUEST IS:
☐ APPROVED AS REQUESTED
☐ APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)

PRIOR AUTHORIZATION NUMBER
FROM DATE MM/DD/YY TO DATE MM/DD/YY
AUTHORIZATION IS VALID FOR SERVICES PROVIDED

☐ DENIED

BY AUTHORIZING AGENT

21. AGENT NUMBER
22. DATE MM/DD/YY
23. COMMENTS / EXPLANATION

	15. PROCEDURE/ DRUG CODE	M O D.	16. SPECIFIC SERVICES REQUESTED	17. REQUESTED UNIT/QTY	18. CHARGES	AUTHORIZED 24. YES	AUTHORIZED 25. NO	26. APPROVED UNIT / QTY	27. APPROVED AMOUNT
1									
2									
3									
4									
5									
6									

19. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR HEALTH CARE PROFESSIONAL _____ TITLE _____ DATE _____

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY.
BE SURE THE IDENTIFICATION CARD IS CURRENT BEFORE RENDERING SERVICE.
SEND WITH PART TWO

FORWARD THIS FORM TO: FIRST HEALTH, P.O BOX 240808, ANCHORAGE, ALASKA 99524-0808
ORIGINAL COPY

AK-PA (05/04)

Figure D-12: Prior Authorization Request (AK-PA)

P.O. Box 240808
Anchorage, AK 99524
(907) 644-6800
https://alaska.fhsc.com/

First Health Services Corporation
A Coventry Health Care Company

Provider Appeals Form

Pre-Appeal ☐ First Level Appeal ☐

Provider Information

Provider Name: _____

Provider ID No.: _____

Contact Name: _____

Contact Telephone No.: _____

Recipient Information

Recipient Name: _____

Recipient ID No.: _____

Date of Service Related to this Appeal: _____

Service(s) or Procedure(s) Related to this Appeal: _____

_____

Reason for Request (i.e., medical justification, timely filing, etc.)

_____

_____

_____

_____

_____

_____

_____

Figure D-13: Provider Appeals Form

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____ . When I first asked for
(doctor or clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide to not be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____ . The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
Month Day Year

I, _____ , hereby consent of my own free will to be sterilized by _____
(doctor)
by a method called _____ . My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human services or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ Date _____
Signature *Month Day Year*

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- ☐ American Indian or Alaska Native
- ☐ Asian or Pacific Island
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
Interpreter (Signature) *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the
name of individual
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

_____
Signature of person obtaining consent *Date*

_____
Facility

_____
Address

■ PHYSICIAN'S STATEMENT ■
(TO BE COMPLETED FOLLOWING SURGERY)

Shortly before I performed a sterilization operation upon _____ on _____
Name of individual to be sterilized *Date of sterilization*
_____ I explained to him/her the nature of the
operation
sterilization operation _____, the fact that
specify type of operation
it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____ *(Date)*
- ☐ Emergency abdominal surgery:
  (describe circumstances): _____

_____ _____
(Signature) *Physician*
Date _____

ALL APPLICABLE BLANKS MUST BE COMPLETED.
STAMPED SIGNATURES ARE NOT ACCEPTABLE.

Figure D-14: Sterilization Consent Form

ALASKA MEDICAID
TPL-AVOIDANCE REQUEST

Complete sections 1 and 2 - please print

Section 1.	**Provider Information**		
Today's Date:	Medicaid Provider Number:	Phone Number:	Fax Number:
Medicaid Provider Name:		Contact Name:	

Section 2.	**TPL-Avoidance Request Information**	
Recipient's Name:	Medicaid ID Number:	Resource Code*:

Do you have an attachment from the insurance company stating that this policy has terminated?: ☐ **- Yes** ☐ **- No**
If yes, please fax the attachment with this request.

↓ ***Please complete only fields that apply to this request*** ↓

Procedure Code(s):	Diagnostic Code(s):	Revenue Code(s):

LIFETIME
maximum exhausted? **Date Exhausted**: / /

YEARLY
maximum exhausted? **Date Exhausted**: / / **Date Renews**: / /

Additional/other related information to be considered for this TPL Avoidance request:

Please fax completed request with valid documentation to:

First Health Claims Operations
Fax: (907) 644-8122

Section 3. (Medicaid Use Only)	**Medicaid Determination**		
Request approved as follows: ☐	**Request Denied:** ☐ (see Comments)		
Recipient's Name:	Medicaid ID Number:	Resource Code:	
Medicaid Provider ID Number:	Type of Service:	Revenue Code:	Other (explain):

Start Date: / / (No end date for **LIFETIME** benefit maximum)

Start Date: / / End Date: / / (**YEARLY** benefit maximum)

Procedure Code(s):	Diagnosis Code(s):	Revenue Code(s):

Comments:

* The Resource Code identifies the insurance resource for which you are requesting TPL-Avoidance. You can find the code on the Medicaid coupon, DKC Card, or by calling the EVS system. If a recipient has more than one insurance, you may request TPL Avoidance for only ONE per form.

NOTE: Claims that are approved for TPL Avoidance will appear with one of the following messages on the Adjudicated Claims page of your Remittance Advice.
404 (TPL Avoidance Match – TPL Resource)
405 (TPL Avoidance Match – Medicare Resource)

07/04

Figure D-15: TPL Avoidance Request Form

Appendix E
Transportation and Accommodation Resource Materials

This appendix includes the following reference materials:

- Air Ambulance Services
- Air Charter Services
- Medical Escorts
- Travel for Recipients Residing in Residential Psychiatric Treatment Centers (RPTCs)
- Taxi Services
- Travel for Eligible Recipients Needing Substance Abuse Treatment Services

Updated 05/05

ALASKA DIVISION

OF HEALTH CARE SERVICES

Air Ambulance Services

- Services will be covered only to the nearest available medical facility that can provide the necessary medical service. The Division of Health Care Services (DHCS) will not cover any additional mileage.
- DHCS will adhere to the industry standard of paying only patient-loaded statute miles.
- DHCS will pay for medevac services to a *higher* level of care. In the case of patients who are unable to travel via commercial airline and are being transferred to a lower level of care, DHCS will reimburse for *the lift-off fee only* at the point of patient pick-up.
- The point of patient pick-up will determine whether the air ambulance is reimbursed at urban or rural rates. If the origin of the transport is Anchorage or out of state, the fee will be based on urban rates. If the point of origin is anywhere in Alaska other than Anchorage, then reimbursement will be at the rural rate.
- All medevacs require a physician's statement/certification of medical necessity to transfer/transport the patient.
- Payment for mileage will be based on the industry standard of payment based on the total miles from point of patient pick-up to city of destination.
- If an air ambulance is en route to pick up a patient and the patient dies before the air ambulance arrives, DHCS will reimburse for the lift-off fee only.
- Medical escorts are not authorized for air ambulance flights.

ALASKA DIVISION

OF HEALTH CARE SERVICES

Air Charter Services

- All charter flights require prior authorization.
- Charter flights will be reimbursed at billed charges, up to the current medevac rate. Reimbursement for medevac services is the highest level of allowable reimbursement for any medical transportation.
- The cost of a charter flight is to be divided among the number of individuals in the plane. For example, if there are 3 people on the plane and only two are authorized by the Division of Health Care Services (DHCS) for travel, then the cost of the charter would be divided by three(3). DHCS would then be billed one-third of the total cost *for each* authorized individual. In this example, DHCS would be billed for two-thirds of the cost for the flight.
- The Charter Flight Attachment Sheet form must be submitted with all air charter claims.

ALASKA DIVISION

OF HEALTH CARE SERVICES

Medical Escorts

What is a Medical Escort?

A medical escort is defined by regulation 7AAC 43.530 (3) as a person who accompanies a recipient to or from a source of medical care.

When is a Medical Escort Needed?

An escort may be necessary to accompany a Medicaid recipient for reasons of medical necessity, age or physical or mental impairment. An escort may be medically trained, but medical training is not required. The Alaska Medical Assistance does not compensate an escort.

When is a Medical Escort Authorized?

A medical escort is authorized for travel, lodging and meals during the time medical evaluation and treatment are being provided.

A medical escort is authorized for the following recipients:

- All Medicaid eligible children under the age of 18
- Medicaid eligible recipients over 18 if the referring or treating physician indicates that an escort is medically necessary.

Medical necessity includes, but is not limited to, individuals who are:

- Elderly and feeble
- Developmentally disabled
- Confined to a wheelchair
- Suffering from uncontrollable seizures
- Physically handicapped
- Blind

When is a Medical Escort Not Authorized?

1) A medical escort is not authorized for the purpose of language interpretation. Under the provisions of the Americans with Disabilities Act (ADA), medical providers must assure adequate capabilities for communications with all patients.

2) A medical escort is not authorized on air ambulance flights. Medical personnel caring for the patient are included in the flight charges. In many instances, the air ambulance is able to accommodate a parent or spouse to travel with the recipient. The Division or its fiscal agent will review requests for escort services in these cases on an individual basis.

3) The Division does not pay for services incurred after the date of death. If a recipient dies while receiving medical treatment, Medicaid will cover the cost of an escort's return trip *if* the travel was originally approved. It is the responsibility of the escort to make arrangements with the airline to change the return date of travel. Transportation expenses of the deceased recipient are a mortuary expenditure that is not covered by Medicaid.

Are There Any Exceptions to the Medical Escort Guidelines?

The following are examples of exceptions to the medical escort guidelines outlined above.

1) Minor children who are parents may escort their child(ren) without an additional escort. Note: These same minors may travel without an escort for their own medical appointments.

2) An adult female may escort a pregnant minor who is traveling to a Prematernal home to await delivery. The Alaska Medical Assistance will pay a reduced fee to the Prematernal home to cover expenses incurred by the escort.

3) Occasionally a recipient may need more than one escort. All requests for an additional escort need to be submitted to FHSC in writing by the treating or referring physician with the attached ***medical justification*** for this additional service.

4) When a family has more than one child travelling to medical appointments, in most cases only one escort is authorized. If there is more than one child under the age of 2 years, or other unusual circumstances, a second escort may be authorized if justified.

Is a Medical Escort Covered for Outpatient and Inpatient Care?

Outpatient Care

Patients and escorts are authorized for lodging and meals during the course of all outpatient treatments requiring an overnight stay. Meals and lodging are not authorized for travel that is completed in the same day.

Inpatient Care

Meals and lodging are not routinely authorized for a medical escort when the Medicaid recipient is hospitalized, but they may be authorized when:

- It is cost effective to do so. For example, it may be less expensive to pay for meals and lodging than to pay for round trip airfare again at a later date.
- The patient is a child.

Coverage for meals and lodging during inpatient care is available when the provider submits information to First Health Services Corporation showing that the authorization is cost effective and reasonable for the welfare of the recipient.

What is Meant by Meals and Lodging?

A unit of lodging is equal to one night's stay. A unit of meals is equal to 3 meals with a maximum of $36.00 authorized per person per unit of lodging (one overnight). For example, if a Medicaid recipient arrives in the evening, then the recipient's dinner, breakfast and lunch would be covered under 1 unit of meals. Meals and lodging are not authorized for children 2 years of age and under.

When a Medicaid recipient travels with an escort, it is expected that the recipient and escort will share a hotel room. Separate rooms are not routinely authorized for escorts. The escort should be appropriate to share accommodations with the recipient. Alaska Medical Assistance will review requests for separate rooms when there are unusual circumstances.

Out-of-State Travel Requirements

Sometimes a Medicaid recipient will need medical services that are not available in Alaska. In that case, the recipient's medical provider must make a request to First Health Services Corporation for out-of-state travel authorization. The medical provider should request prior authorization for a diagnosis or procedure before requesting authorization for out-of-state services.

A request for out-of-state services requires a medical provider referral and medical justification. The provider must state that the covered services are not available in Alaska. Examples of such services include appointments with specialists, evaluations, consultations, surgical procedures, and transplants.

Services for follow-up care or complications resulting from medical interventions initiated out of state should be provided in Alaska whenever possible.

Out-of-state services will be authorized to the nearest medical facility or provider.

If out-of-state medical services are required and authorized, appointments should be scheduled so as to minimize the time spent out of state. Travel will be authorized for the day before scheduled services if airline travel does not permit arrival on the date of the recipient's appointment. The cost for any travel scheduled before or after medical appointments is at the recipient's expense.

Travel extending over a weekend will only be authorized for confirmed medical necessity as specified by the medical provider of record.

When minors travel out of state for services, medical escorts must be the minor's legal parent or guardian.

ALASKA DIVISION

OF HEALTH CARE SERVICES

Travel for Recipients Residing in Residential Psychiatric Treatment Centers (RPTCs)

The following policies apply to all travel services provided to Alaska Medical Assistance recipients receiving RPTC services:

- All medically necessary non-emergency travel must be prior authorized and booked through the State Travel Office at 1-800-514-7123.
- Travel will be authorized for one parent, legal guardian, or designee for the purposes of providing an escort when traveling to or from an RPTC. A second escort can be authorized when medically necessary.
- In order to receive prior authorization for travel to attend family therapy sessions, the RPTC must provide a Plan of Care that documents treatment objectives, appropriate therapies, activities, and experiences designed to develop the recipient's ability to function independently in the recipient's environment. The plan, which will be reviewed by First Health, must indicate why family therapy cannot be performed over the telephone.
- The frequency of covered travel for the parent, guardian, or designee for family therapy will be based on medical necessity as documented in the Plan of Care.

ALASKA DIVISION

OF HEALTH CARE SERVICES

Taxi Services

- Taxi providers must meet all of their local licensing requirements.
- Only medical taxi transport is authorized. Taxi providers are not reimbursed for personal recipient travel.
- Driver tips are not an authorized medical expense. Tips must be paid by the recipient.
- Taxi providers should document the recipient's pick-up and destination points on the AK-04 billing form.
- Taxi drivers will not be reimbursed for time spent waiting for the recipient.

ALASKA DIVISION

OF HEALTH CARE SERVICES

Travel for Eligible Recipients Needing Substance Abuse Treatment Services

- All medically necessary non-emergency travel must be approved in advance and booked through the State Travel Office at 1-800-514-7123**.**
- Transportation is reimbursable if treatment is received at a substance abuse treatment facility that is enrolled as a Medicaid provider.
- The Division of Behavioral Health approves the travel if the referring agency has documented that the necessary services are not available in the recipient's home community.
- The referring agency calls First Health Services Corporation to complete the Medical Assistance Transportation Authorization & Invoice Form (AK-04). *See Section I of the Transportation and Accommodation Provider Billing Manual.*
- If a child is accompanying a mother needing treatment, the Medical Assistance Program will pay for the mother's transportation only. The child's travel costs must be paid from other sources, such as the Division of Behavioral Health (DBH) Travel Fund.
- The initial travel approval is for one-way travel only. The receiving agency calls FHSC to request authorization for the patient to return home. *DBH approval for the patient to return home is not required.*
- If the recipient does not travel, it is the responsibility of the referring counselor to notify FHSC.