

Attention: Crosswalk Developed for Alaska State Unique Codes

Effective beginning with January 1, 2004 dates of service, the state unique/local codes used by Alaska Medical Assistance will change. In addition, the prior authorization form will also be changed. The enclosed information will help you transition to the new codes and form.

In this packet...

The enclosed packet contains the following information:

- A crosswalk comparing the old state unique/local codes and the new national codes
Important: The “old” codes can only be used for services provided on or before December 31, 2003. Use the “new” codes for services provided on or after January 1, 2004.
- A list of Questions and Answers to be referenced when filing your claims to Alaska Medical Assistance
- A new prior authorization request form containing the new national codes
Important: The “new” prior authorization request form can only be used to request prior authorization for services provided on or after January 1, 2004.

If you have any questions...

If you have any questions, please contact FHSC’s Provider Inquiry Unit at (907) 561-5650 or 1-800-770-5650 (toll-free in Alaska) and choose option #82.

Day Treatment Services Crosswalk

Current Codes through 12/31/03 dates of service	Description	Max Allowable	Approved New Code for dates of service on or after 1/1/04	Max Allowable	Description
1002F	Children's Day Treatment Services, Full Day, Minimum of Six Hour per Day	\$150.00 per Day (1 Unit = 1 Day)	H2012 (1 Unit = 1 hour)	\$25.00 per hour	Behavioral Health Day Treatment, per hour
1022F	Children's Day Treatment Services, Half Day, Minimum of Three Hour per Day	\$100.00 per Half-day (1 Unit = 1 Half-day)	H2012 (1 Unit = 1 hour)	\$25.00 per hour	Behavioral Health Day Treatment, per hour

Note: There is NO per diem code for dates of service on or after 1/1/04.

For calendar year 2004, the procedure code H2012 requires prior authorization for all services on or after 1/1/04.

Questions and Answers for Day Treatment Facility Providers

First Health Services, in conjunction with the Department of Health and Social Services, has developed these Questions and Answers to assist you in filing your claims with Alaska Medical Assistance. More specifically, this information may be useful to providers as they transition from the use of current local/state unique procedure codes to national codes as required by HIPAA.

Question: What is a “crosswalk” and how is it used?

Answer: A “crosswalk” is a table or matrix that correlates the current local/state unique procedure code and service description with the replacement national code and service description. Providers may bill using state unique codes only through dates of service 12-31-2003 and will be required to use the replacement national codes for all dates of service on or after 1-1-2004.

Question: Which national code sources were used to choose the replacement codes for local/state unique codes that are reflected in the crosswalks?

Answer: To the extent possible, replacement codes were chosen from comparable services included within two national coding systems: the American Medical Association’s CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes. In the absence of comparable CPT or HCPCS codes, a third national code source, developed by Alternative Link and referred to as ABC (Alternative Billing Concepts) codes, was utilized.

Question: Have the time increments associated with the services changed?

Answer: Yes, the time increment for the national replacement code is different. The new code, H2012, is an hourly code, so 1 unit equates to 1 hour of day treatment services. There is no longer a half-day or full-day code. The reimbursement rate for H2012 is \$25.00 per hour. Ensure that you billed the correct number of units to identify the quantity of services actually rendered.

Question: Have the service limitation and prior authorization requirements changed?

Answer: The Alaska Medical Assistance regulations specify the limitations and have **not** changed. However, the Division of Behavioral Health has decided that all day treatment services will require prior authorization for calendar year 2004 until the enhancements to the Medical Assistance payment system can be completed to accommodate the service limits for the new day treatment procedure code. It is anticipated that the service limit programming can be accomplished for calendar year 2005.

Please remember, both the new 2004 Prior Authorization request form and any claims billed for services rendered in 2004 should reflect **hours per day** in the number of units rather than full-day or half-day services.

**DAY TREATMENT SERVICES
PRIOR AUTHORIZATION REQUEST**
(See instructions on the reverse side)

1. Request Date _____

2. Contact Name and Address (decision will be returned to this address)

Additional Contact Information

3. Phone No. _____

4. Fax No. _____

5. E-Mail Address _____

6. Provider Name _____

7. Provider ID No. _____

8. Recipient Name _____

9. Recipient ID No. _____

10. Date of Birth _____

11. (Use only if new request): A. **Initial Request** B. Request Dates: From: _____ Thru: _____

C. PA No. _____ (For FHSC use only)

12. (Use only if an update to an existing PA): A. **Update** B. Update: From: _____ Thru: _____

C. PA No. _____ (Required for PA updates only)

Day Treatment Services - SED Child Only

	<u>Unit</u>	<u>Code</u>	<u>13. Units Requested</u>
Behavioral Health Day Treatment, per hour	1 hour	H2012	_____

By submission of this form the provider:

- affirms the assessment of the recipient's symptomatology and current level of functioning is documented in the recipient's record and indicates the units and duration of Day Treatment Services requested are medically necessary;
- affirms the recipient is a severely emotionally disturbed child at risk for out-of-home placement, and recipient's record includes documentation that the interdisciplinary team establishing the treatment plan has recommended the requested Day Treatment Services as medically necessary; and
- acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules. The Department of Health and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules.

14. Signature _____

Title _____

Day Treatment Prior Authorization Request Instructions

Submission Requirements: This prior authorization (PA) form must be completed to indicate the amount of Day Treatment services requested beyond the service limitation set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting clinic. **Submit all other requests directly to FHSC.**

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Contact Name and Address:** Enter the name and address of the person FHSC should contact regarding the authorization request. The authorization will be returned to the address entered here.
3. **Phone No.:** Enter the contact person's telephone number.
4. **Fax No.:** Enter the contact person's fax number, if applicable.
5. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
6. **Provider Name:** Enter the name of the enrolled Day Treatment Services provider.
7. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the Day Treatment Services provider for Day Treatment Services. If a clinic has multiple identification numbers, separate authorizations must be requested for each provider identification number (i.e., all other rehabilitation service requests must be submitted on the Community Mental Health Clinic PA form).
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
10. **Date of Birth:** Enter the recipient's date of birth.
11. **A. Initial Request**—Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual.
B. Request Dates—Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
C. PA No.—Leave this field blank. FHSC will enter the prior authorization number here.
12. **A. Update**—Mark this box when
 - a) Requesting an update to add additional units of service to the existing PA record referred to in Field 12C
 - b) Extending the “thru” date of the authorization period for the existing PA record referred to in Field 12C.**B. Update**—Enter the “from” and “thru” dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
C. PA Number—Enter the number of the PA being updated.
13. **Units Requested:** Enter the number of **additional units** of Day Treatment Services being requested.
14. **Signature:** The signature must be by a person authorized to bind the clinic to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.