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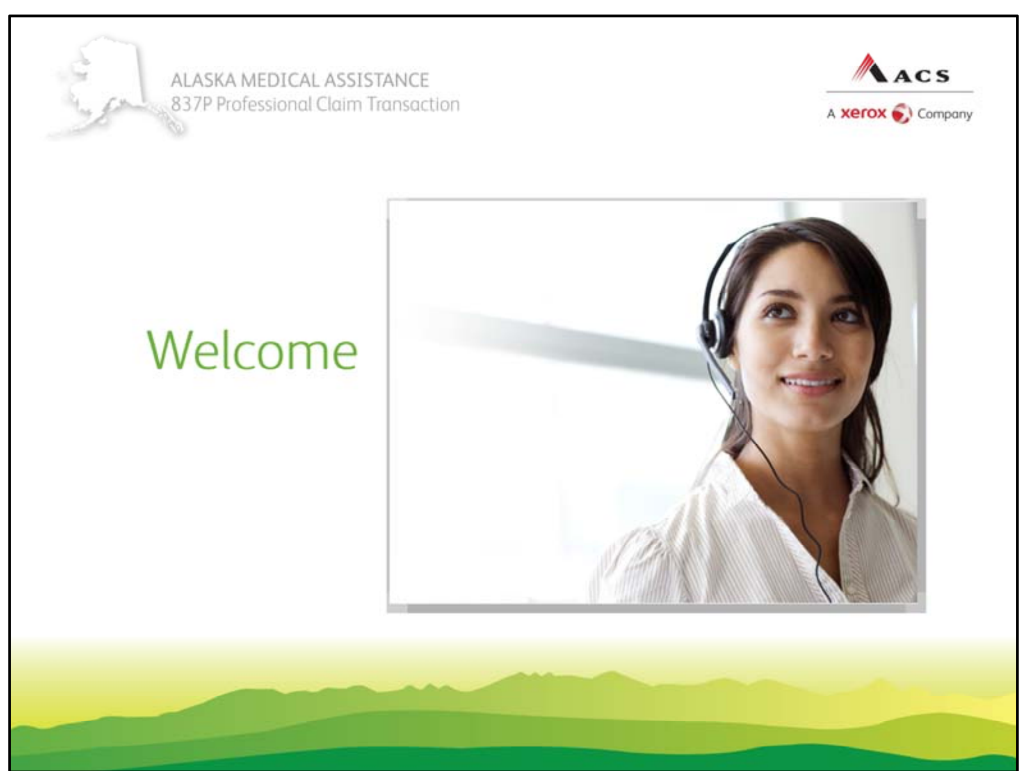
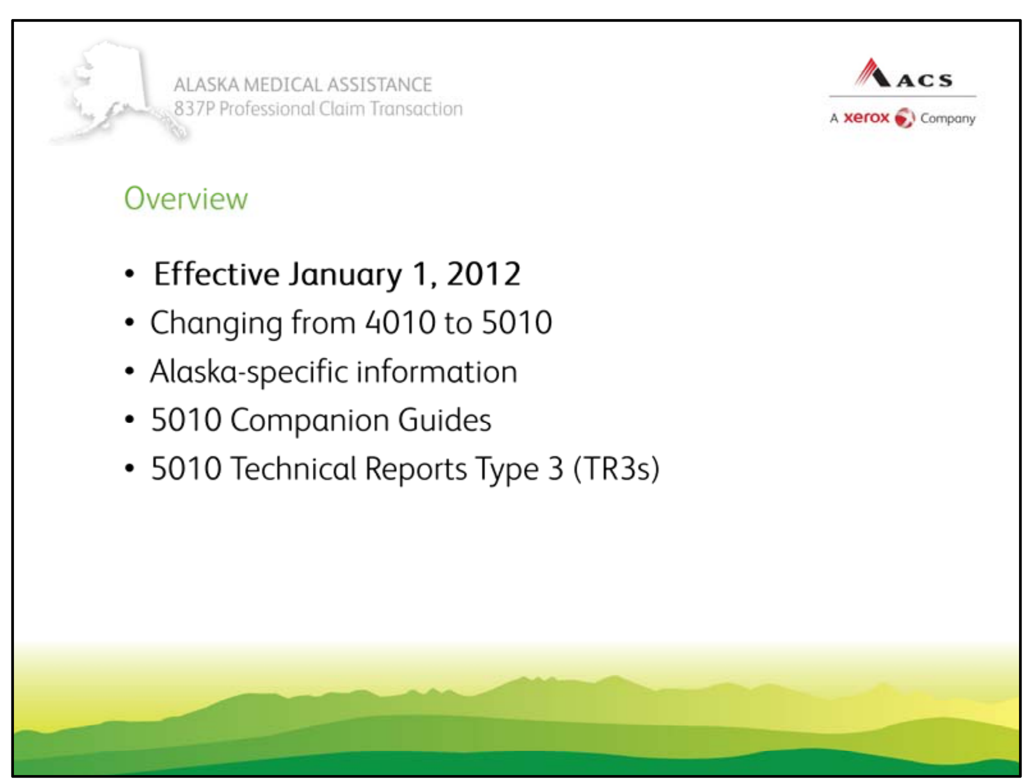


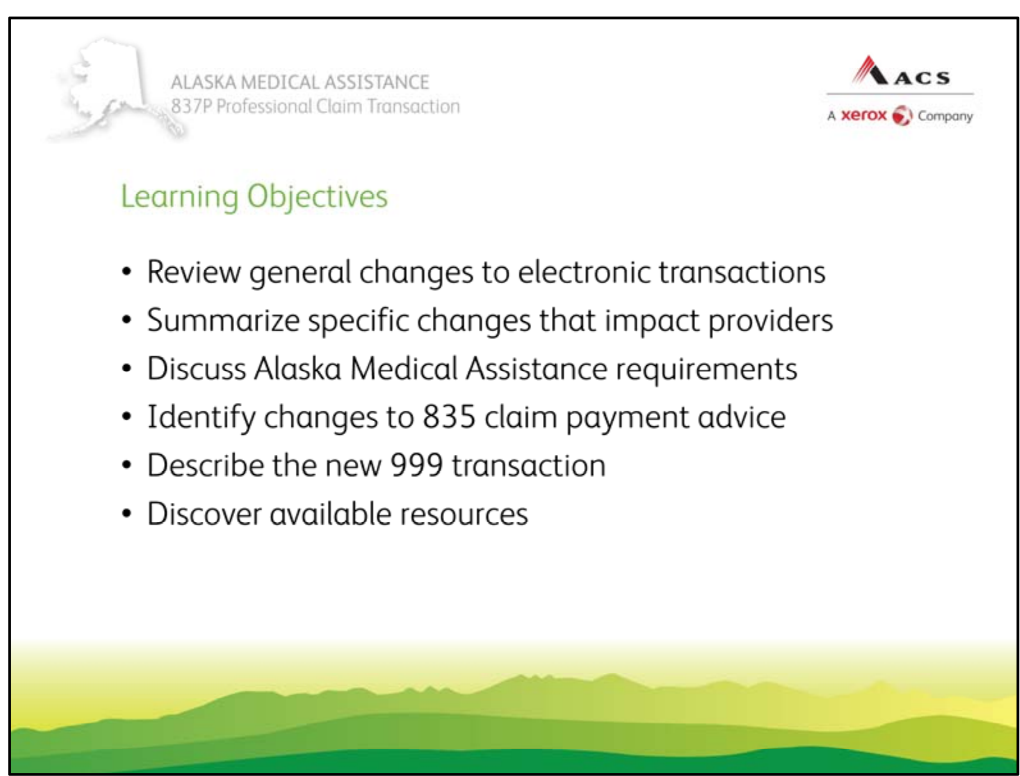
Thank you for attending this webinar session on 5010 changes to the 837P professional claim transaction. [Introduce self.] I would also like to introduce our Subject Matter Experts. [Introduce SMEs.] At the end of this webinar, they can help answer questions you may have, so be sure to write down your questions as we go along. A copy of today's presentation will be published on medicaidalaska.com. Let's get started.



As you already know, changes to electronic transaction formats will be effective January 1, 2012, and we want you to be aware and ready for the implementation of the federally-mandated HIPAA changes. All HIPAA-covered entities must convert from HIPAA X12 Version 4010A1 electronic transaction standard to the new Version 5010. HIPAA-covered entities are our trading partners, which includes providers, clearinghouses, and health plans.

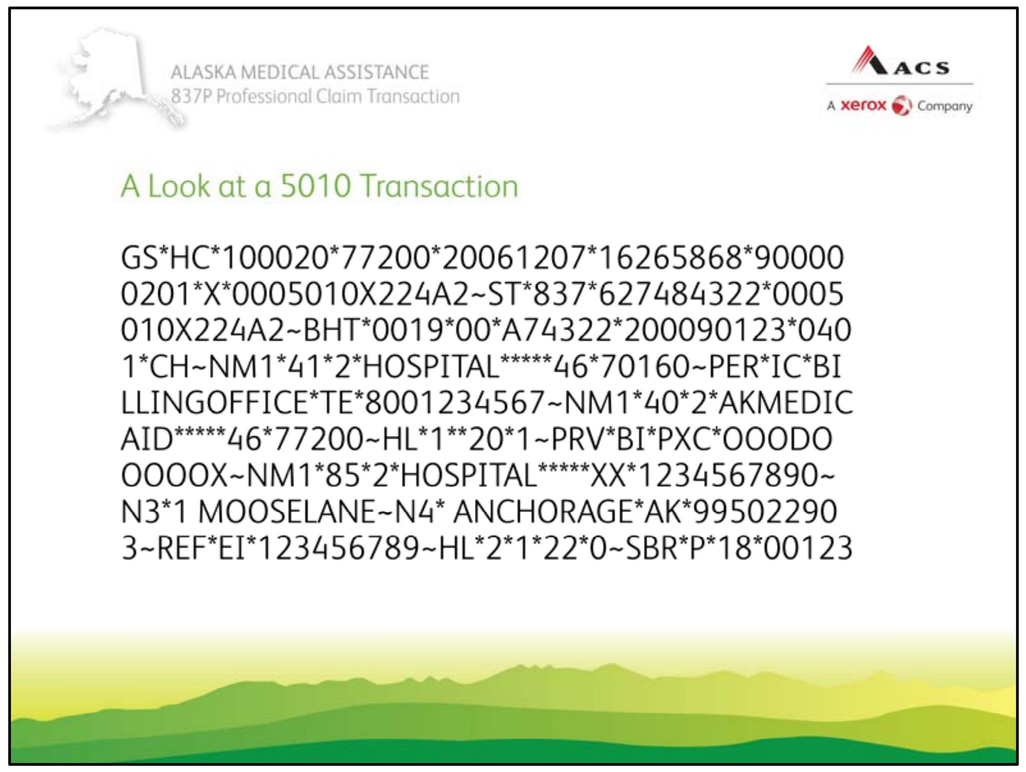
During this webinar, we will go over some of the 5010 changes that you may need to know. Mostly we will review information that is Alaska Medical Assistance-specific. You will learn what to expect in the 5010 formats as it applies to your interactions with us.

The information we will discuss is not a step-by-step guide on completing electronic transactions. It is an introduction to things you should pay attention to in your 5010 Companion Guide and TR3, which stands for Technical Report Type 3. These documents provide thorough information about the mandated HIPAA changes. TR3s are developed and approved by the ASC X12 committee which is part of the American National Standards Institute, or ANSI. The federal Department of Health and Human Services Centers for Medicare and Medicaid Services, known as CMS, passes regulations to enforce use of these transaction standards. They give you technical details on how the electronic transactions need to be formatted. Each electronic format has its own TR3. You can purchase them from Washington Publishing Company. Trading partners, which includes providers, must adhere to the most current TR3s. ACS published the Alaska Medical Assistance version of the 5010 Companion Guide.



This webinar will cover the objectives listed on the screen. Everything we discuss is meant to give you a better understanding of the changes in 5010 – from submitting your 837P transaction to reading your 835 claim payment advice to dealing with errors.

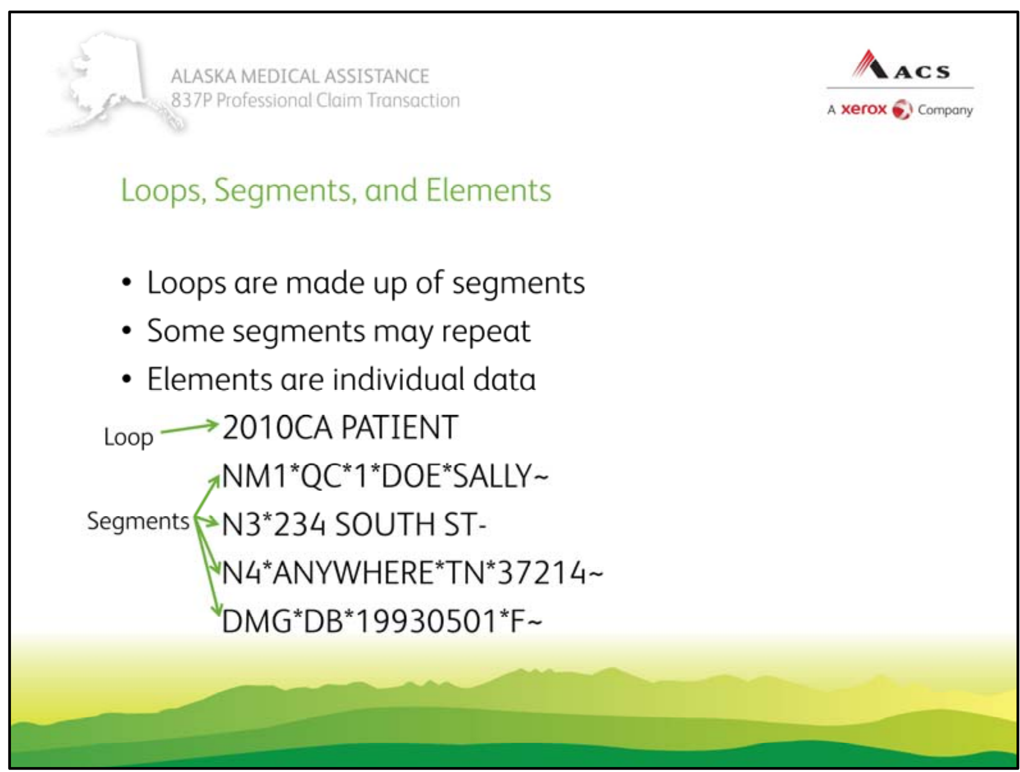
Some changes apply to all electronic transactions. Other changes relate specifically to a particular format, such as the 837P. And then there are changes that are unique requirements for Alaska Medical Assistance.



5010 transactions are complex. Some transactions are more than 1000 pages long. Claim information entered into your billing software is converted to comply with rules for transmitting this information electronically. This slide is a partial example of claim information that has been converted and is ready to send to the payer. The work to convert this information is accomplished by your software vendors and programmers.

When you submit an 837 electronically or get back an electronic 835, you hardly ever have to deal with all of the coding that makes claims readable. The claim information automatically uploads into your office's database or Alaska Medical Assistance's system so all of us can track claims and payments. Today you'll learn how to read some of the elements of the 5010 electronic transaction.

There are some new codes and some deleted codes. There are some new segments and some new elements. However, for the most part, these changes won't affect or bother you – unless you go looking for them. As a result, we're not going to review all of the changes. We'll only go over what you need to know.

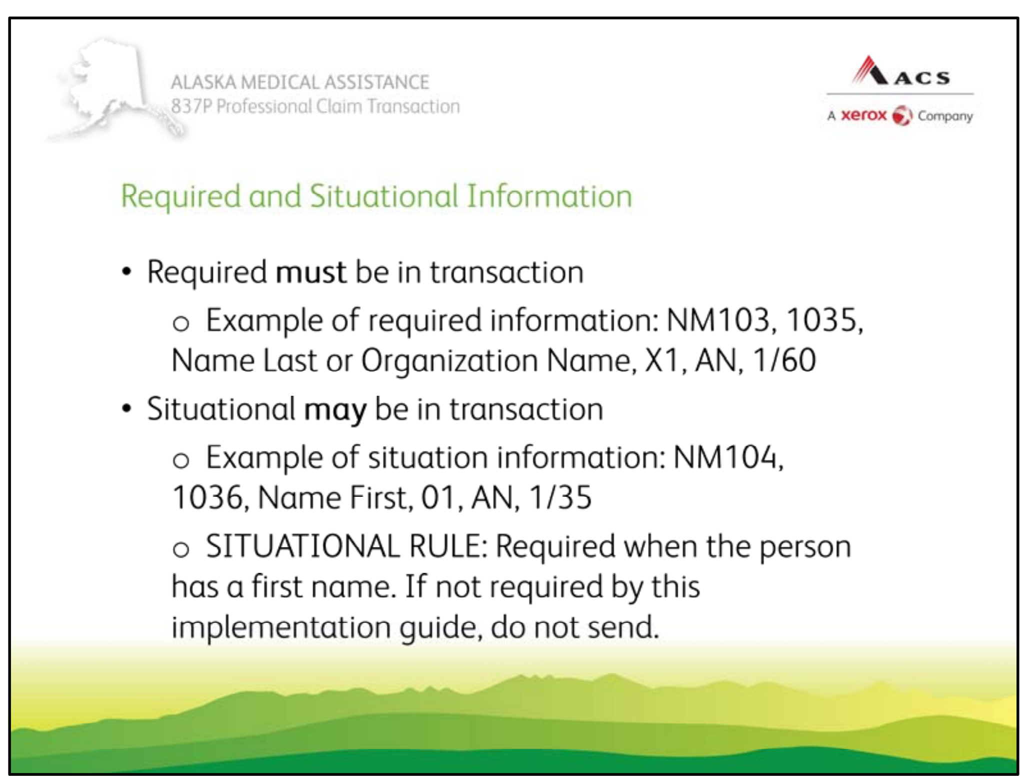


Let's start with a quick review of loops, segments and elements. These terms refer to the different components of electronic claim transactions.

Information hierarchies exist within each transaction. These are represented by a basic loop, segment and element structure. Loops are the highest level of information. Segments provide more specific information within a loop. Elements (data fields) within segments are the most specific level. For example, the patient name loop is the highest level of information about the patient's name. Segments within this loop break out patient information such as a name segment, an address segment, and demographic information segments. Elements within a segment, such as first name, last name, middle initial and name suffix within the patient name segment, allow for reporting the most specific information.

On the screen, you will see the 2010 CA Patient Loop. There are 4 segments with this loop: NM1, N3, N4, and DMG. There are many elements within each of these segments. These are separated by an asterisk. The end of a segment is signified by a terminator, usually a tilde (~).

Some loops, segments, and elements are not used for processing in, depending on the transaction type. These unused components are documented in Companion Guides and TR3s.



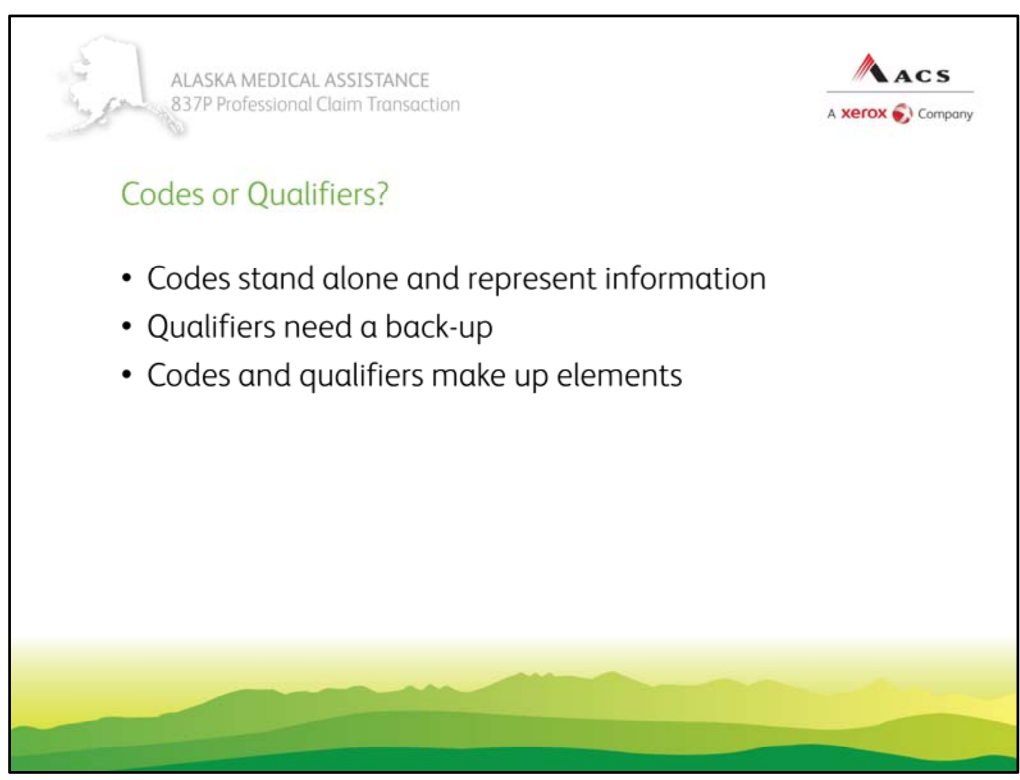
Throughout this webinar, you will hear us refer to required or situational loops, segments, and elements.

If something is required, it must be included. Using the example presented in Slide 6, a required segment is the patient name segment and one of the required elements is the patient last name.

On that note, it is important for us to stress that a required segment may have both required and situational elements. The example in Slide 6 has the patient last name as a required element but the patient first name as a situational element. The patient first name situational rule in the TR3 defines when this information must be sent.

A required element for all claims billed to Alaska Medical Assistance is the recipient ID number. A situational element critical to Alaska Medical Assistance is prior authorization number for those services for which a PA is required.

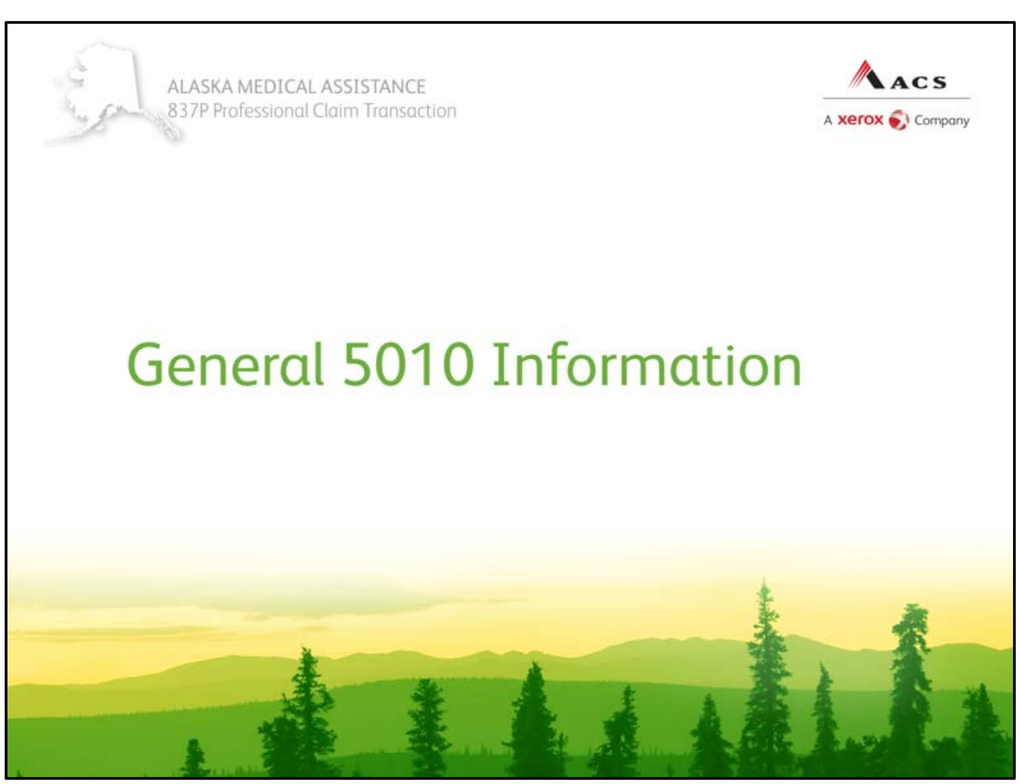
You should always check your Companion Guides and TR3s to make sure you are including all of your relevant situational information.



The last thing we need to go over is the difference between codes and qualifiers.

A code stands on its own and represents something. For instance the code, CHK means a check has been put in the mail and does not introduce something else. A qualifier, on the other hand, announces something else is coming. For instance, the qualifier PI in one field means that another field will have the payer's identification number.

Both codes and qualifiers help make up elements.



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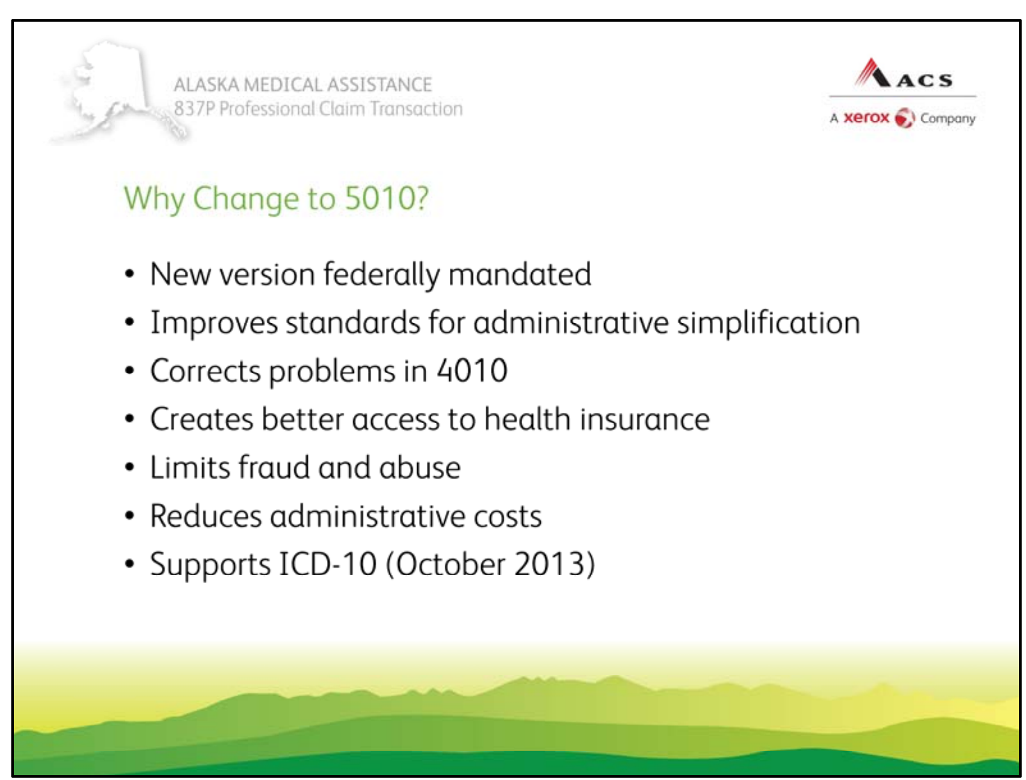
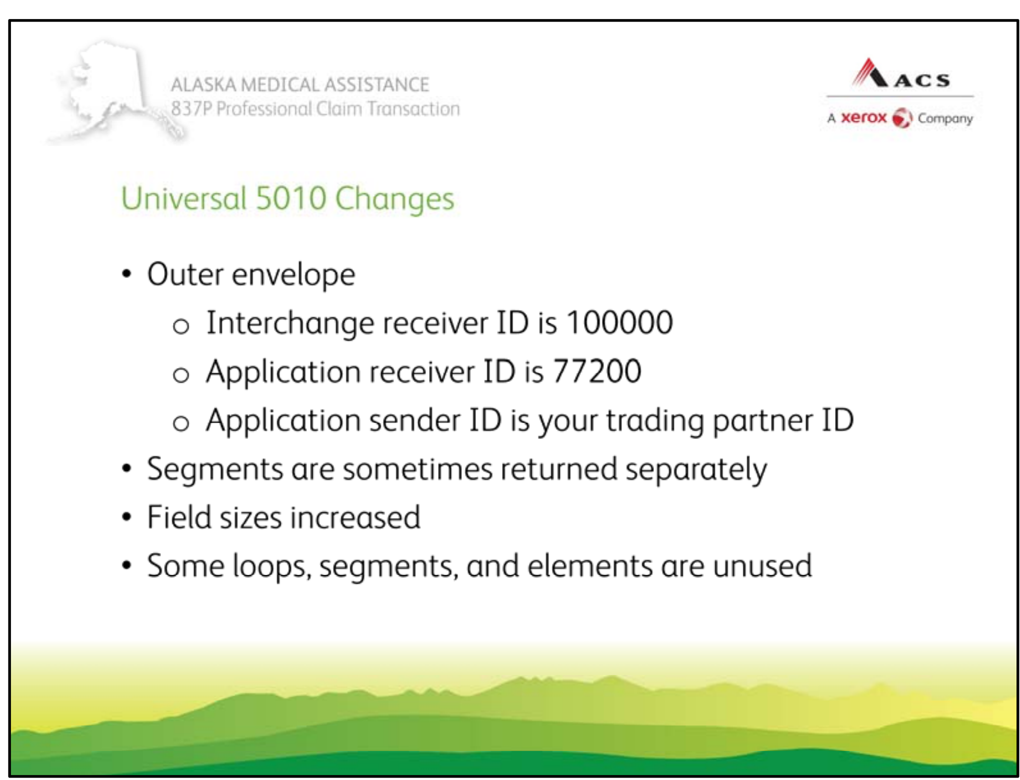


You may be wondering, “Why are we changing from 4010 to 5010?” The short and simple answer is that it is law. We must do it.

ANSI, which I mentioned earlier and is the acronym for the American National Standards Institute, originally implemented transaction standards referred to as 4010 in 2003 and CMS mandated the ANSI 4010 standards. However, numerous deficiencies and inconsistencies have been identified since 4010 was implemented. As a result, ANSI updated the electronic transmission standards to improve the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. ANSI ensured that 5010 corrected these problems.

CMS is mandating the 5010 electronic transmission standards effective January 1, 2012. By using these standards, CMS is able to create better access to health insurance, limit fraud and abuse, and reduce administrative costs. The 5010 changes are also a critical step in preparing for the implementation of ICD-10 that is planned for October 2013.

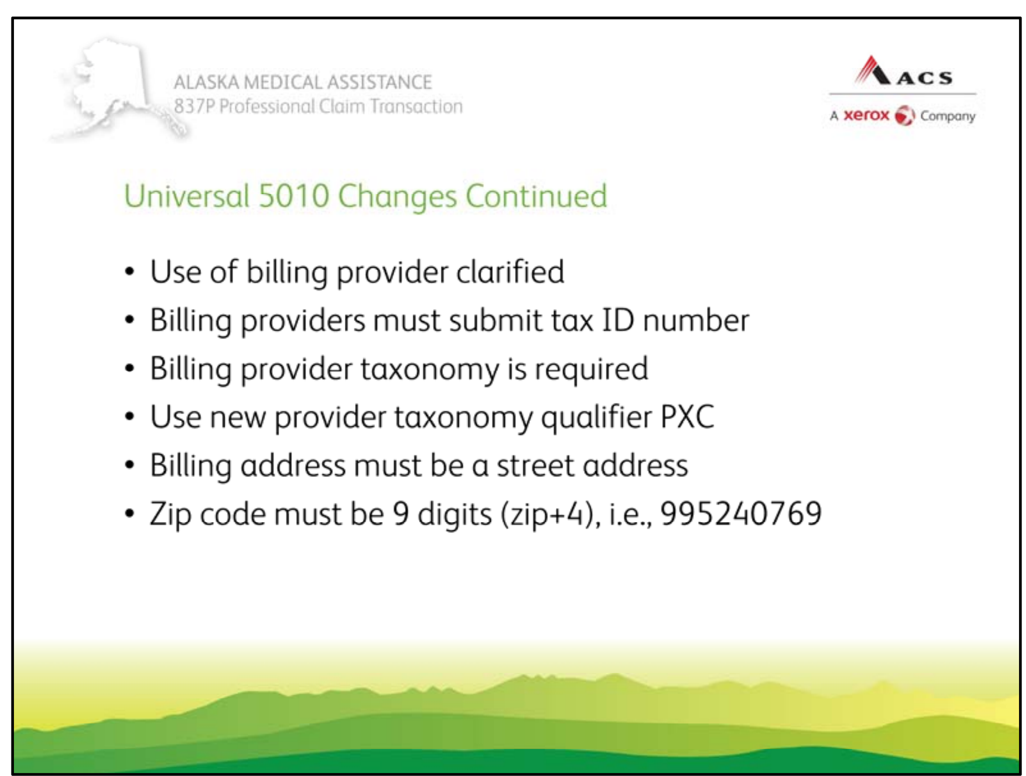
Just to be clear, as of January 1, 2012, we will no longer accept 4010 transactions.



Now we are going to review some of the common changes that apply to all parts of 5010. Although we can't cover all of the changes in detail, we'd like to introduce you to some that are important and deserve special attention. We'll start with an overview of high-level changes to the 5010 transactions. The changes you are about to see impact everything from 837s to 835s and CMS requirements to Alaska Medical Assistance requirements.

For all 5010 transactions, the version, transaction, and implementation codes have been updated. In the outer envelope, there is a new code for the interchange receiver ID which is found in ISA08. This is 100000. And in the GS segment, the new code for the sender – the trading partner – in GS02 is your trading partner ID number assigned by Alaska Medical Assistance, and the ID for the application receiver – Alaska Medical Assistance – in GS03 is 77200.

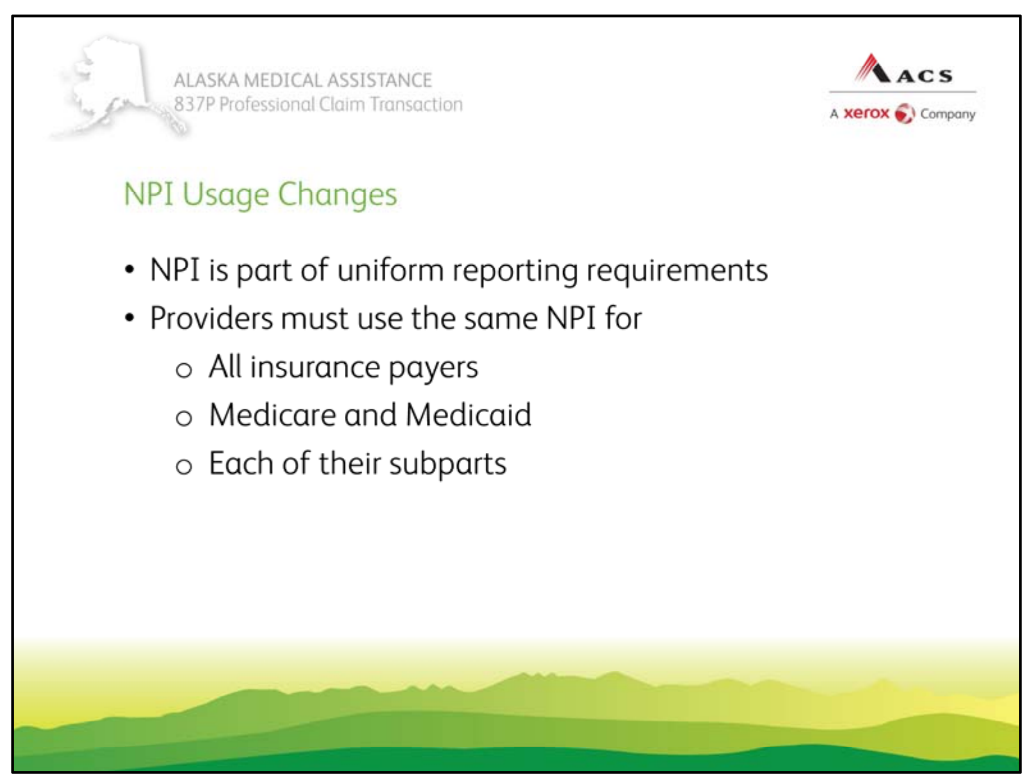
One of the most common changes for 5010 is that many of the fields have increased in size. For example, the first name and last name for providers, clients, payers, etc. increased to 35 and 60 characters, respectively. Certain identifiers such as medical record numbers and referral numbers increased to 50 characters. Alaska Medical Assistance will accept and return these expanded field values. At the present time, however, we will continue to use current field sizes internally for processing claims.



An NPI is required for the billing provider identifier along with the identification code qualifier value "XX" for all HIPAA covered entities. The billing provider taxonomy code must also be submitted in the billing provider specialty information segment with the new taxonomy qualifier value "PXC". Please note that this new taxonomy qualifier field length increased from two to three bytes between version 4010 and 5010. The billing provider must also submit a tax ID number in the billing provider tax identification segment.

The taxonomy changes just mentioned are important, so to say them again they are required with billing provider information and new qualifier field length and value. The taxonomy code provides Alaska Medical Assistance with additional information to identify the billing provider to be paid for the services billed. It is crucial that you submit on your claims the taxonomy code you provided for your Alaska Medical Assistance enrollment record. The taxonomy codes on your claims and corresponding billing provider enrollment record must be kept in sync.

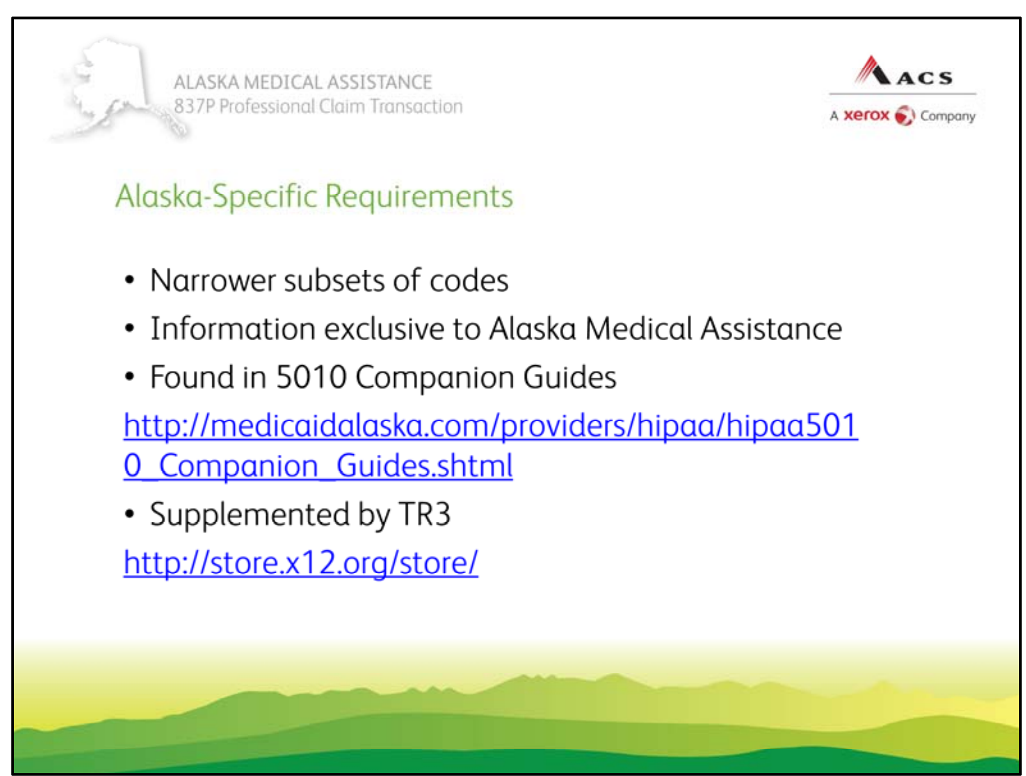
According to the new 5010 standards, any time you enter a billing or servicing address it must be a physical address. If you enter a post office box in these segments, your transaction will be rejected. The same is true for the zip code fields. You must enter a 9-digit zip code (zip+4) for the transaction to process. If unknown, these can be found for your address at http://zip4.usps.com. An acceptable zip code is entered without hyphens or spaces.



Speaking of NPIs and taxonomy qualifiers, it is important to cover some NPI usage changes.

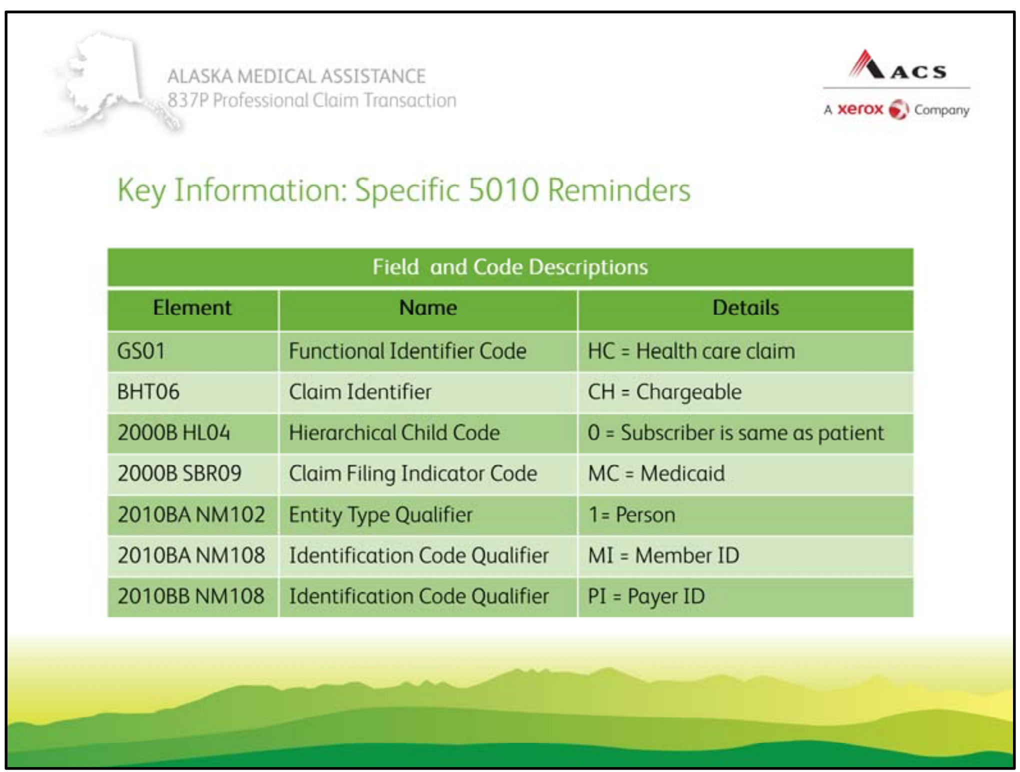
In 5010, if you have an NPI, you need to include it. The NPI lets us identify billing providers. For example, the NPI submitted to Blue Cross must be the same NPI submitted to Alaska Medical Assistance. Do not use multiple NPIs for the same service, even if you are billing different insurance carriers.

5010 standards now require consistency in use of NPI's. These NPI's might be either an organizational NPI or a subpart NPI. Organizational NPI's identify the business entity and subpart NPI's define a specific line of business for the entity. If a subpart NPI is used in billing, you must use it consistently for claims for the same services. You cannot use the organizational NPI for a claim one time, then the subpart NPI another time for billing the same service. It is crucial that you submit on your claims the NPI number you provided for your Alaska Medical Assistance enrollment record. This could be either the organizational or subpart NPI. The NPI numbers submitted on your claims and on corresponding billing provider enrollment records must be kept in sync.



Now that we have reviewed some general information about the new 5010 transactions, we are ready to discuss some Alaska-specific things. We'll start with the 5010 in general and then move to the 837P, 835, and error reports. What we are about to review from this point on will be helpful for you only if you submit transactions to or receive transactions from Alaska Medical Assistance. The changes we are going to look at help you decipher the meaning of the codes you could receive.

Remember to refer to your Companion Guides for information about Alaska Medical Assistance-specific 5010 transactions. Since we have mentioned the Companion Guides several times now, we have included the link on the screen where you can go to get them. They are available free-of-charge for you to review and print. If you need more information about Companion Guides, please refer to the 5010 Companion Guide webinar. You may want to supplement the Companion Guides with the TR3s. That link is listed on the screen as well.



Field and Code Descriptions		
Element	**Name**	**Details**
GS01	Functional Identifier Code	HC = Health care claim
BHT06	Claim Identifier	CH = Chargeable
2000B HL04	Hierarchical Child Code	0 = Subscriber is same as patient
2000B SBR09	Claim Filing Indicator Code	MC = Medicaid
2010BA NM102	Entity Type Qualifier	1= Person
2010BA NM108	Identification Code Qualifier	MI = Member ID
2010BB NM108	Identification Code Qualifier	PI = Payer ID

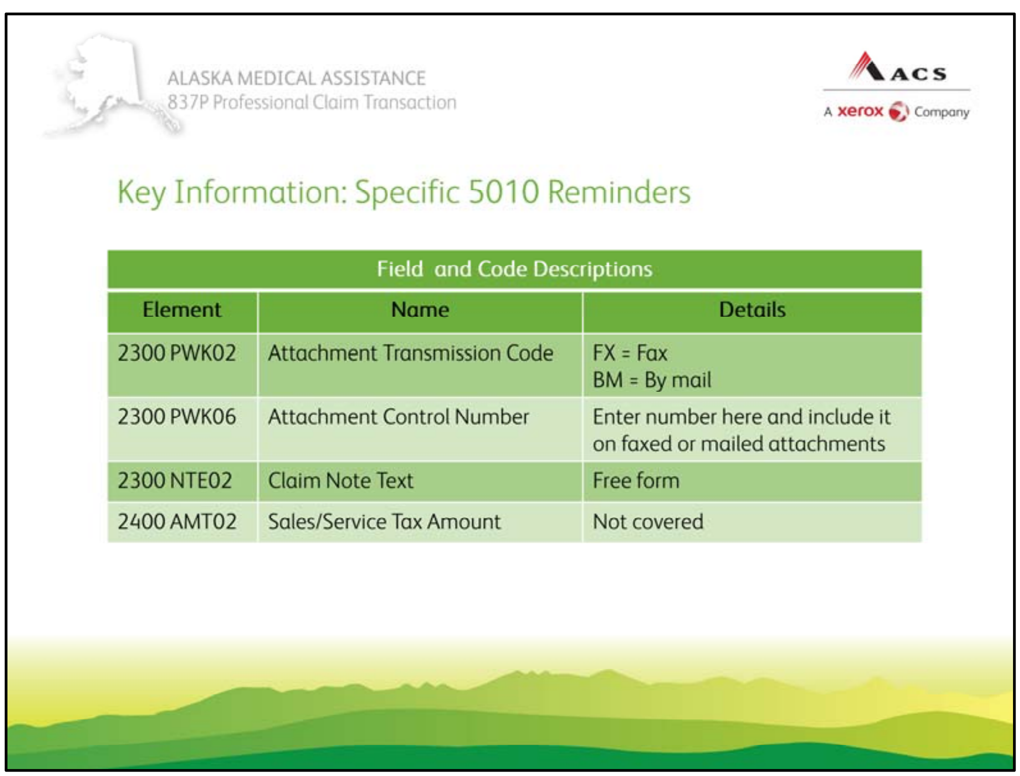
This chart and the next one give you information about a few other things that are unique to Alaska Medical Assistance when submitting or receiving any 5010 transaction. In all the charts you see throughout this webinar, the first column refers to the specific field name in the transaction. The second column states what that field is commonly referred to as, and the last column shows what valid values Alaska Medical Assistance accepts in the field and gives you any special instructions. In many instances, Alaska does not accept all the codes specified in the TR3 so it is important to refer to our 5010 Companion Guides to determine what is acceptable.

Control structures within the functional group envelope include the GS01 element, which always has the code HC on claim (837) transactions. Basically, the HC code lets the system and related parties know this claim is health-care related. Other segments, like BHT06 tell us that the services can be charged, hence the CH code.

For Alaska Medical Assistance, the subscriber is always the person who is the Alaska Medical Assistance recipient, which is why there is always a 0 in 2000B HL04.

Naturally the claims we are talking about today are exclusive to Alaska Medical Assistance. As a result, when you see the MC code in 2000B SBR09, you know that this claim is for us, not a private insurance company.

The 2010BA NM102 and 08 are connected. A 1 informs us that it is a person receiving services. Who is the person? The recipient ID you enter in NM108 identifies the person.

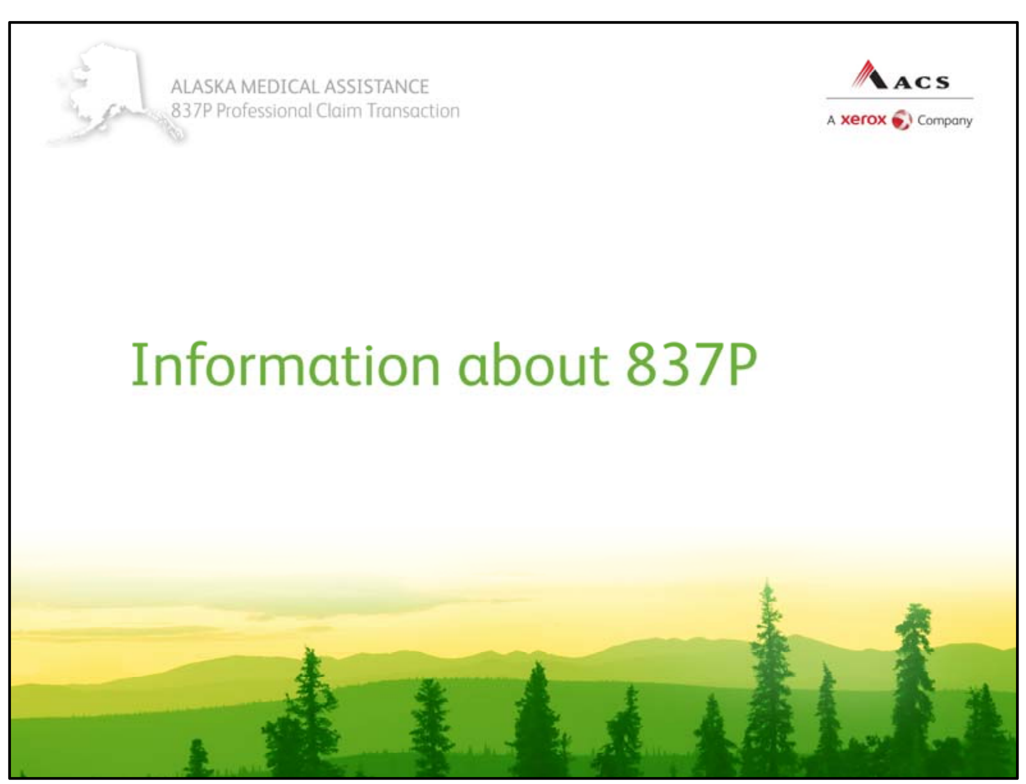


Element	Name	Details
2300 PWK02	Attachment Transmission Code	FX = Fax BM = By mail
2300 PWK06	Attachment Control Number	Enter number here and include it on faxed or mailed attachments
2300 NTE02	Claim Note Text	Free form
2400 AMT02	Sales/Service Tax Amount	Not covered

The Attachment Transmission Code indicates whether or not additional information is being sent to support the claim. Supporting documentation should be faxed or mailed the same day the claim is transmitted. If you do send an attachment, you must generate an attachment control number and enter it in PWK06.

The Claim Note Text element is free form. There are no guidelines as to what can or cannot be submitted. It should be used if you feel additional information is needed to explain why that medical treatment was provided. Because it cannot be automatically processed, a claim with data in 2300 NTE02 suspends for manual review.

Regardless of the type of 837 you submit, Alaska Medical Assistance does not cover any taxes. Therefore, do not include this amount in this element or in any of the line item charges.



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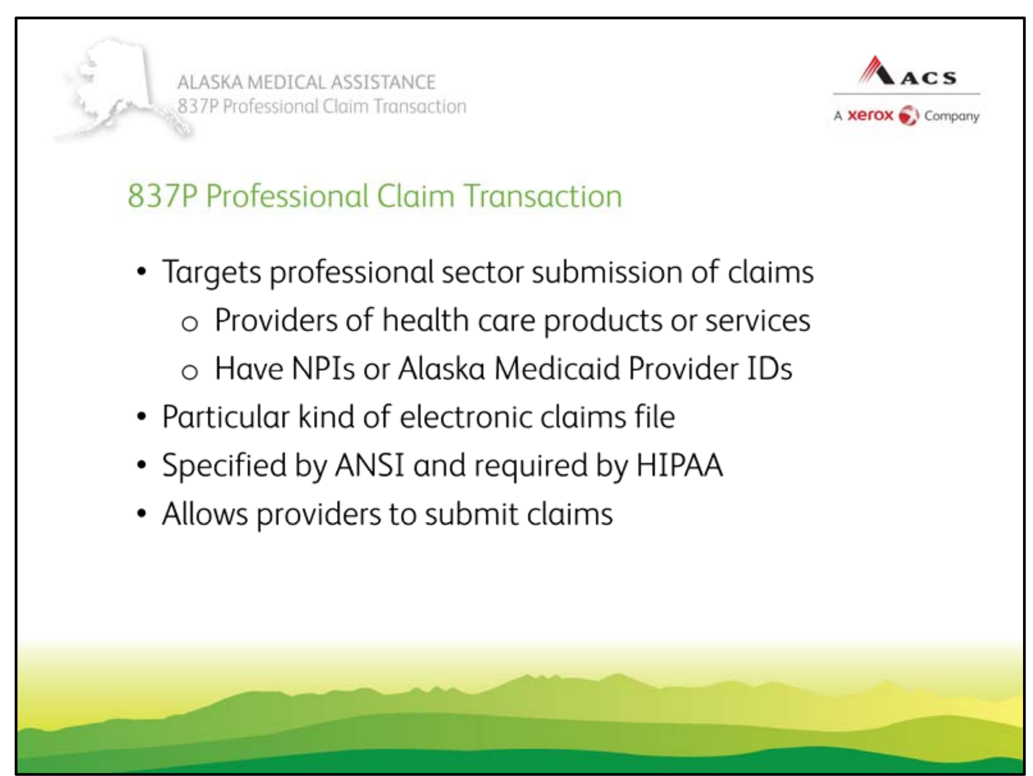
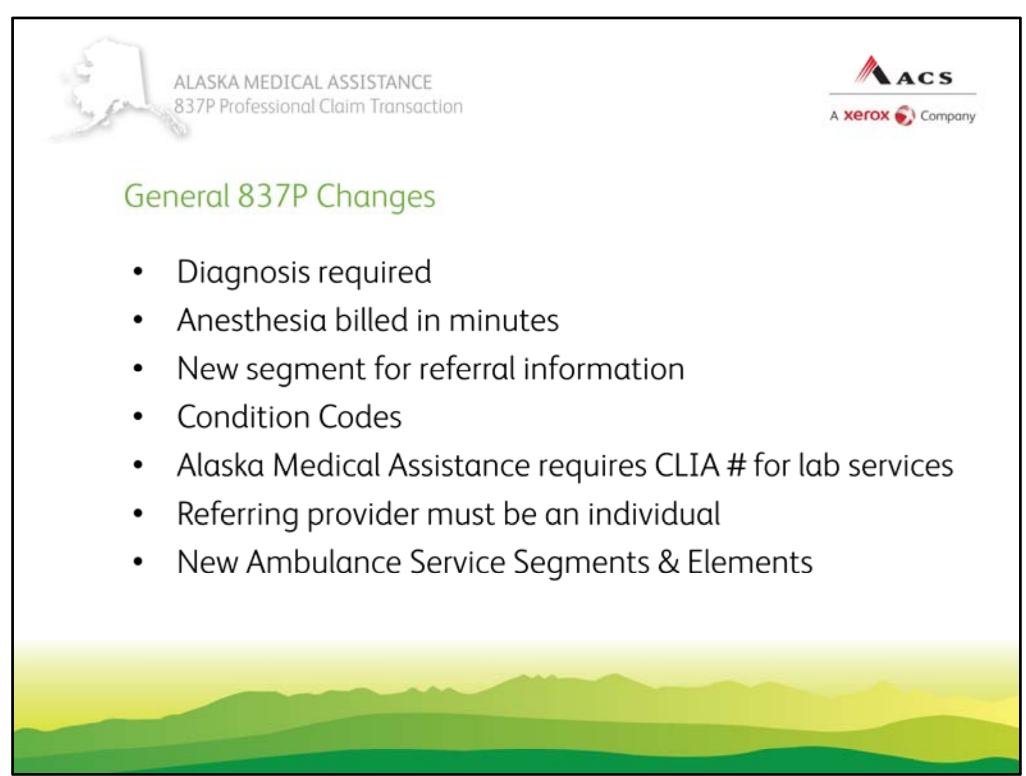


Now we are ready to go over some of the changes that are specific to submitting electronic professional claims to Alaska Medical Assistance. The 837P transaction is used to submit claims for professional health care products or services. This transaction is used by a wide variety of Alaska Medical Assistance provider types. These providers may be MD's, ANP's, health professional groups, DME suppliers, taxi cabs, congregate meal providers, or orthotic/prosthetic suppliers, among many others. This webinar is directed to HIPAA covered entities – those ***mandated*** to use this transaction for electronic submission of claims. An upcoming presentation will focus on specific requirements for atypical providers.

ANSI dictates the 837P electronic claim transaction format. Claims go to ACS who process them on behalf of Alaska Medical Assistance. As we mentioned earlier, there are many 5010 837P changes, but we'll only go over some of the most important ones.



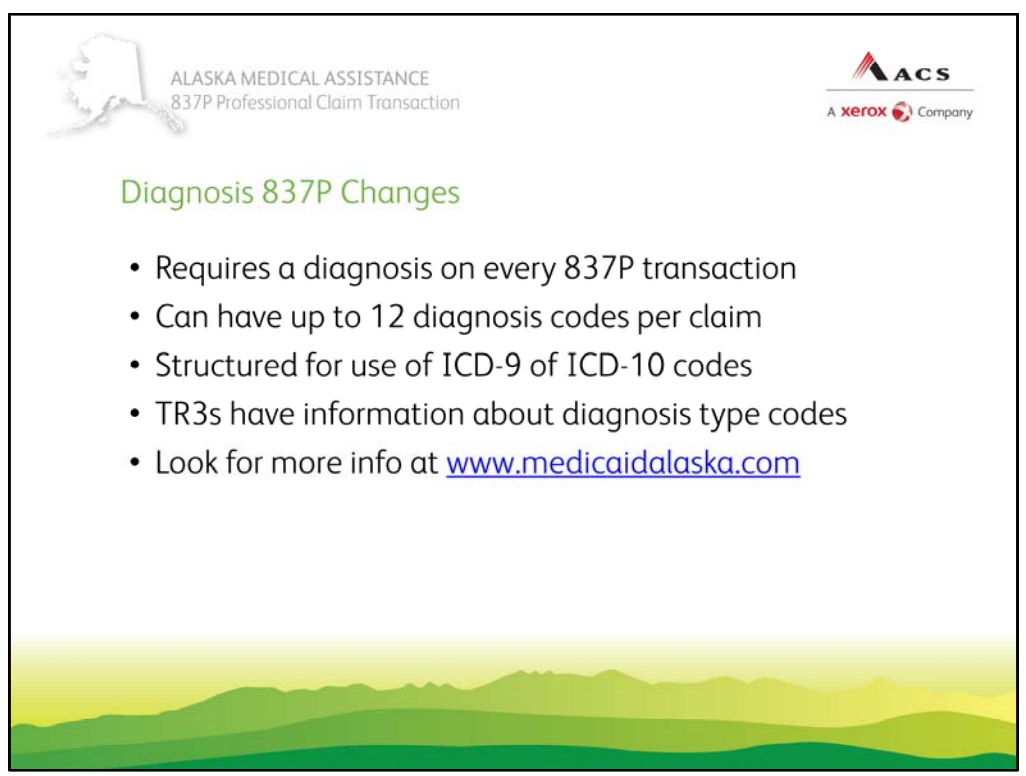
This slide summarizes highlights of version 5010 837P changes significant to billing Alaska Medical Assistance. (Read bullets.) We will discuss these diagnosis and anesthesia reporting rules in more detail in subsequent slides.

A new segment for referral number has been added. Per our 837P Companion Guide, this segment is used to report the CCAN number for Care Coordination service claims. Referring provider information has also changed to require that the referring provider be an individual.

Previously, condition codes were reported only on institutional claims. The 837P transaction now allows for reporting certain condition codes. The acceptable condition codes for the 837P relate to abortion services. The valid condition code values are AA through AH as defined in the NUBC manual.

For lab service claims, Alaska Medical Assistance requires submission of the CLIA number for the lab performing the service. As a reminder, the lab providing the service must bill for the service.

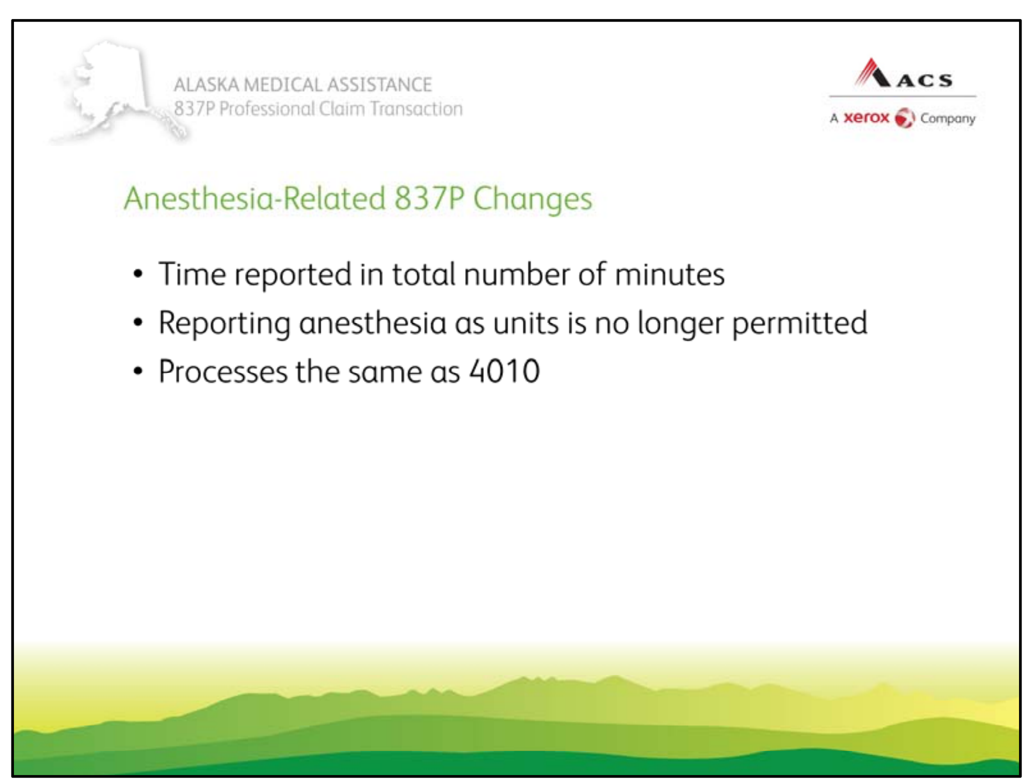
New segments exist in version 5010 for ambulance pick up and drop off locations. In addition, a new segment exists to report the number of patients transported in a single trip. Alaska Medical Assistance requires this information on ambulance claims when more than one patient is transported in the same ambulance run.



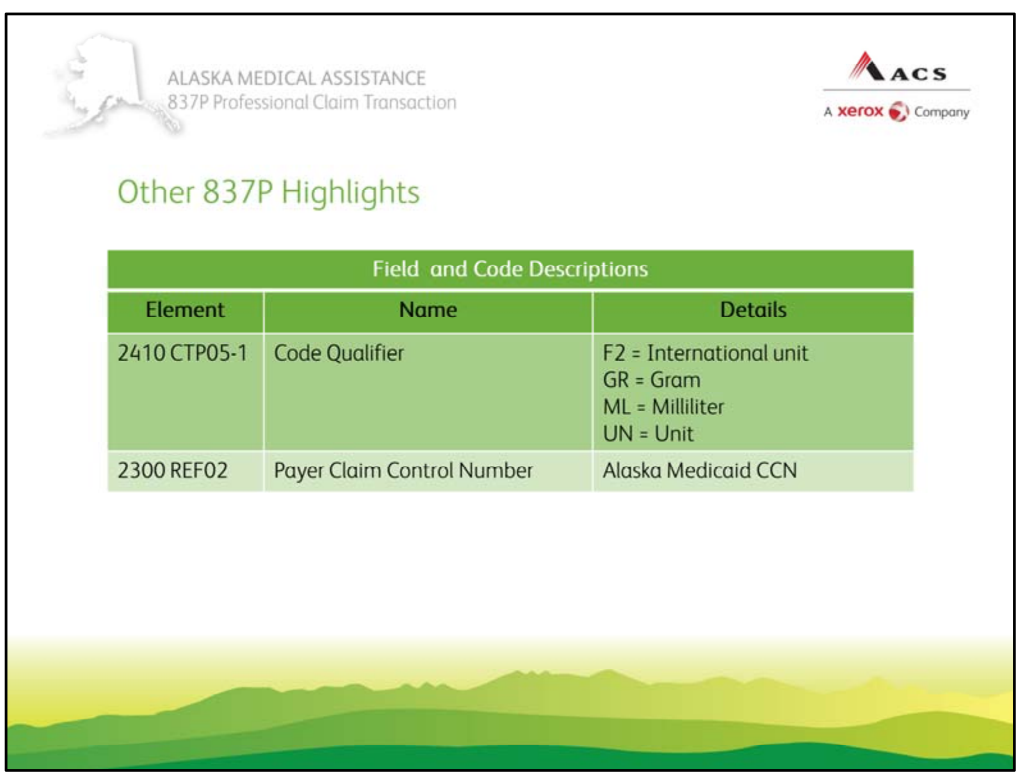
For the version 5010 837P, there are several changes related to reporting diagnosis codes. ***A diagnosis code is now required on every 837P claim***. Alaska Medical Assistance recognizes this is a significant impact to certain provider types who currently are not required to submit diagnosis codes on claims, such as transportation/accommodation providers and Home and Community Based service providers. Alaska Medical Assistance guidance will be forthcoming to assist these provider types in making this transition.

Version 5010 837P allows up to 12 diagnoses to be reported at the *claim level*. For each line, up to 4 diagnosis pointers can be submitted. The first pointer designates the primary diagnosis for the service line. Alaska Medical Assistance will utilize in claims processing the first two diagnoses indicated by the diagnosis pointers for each claim line. These will be considered the primary and secondary diagnoses.

Version 5010 changes allow reporting of a diagnosis type code to indicate whether the biller is sending ICD=9 or ICD-10 codes. Continue to submit ICD-9 codes to Alaska Medical Assistance until October 1, 2013, when ICD-10 is mandated for use.



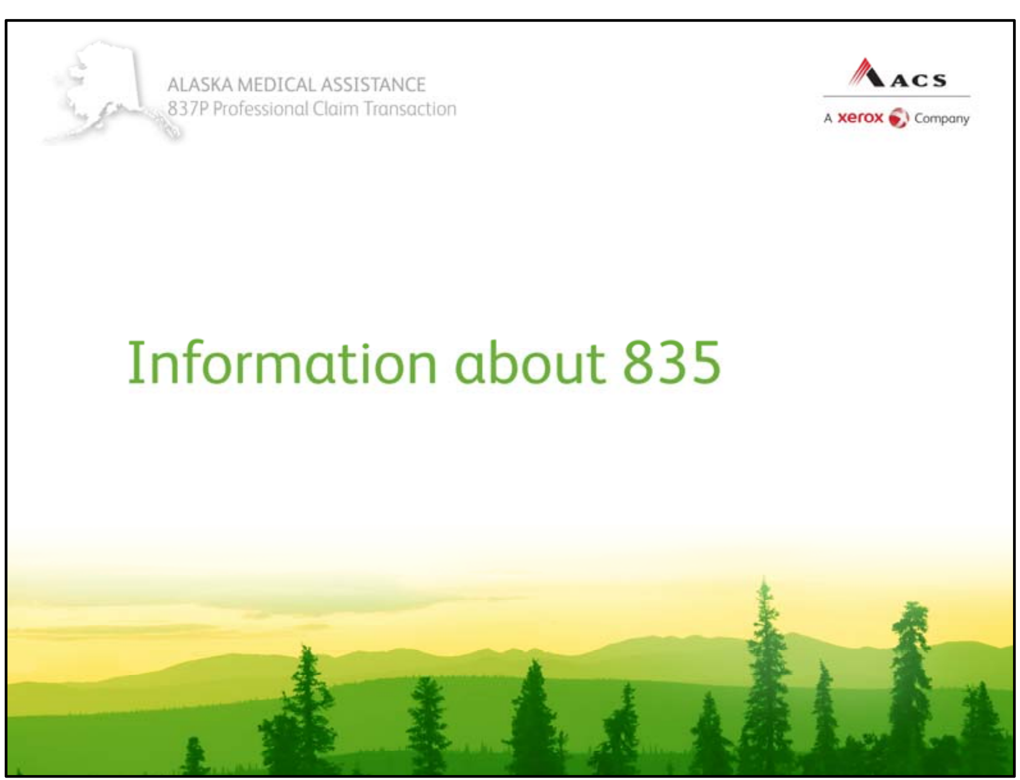
In 4010 transaction, anesthesia time could be reported as the total number of minutes or as units of time. For reporting to Alaska Medical Assistance, 1 unit was the equivalent of 10 minutes. In 5010, however, anesthesia time can only be reported as the total number of anesthesia minutes. Although there are changes in how you report the minutes of time, there are no changes in how Alaska Medical Assistance processes anesthesia-related services.



Additional 837P elements significant to Alaska Medical Assistance claims processing are presented in this slide.

The Loop 2410 CTP05-1 element is used when billing for drugs administered in the provider's office. The qualifier codes listed in the slide are accepted by Alaska Medical Assistance. Note there is a new code value ME (milligrams), but this code will not be used by Alaska Medical Assistance for drug claims processing.

The Loop 2300 REF02 element for the Payer Claim Control number is used when submitting an adjustment or void for an Alaska Medical Assistance adjudicated claim. Enter the Alaska Medical Assistance assigned claim control number for the claim being adjusted. When submitting this adjustment action, remember to enter the proper replacement or void value code in the CLM05-3. The CLM05-3 valid value for a replacement claim is 7 and the valid value for a void is 8.



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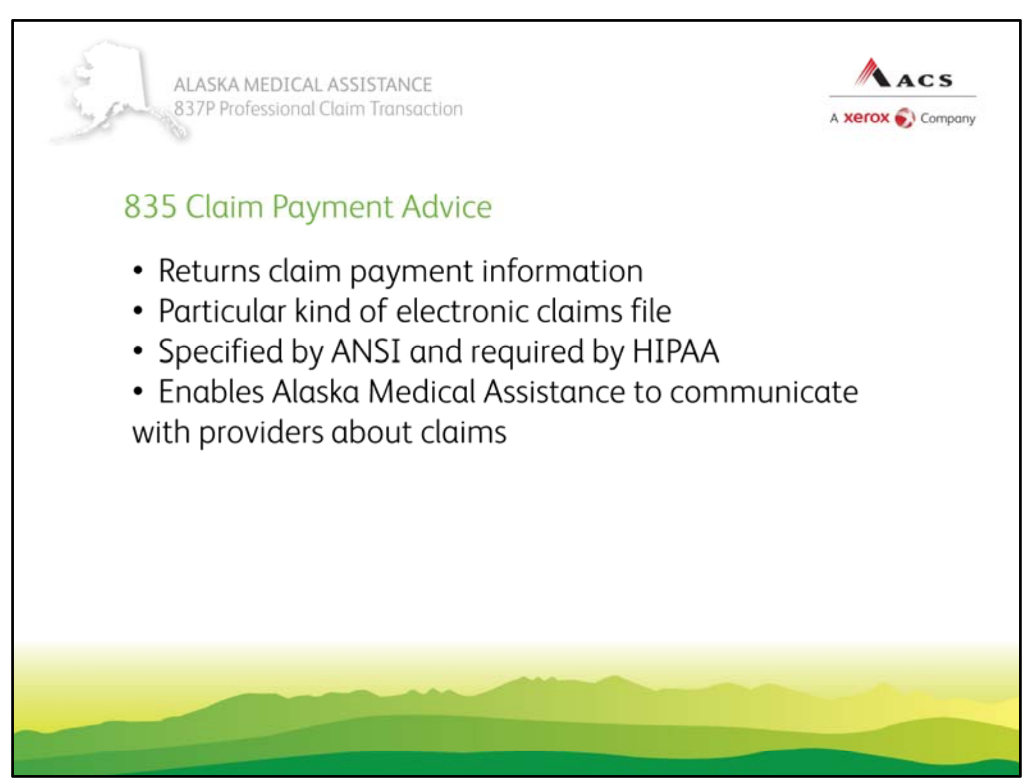
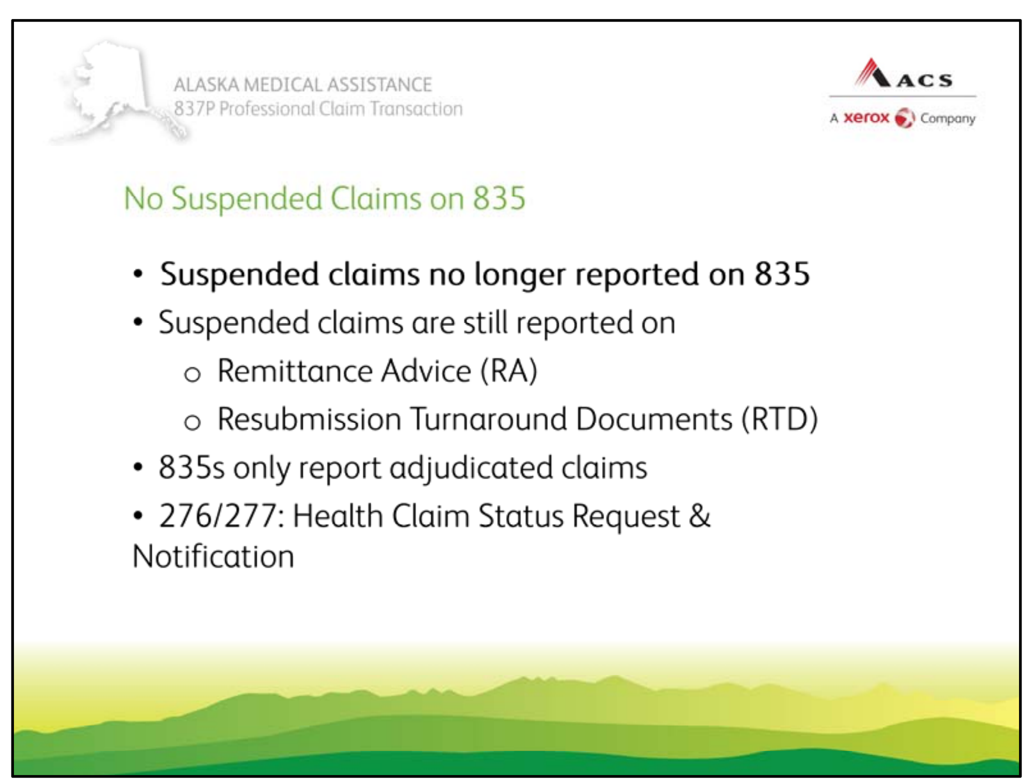


What happens after you submit a transaction? When claims are adjudicated by ACS they are reported on the 835 transaction. This transaction is returned to the trading partner delegated to receive it on behalf of the provider. Sometimes, 835's have been called claim payment advice or pended claim reports. 835 electronic transactions are undergoing changes as part of 5010.

Let's start by highlighting a few changes in the 835 that apply to Alaska Medical Assistance.

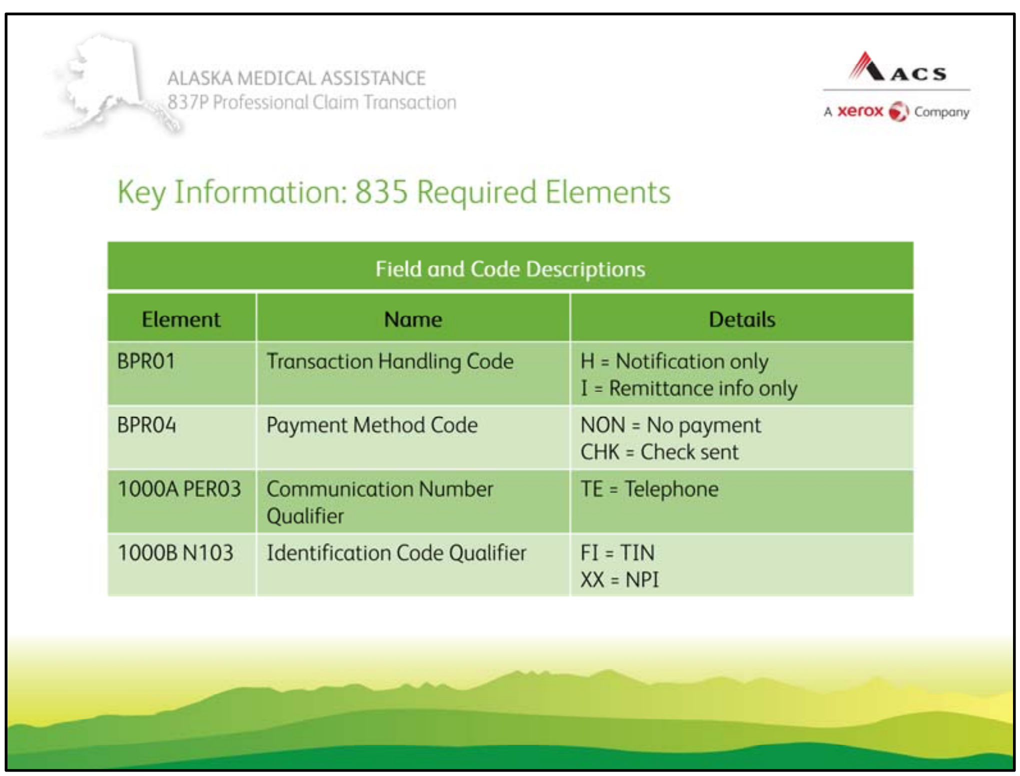


An important change to the 5010 version 835 is that suspended claim information (pends and RTDs) may no longer be reported here.

However, you will continue to receive a paper Remittance Advice, which we often call RAs, as well as paper Resubmission Turnaround Documents, commonly known as RTDs. The 835s you receive will only provide information on adjudicated claims.

The 276/277 transaction pair provides electronic claim status information on both adjudicated and suspended (pends and RTDs) claims. The 276 is a request for information and the 277 is the notification response. More information about this transaction set will be available at a future date.

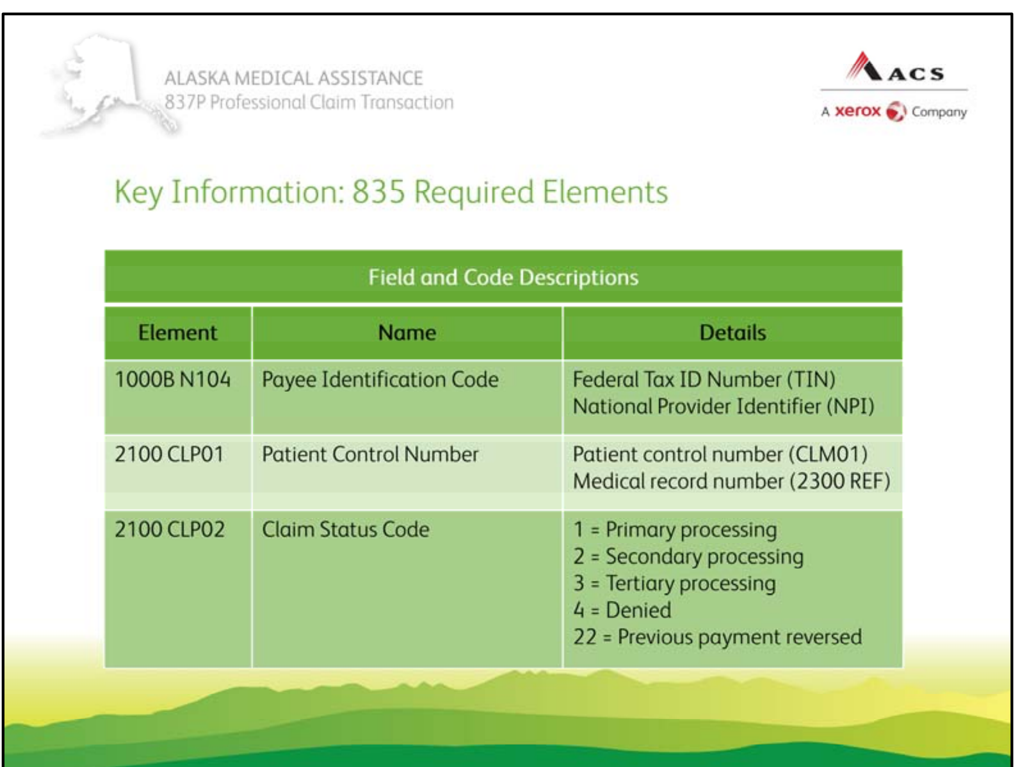
The other important thing you need to know is that after 5010 is implemented on January 1, 2012, you will receive the 5010 version of the electronic claim payment advice even if you submitted a claim using the 4010 format. For example, if you submit a claim in November 2011 using the 4010 837P, but it is not adjudicated until January 2012, your 835 will be in the 5010 format because at that point we will only send 5010s and will not accept 4010s.



Field and Code Descriptions		
Element	**Name**	**Details**
BPR01	Transaction Handling Code	H = Notification only I = Remittance info only
BPR04	Payment Method Code	NON = No payment CHK = Check sent
1000A PER03	Communication Number Qualifier	TE = Telephone
1000B N103	Identification Code Qualifier	FI = TIN XX = NPI

Elements in BPR deal with financial information relating to the entire 835 transaction. There are 2 important elements, and they are connected. BPR01 lets you know if payment is coming, and BPR04 lets you know how it is coming. In BPR01, Alaska Medical Assistance may return one of two codes. An H lets you know that there is no payment. If you see an H, you will see NON in BPR04. NON means non-payment. If an I is returned in BPR01, a check has been issued. The corresponding BPR04 code value will be CHK. Information in 1000B N1 lets you know who is being paid.

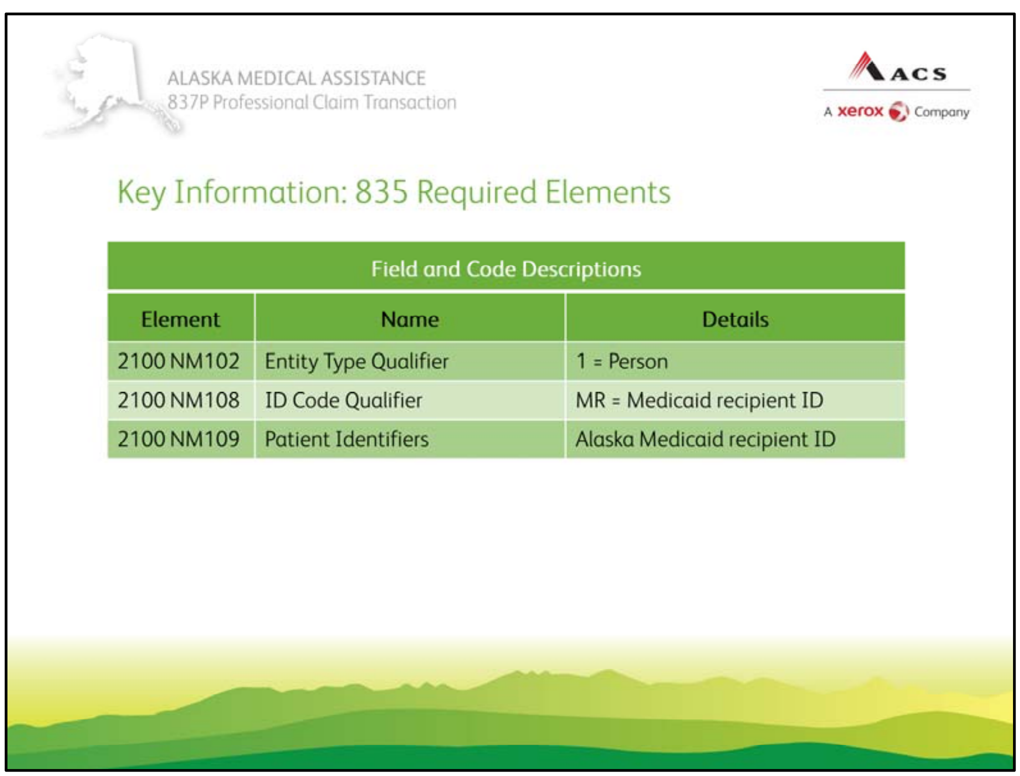
For Alaska Medical Assistance, if you are an atypical provider, you will see an FI in N103, otherwise, you will see value XX in N103. FI means the number in N104 will be the federal Taxpayer's Identification Number, such as a social security number. Value XX means the number in N104 is the NPI.



Field and Code Descriptions		
Element	**Name**	**Details**
1000B N104	Payee Identification Code	Federal Tax ID Number (TIN) National Provider Identifier (NPI)
2100 CLP01	Patient Control Number	Patient control number (CLM01) Medical record number (2300 REF)
2100 CLP02	Claim Status Code	1 = Primary processing 2 = Secondary processing 3 = Tertiary processing 4 = Denied 22 = Previous payment reversed

For pharmacy claims, the 835 CLP01 element reports the prescription number. For all other claims, this is the patient control number reported in the 837 2300 CLM01. If the provider did not report a patient control number on the submitted claim, the medical record number reported in the 837 2300 REF will be returned here.

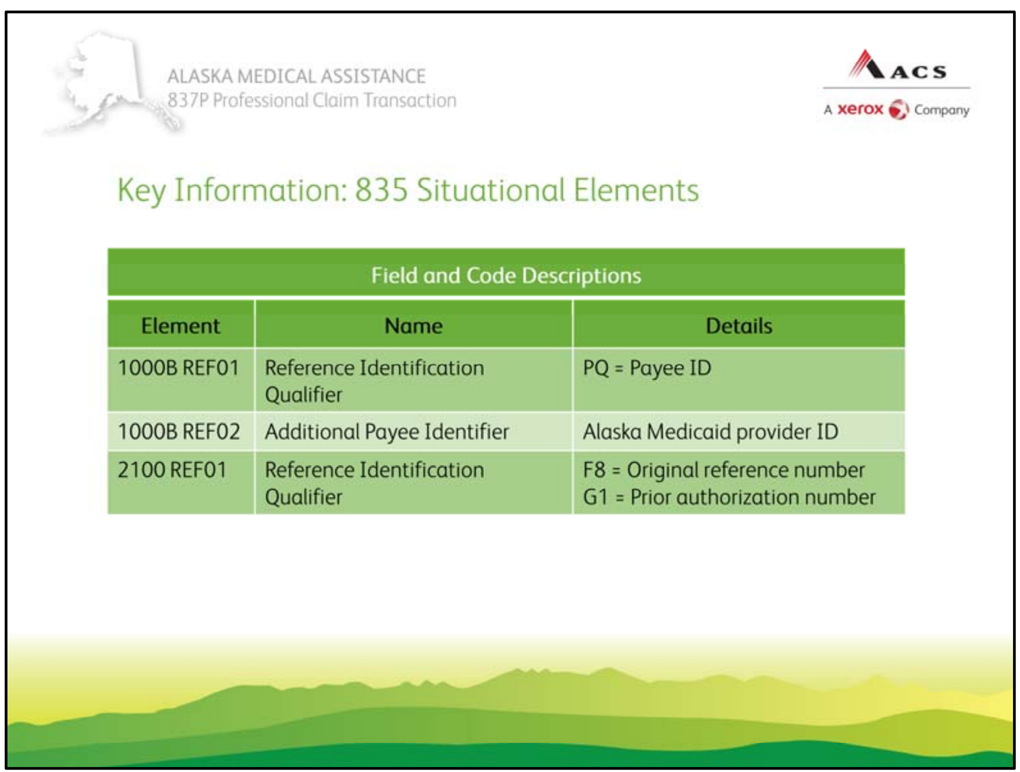
The CLP02 reports the hierarchy of Alaska Medical Assistance as a payer when other insurance is involved.



Field and Code Descriptions		
Element	Name	Details
2100 NM102	Entity Type Qualifier	1 = Person
2100 NM108	ID Code Qualifier	MR = Medicaid recipient ID
2100 NM109	Patient Identifiers	Alaska Medicaid recipient ID

The last required elements we will go over are in 2100 NM1. Here you get information about the patient. NM108 is a required element and when information is entered in NM108 then there must also be information in NM109. A code is always entered by us in NM108 and – according to ANSI – if information is entered in NM108, then there must also be information in NM109. The code MR in NM108 lets you know you will see the Alaska Medical Assistance recipient's ID in NM109.

Remember, everything in these last three charts are some of the things you can always expect to see in the new 5010 835.

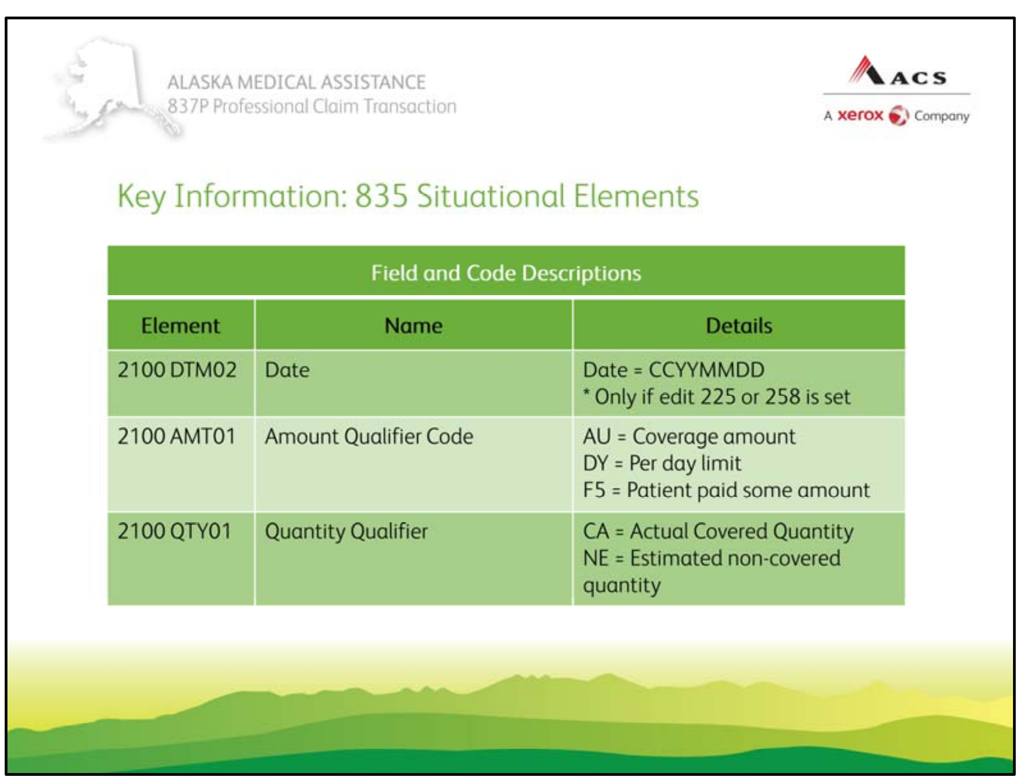


Field and Code Descriptions		
Element	Name	Details
1000B REF01	Reference Identification Qualifier	PQ = Payee ID
1000B REF02	Additional Payee Identifier	Alaska Medicaid provider ID
2100 REF01	Reference Identification Qualifier	F8 = Original reference number G1 = Prior authorization number

The information in the next four charts are situational which means that depending on a specific claim, you may find these elements included in your 835. If they are included, the details you see in the right column will apply.

In the PER Payer Technical Contact segment, technical support contact information is reported. If you see something in PER03, then there must be something in PER04. A TE in PER03 means that the contact's telephone number will be in PER04. Elements in 1000B REF provide additional identification about a payee. When this segment is used, Alaska Medical Assistance always returns a PQ in REF01. This code always means that you will see an Alaska Medical Assistance provider ID in REF02. This situation applies to atypical providers only.

The 2100 REF01 Reference Identification Qualifier segment is used to provide additional reference numbers used in the adjudication of the current claim. The F8 qualifier is issued with adjustments and voids to report the original CCN while the G1 qualifier reports the PA number submitted on the 837.

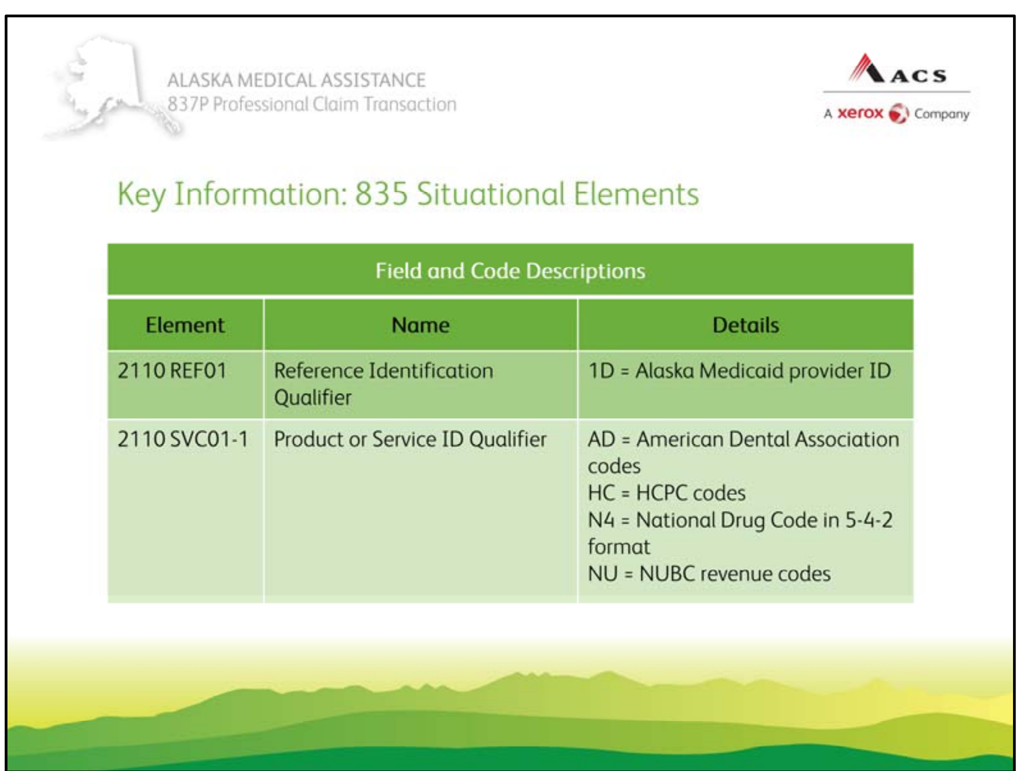


Field and Code Descriptions		
Element	Name	Details
2100 DTM02	Date	Date = CCYYMMDD * Only if edit 225 or 258 is set
2100 AMT01	Amount Qualifier Code	AU = Coverage amount DY = Per day limit F5 = Patient paid some amount
2100 QTY01	Quantity Qualifier	CA = Actual Covered Quantity NE = Estimated non-covered quantity

The whole 2100 DTM Coverage Expiration Date segment relates to dates and times and may or may not be sent. If it is sent, Alaska Medical Assistance will have information in DTM02. This particular field lets you know information about expired Medicaid coverage. A date here means that there is a 225 or 258 edit in a claim line. What is a 225 or 258 edit? The 225 edit appears if the recipient's date of death is prior to the date of service and a 258 edit appears if the recipient is not eligible for Medicaid on the dates of service.

Information in the 2100 AMT segment helps you review supplemental information about claims. If 2100 AMT applies to your claim, you may see one of three qualifier codes in AMT01. An AU refers to the coverage amount and will be followed by the sum of the original submitted provider charges that are considered for payment. You may also see a DY which means the following number is the per day limit. Finally, you may see an F5. If there is an F5, the patient has paid some amount, and that amount will follow the F5.

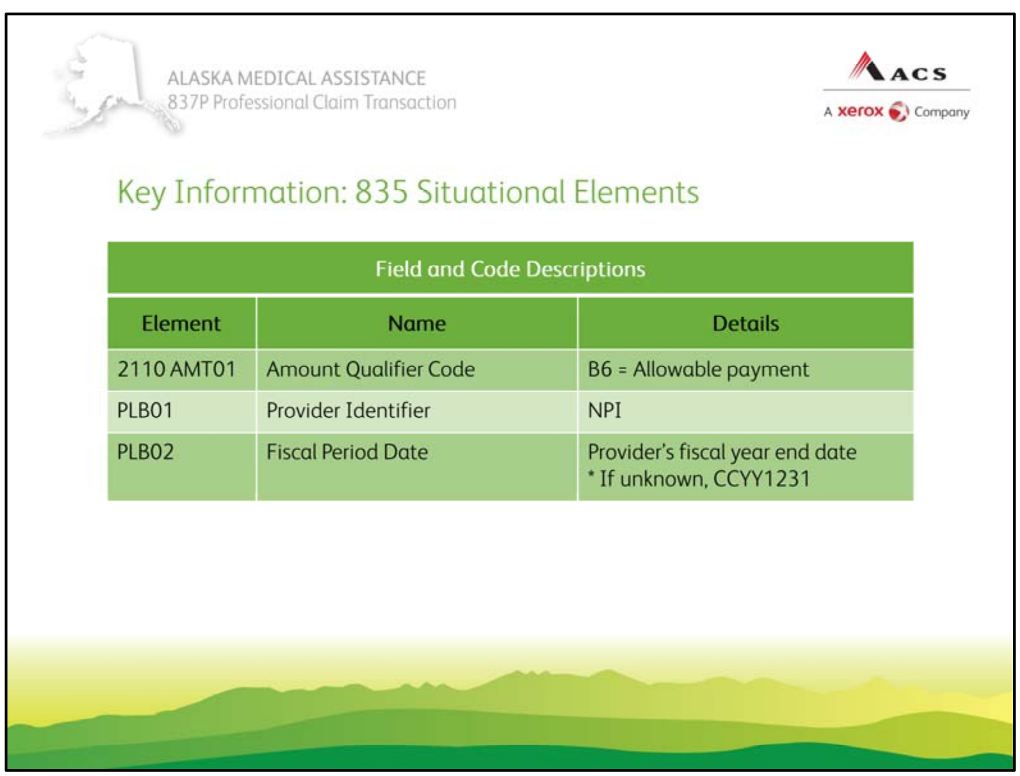
2100 QTY contains more supplemental claim information, particularly regarding quantity. Alaska Medical Assistance may return CA or NE on QTY01. CA means the actual covered quantity, and NE is the estimated non-covered quantity.



We're more than halfway through the 835 situational elements.

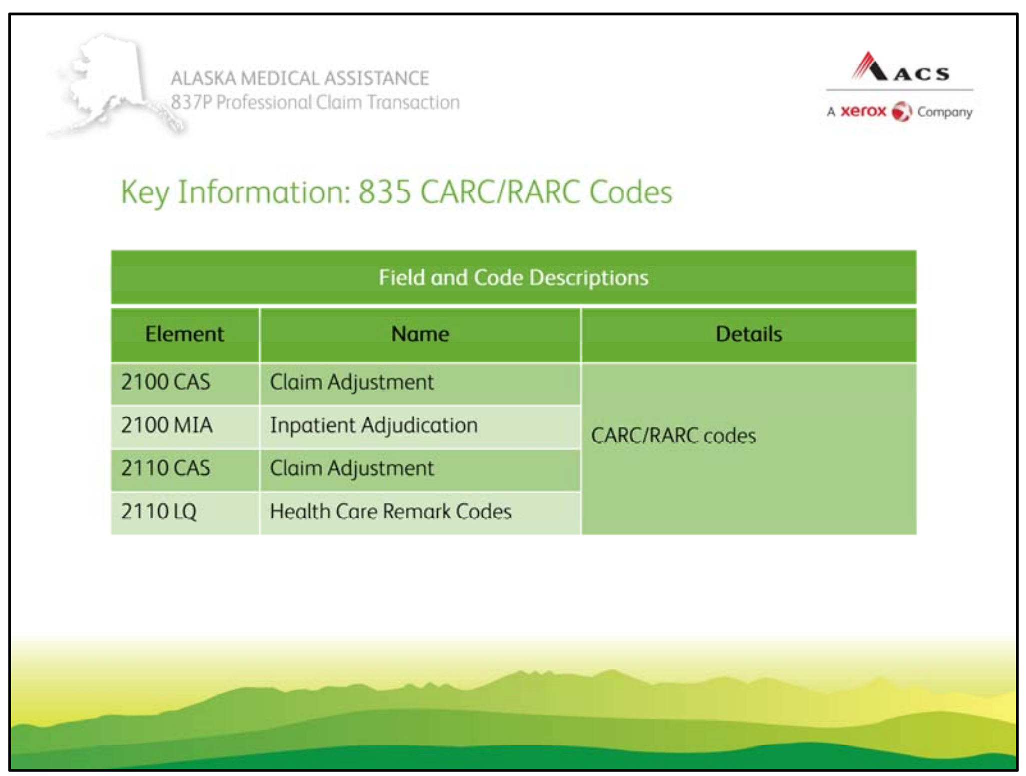
Alaska Medical Assistance returns the qualifier 1D in the REF01 in the 2110 REF Rendering Provider Identification segment for atypical providers. A provider's Alaska Medical Assistance identification number will then be found in the REF02. Elements in the 2110 SVC segment identify specific services and are required when these are needed for adjudication.

You will also get qualifiers about the product or service you provided. The qualifier you get depends on the type of transaction and the kind of information you provided.

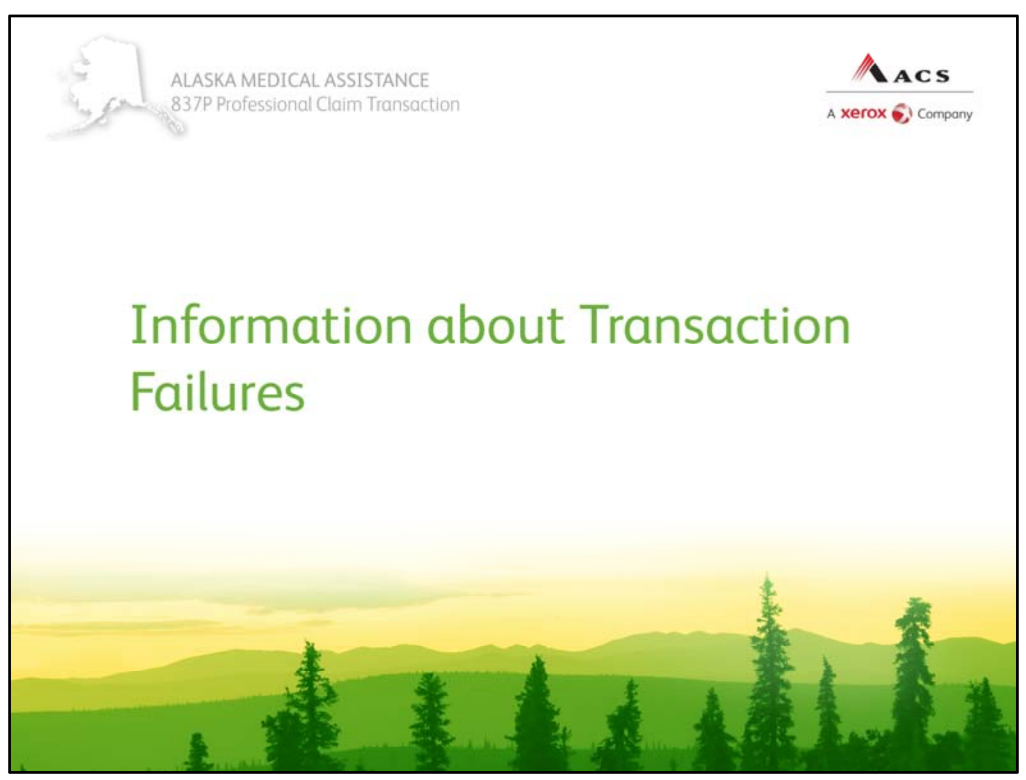


2110 AMT requires several elements when the value of any specific amount identified is non-zero. The amount qualifier code in AMT01 will be B6. B6 lets you know what payment is actually allowed by Alaska Medical Assistance.

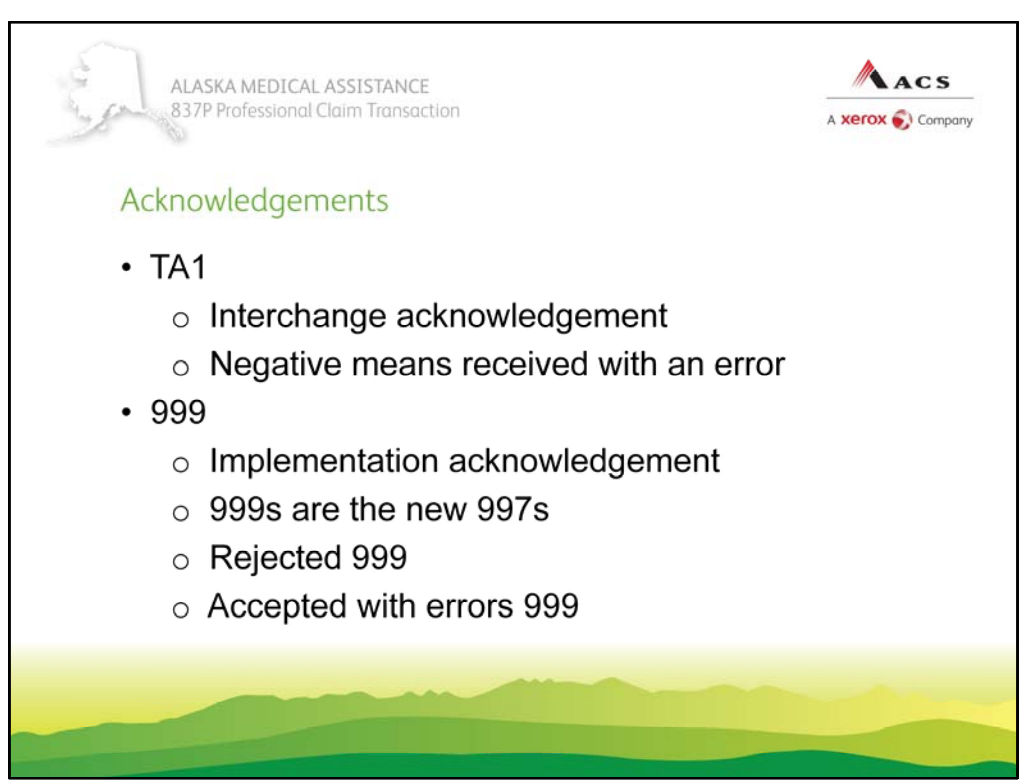
Finally, PLB elements deal with provider adjustments relating to debit or credit transactions that are not related to a particular claim or service. In PLB01, Alaska Medical Assistance returns an enrolled provider’s NPI. In PLB02, a day may be entered to show what we have on file as the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, December 31 of the current year is used.



The elements listed in this chart use the CARC/RARC codes. Details about these codes can be found in Section 4.4 of the Companion Guide.



[Title slide only.]



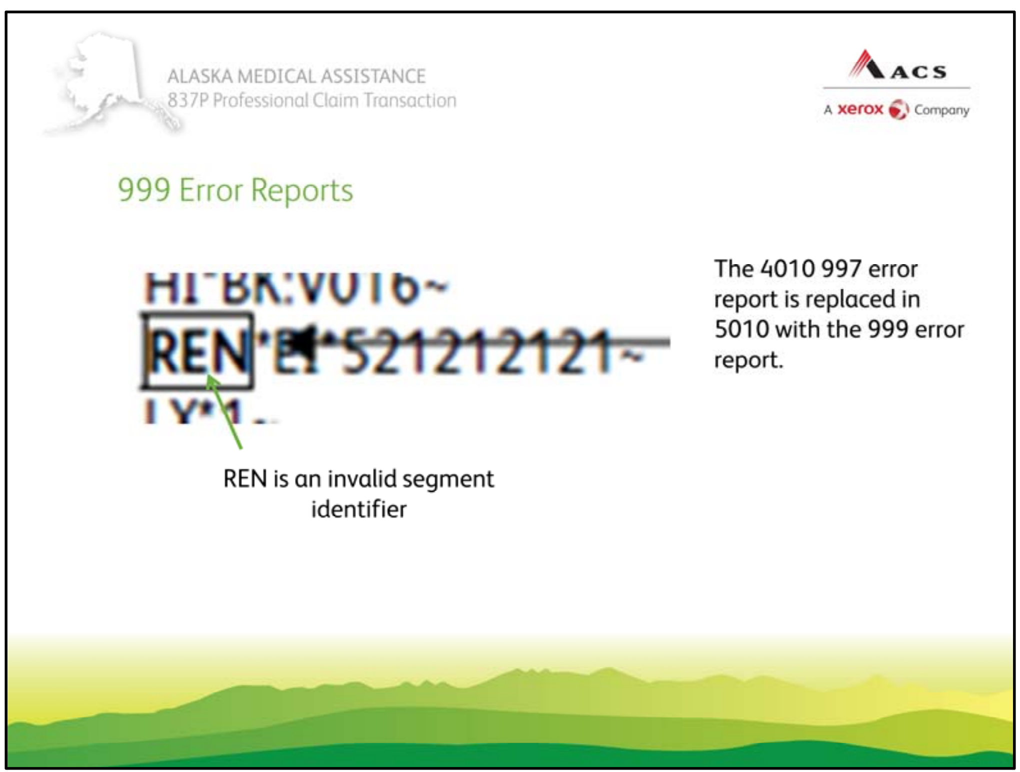
If your 837P transmission does not go through or has problems, you will be notified.

If there are problems with your submission, you will receive a TA1 or 999.

If your submission was successfully received you will get a 999.

These will detail accepted or rejected claims.

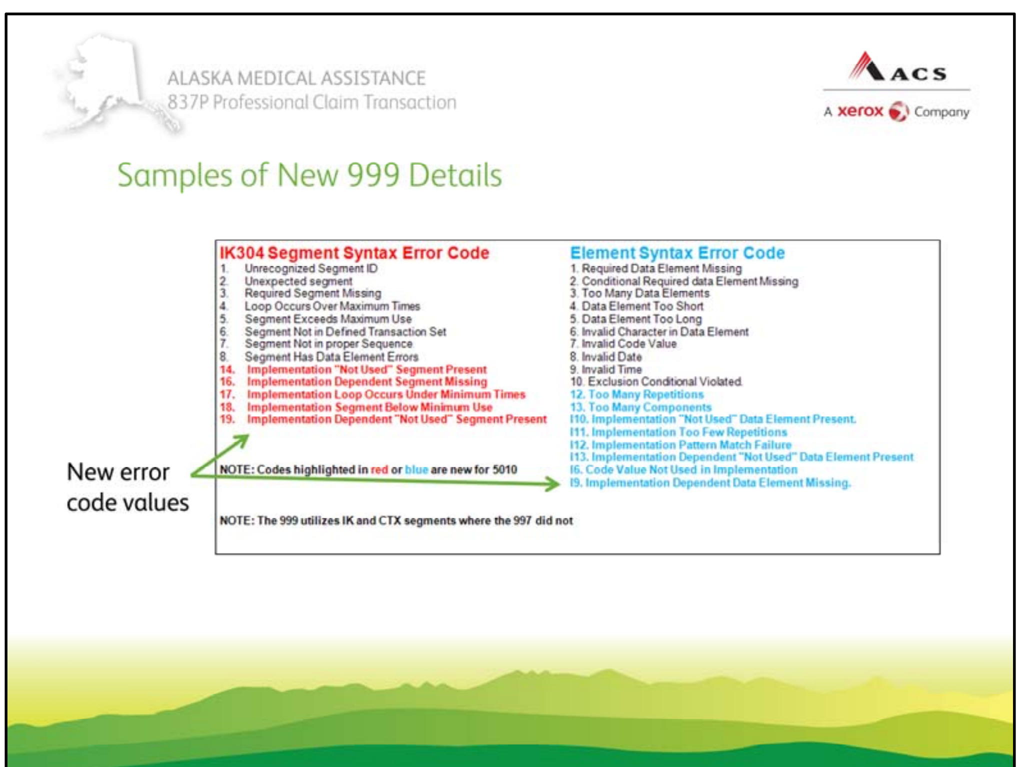
The 5010 999 error report replaced the 4010 997 error report.



999 error reports show up under your file rejection claims. Many times providers look at the reasons the claim was returned and not the codes. Looking at the reasons is fine. They give you a good understanding of what you need to do to fix the problem. However, if you want to dig a little deeper, you may want to look at the codes.

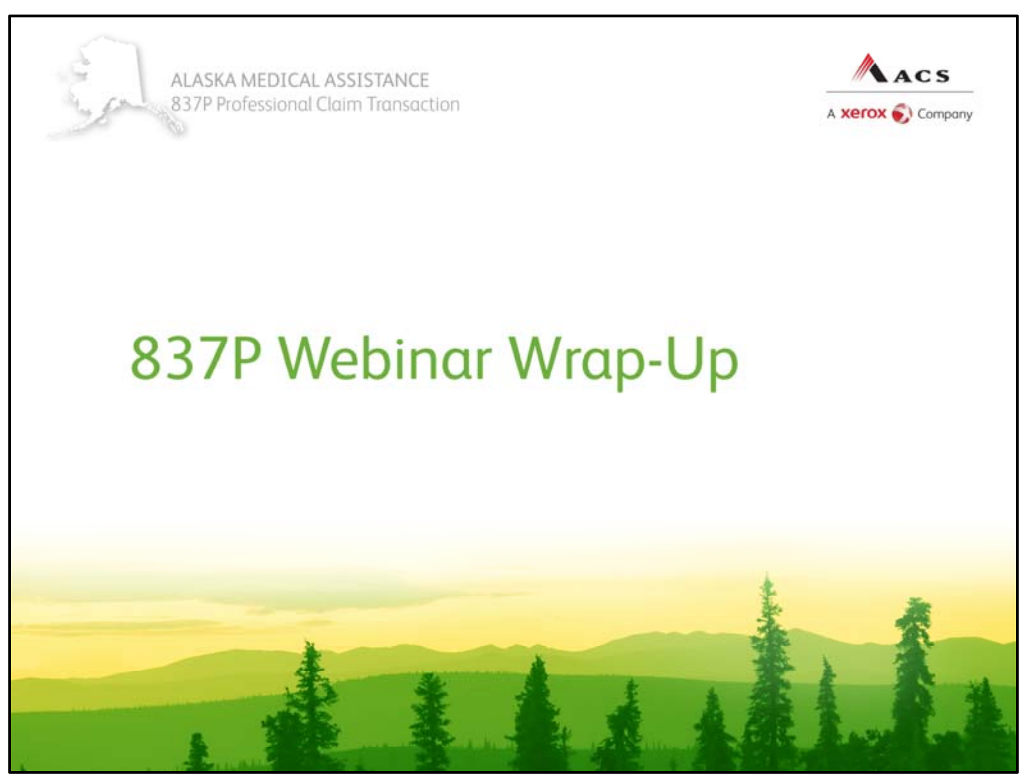
In a case where the header, submitter, receiver, provider, and subscriber loops are all valid, but an error occurs in a single claim, only the claim containing the error is rejected.

On the screen, you see an example of a claim-level error as it appears in the 999 error report. Notice that the boxed and bolded segment REN was submitted, but it is not a valid segment identifier. Perhaps, the trading partner meant REF? REN would be rejected, but everything above it would be passed on for processing.

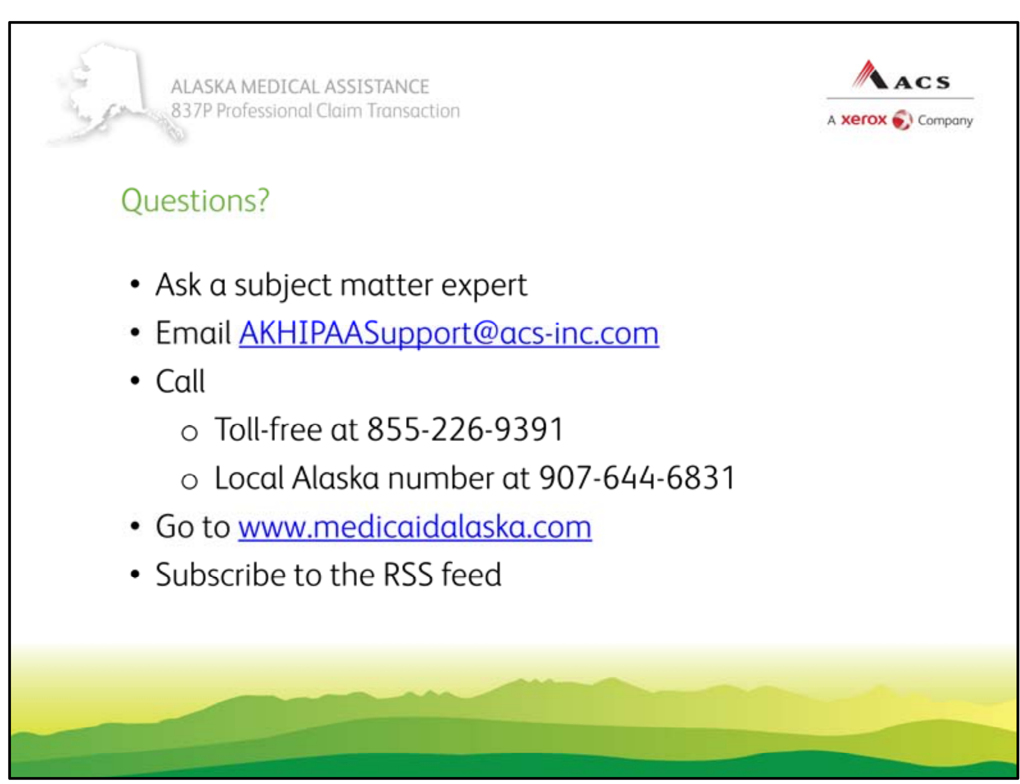


In the 999 error reports, you may notice some new codes. Note that there is additional information both at the segment and the element level. The segment syntax errors are in red in the image on the screen and the element syntax errors are in blue. The entire list of error codes can be found in the 999 TR3.

In the left column, you can see some of the IK304 segment syntax error codes. 1 - 8 are codes that were in 4010 error reports and may still apply to your claims in 5010. However, there are some new codes and you can see samples of those listed in red. Some of the new codes include 14 and 16 – 19. In the right column, you can see some of the element syntax error codes. Again, the codes in black are codes that you may already be familiar with. But the codes in blue, in this case 12, 13, I10 – I13, 16, and 19, are new.

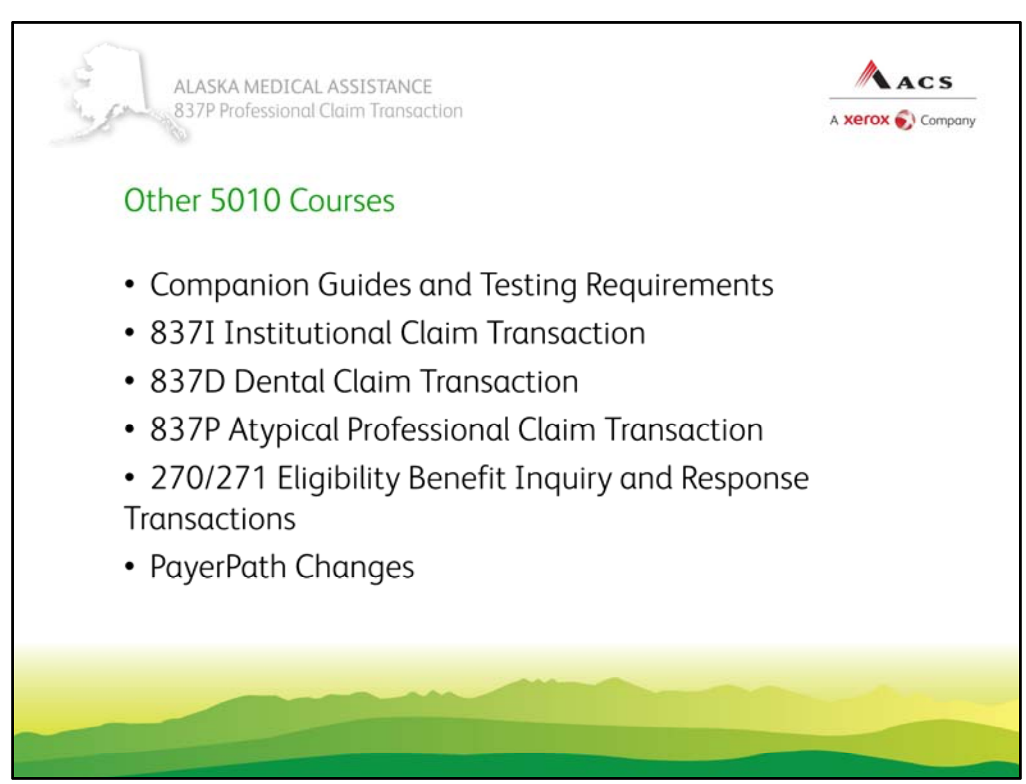


[Title slide only.]

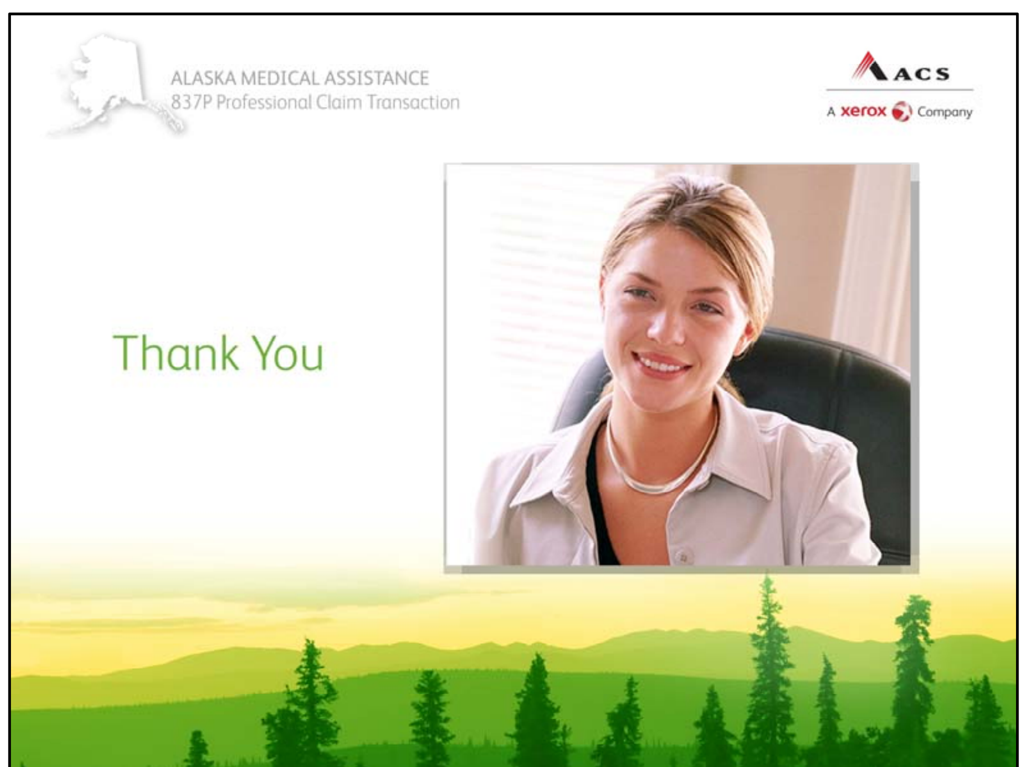


Now we'd like to give you an opportunity to ask any questions you might have about 5010. Remember, a subject matter expert is on this call to help answer your specific or technical questions. Does anybody have any questions?

[Wait for Q&A to conclude.] Be sure to write down the contact information on the screen so you know who to contact if you think of other questions about 5010. You can also subscribe to our RSS feed to get information sent automatically to you anytime something new is posted on our website.



As we've gone through the changes in the 837P, the 835, and the error reports and as we've taken your questions, you may have realized that you would like to learn more about 5010. If that is the case, we have several training opportunities available, and we encourage you to take advantage of them. You can register for these other webinars by going to our website at www.medicaidalaska.com. Like all Alaska Medical Assistance training presentations, the 5010 presentations will be posted to the website for provider reference to view at your convenience.



Thank you for your attendance to this webinar. And remember, if you'd like to review this webinar, you can. It will be published on the medicaidalaska.com website within the next few days. Have a great day.