



A **xerox**  Company



Direct Entry Midwife Services

ACS is now a Xerox company

Overview

- Enrollment Requirements
- Record Keeping/Request for Records
- Audits and Reviews
- Recipient Eligibility



Overview

- Covered/Non-covered Services
- Reimbursement
- ClaimCheck®



Alaska Medical Assistance Provider Enrollment

Providers must be enrolled in Alaska Medical Assistance to bill for reimbursement of covered health care services provided to eligible Medical Assistance recipients.



Direct Entry Midwife

- Individual

- Occupational license

- Certificate:

- Alaska Board of Certified Direct Entry Midwives (DEM)

- AS 08.65

- 7 AAC 105.200 (L) and 7 AAC 110.180



A **xerox**  Company

Free-Standing Birth Center

- Must be licensed under 7 AAC 12.610 and AS 47.32 before operating a facility
- Reimbursement to an enrolled, licensed midwife for a normal uncomplicated vaginal delivery



Independent Laboratory Provider

- Requirements
 - Clinical Laboratory Improvement Act (CLIA) Certificate of Registration or Certificate of Waiver.
 - Document from Centers for Medicare and Medicaid Services (CMS) identifying approval of their specialty codes (e.g., CMS-1557, "Clinical Laboratory Survey Report").



Clinical Laboratory Improvement Amendments

- All laboratory test sites, including health care provider, must have CLIA certification to legally perform laboratory services.
 - Certificate of Registration or
 - Certificate of Waiver
- Certificate must be submitted with enrollment application or to Provider Enrollment unit before lab tests are billed.
 - Division of Health Care Services, Health Facility Certification & Licensing (907) 334-2482



Records

- Record keeping requirements
 - Provider agreement
 - Provider type specific
- Record request regulations
 - Audits and reviews
 - Investigations



DEM Record-Keeping Requirements

12 AAC 14.540

- A certified, direct-entry midwife shall maintain records of each client on standard obstetric forms prescribed by the Board.
- A certified, direct-entry midwife shall maintain records of the recommended medical visit, all prenatal visits, the charting of labor and delivery, the summary of birth, and the charting of the newborn examination and postpartum visits.



DEM Record-Keeping Requirements

12 AAC 14.540

- A certified, direct-entry midwife shall maintain birth records of an infant until at least two years after the infant has reached the age of 19 years. Prenatal and infant records must be maintained for at least seven years from the date of the birth.
- A certified, direct-entry midwife shall provide copies of pertinent records to medical personnel when the client or infant is referred for medical care or transported for emergency care.



Recipient Eligibility

- Always verify recipient eligibility
- Eligibility period:
 - One month
 - Exceptions:
 - Denali KidCare
 - Eligibility code 53 Emergency services for some aliens
 - Dates covered will be listed on coupon
- Eligibility codes
 - Listed in section I in billing manual



Recipient Eligibility

- Before rendering service:
 - Request to see and photocopy the recipient's Medical Assistance coupon or card that shows the current month of eligibility
 - Call Eligibility Verification System (EVS): (800) 884-3223
 - Submit a Health Insurance Portability and Accountability Act (HIPAA) compliant, ANSI ASC X12 270/271, electronic transaction

You must have Practice Management Software that supports these transactions.

<http://medicaidalaska.com>

<http://www.wpc-edi.com>



Recipient Eligibility

- Before rendering service:
 - Fax to ACS Provider Inquiry (PI) unit
(907) 644-8126 or (907) 644-8127
 - Call ACS PI unit
(907) 644-6800 or (800) 770-5650 (Toll free in Alaska)



Direct Entry Midwives

- Direct entry midwife services are those services for the management of prenatal, intrapartum and postpartum care that direct entry midwives are licensed to provide in accordance with duties and responsibilities outlined in
 - 12 AAC 14.500 through 12 AAC 14.620.
- Care includes the management of low risk pregnant women whose labor, delivery, postpartum course, and infant care are not reasonably expected to require consultation with a physician or referral for medical care.



Obstetrical Care

- Routine global obstetrical care
 - May only be billed AFTER antepartum, delivery, and postpartum care have occurred
 - Procedure codes that can only be billed with third party liability (TPL):
 - 59400 global vaginal delivery
 - 59510 global cesarean delivery



Obstetrical Care

- Non-global obstetrical care
 - Antepartum care
 - Appropriate evaluation/management (E/M) codes
 - Delivery & postpartum care
 - 59410 vaginal
 - Delivery only
 - 59409 vaginal



Obstetrical Care

- Non-global obstetrical care
 - Postpartum care only (59430)
 - All inclusive code for all office visits following delivery
 - Billable only **once**, regardless of how many times the provider sees the patient during the postpartum period
 - A certified, direct-entry midwife shall maintain close contact with the client during the first 72 hours postpartum, making at least one postpartum visit to evaluate the condition of the mother and infant within 36 hours of birth. 12 AAC 14.520(e).



Obstetrical Care

- Home visits (99341-99343 and 99347-99349)
 - Codes to report evaluation and management services provided in a private residence
 - Must be medically necessary and documented accordingly
 - Should not be billed in conjunction with newborn care



Infant Care

- In accordance with 12 AAC 14.530
 - Within two hours of birth, administer appropriate eye prophylaxis
 - Offer to administer vitamin K
 - If parent consents, administer within 2 hours of birth
Note the parent's acceptance or refusal in the client's record
 - **Ensure the newborn receives blood screening for metabolic disorders**

Infant Care

- In accordance with 12 AAC 14.530
 - Newborn hearing screening should be administered before discharge or arranged for in the community to ensure screening is completed prior to one month of age.
 - Recommend to the client an evaluation of the infant by a physician within one week or sooner if it becomes apparent that the infant needs medical attention.



Laboratory Services

- As required by 12 AAC 14
 - Ordered or performed by appropriately licensed professionals
 - Covered services include professional and technical components of laboratory procedures



Medications

- A certified direct entry midwife may NOT administer restricted drugs or medications:
 - Except for those listed in 12 AAC 14.570 **and**
 - Only if the certified, direct entry midwife has documented the training and skills demonstrating competence to administer them as required in 12 AAC 14.560.



Free-Standing Birth Center

- Billed charges for a free-standing birth center for a normal, uncomplicated vaginal delivery include:
 - Charges for the midwife services
 - Birth center use
 - Nursing and facility support staff
 - Medication and supplies



Free-Standing Birth Center

- Billing requirements
 - Provider must be licensed and enrolled as a nurse midwife, direct entry midwife, or advanced nurse practitioner
 - Procedure code 59409 only with modifier U5



Free-Standing Birth Center

- Billing requirements
 - Place of service code 25 in the unshaded area of field 24B
 - Billed charges must include the birthing center fee **and** provider fee on **one** claim line
 - Maximum allowable \$2,389.75
 - Includes \$1,052.48 for procedure code 59409
 - Enter the name of the birthing center in field 32



Free-Standing Birth Center

- Augmented rate limitations
 - Vaginal deliveries with postpartum care (59410)
 - Home deliveries



Free-Standing Birth Center

- In accordance with 7 AAC 43.944(a)(2)
 - Portion of payment rate for Medicaid services is \$1,337.27.
- Link to the PDF version of the regulations
 - <http://www.hss.state.ak.us/publicnotice/PDF/198.pdf>



Non-Covered Services

- Direct entry midwives in training or in apprentice programs do not qualify for reimbursement.
- Routine office medical supplies are not reimbursed separately.
 - Exception for non-routine supplies and surgical supplies.
- Direct entry midwife services are not reimbursable for CAMA recipients (eligibility code 21).



Pricing Methodology

- Professional services of direct entry midwives are reimbursed at the lesser of billed charges or at 85% of the Resource Based Relative Value Scale (RBRVS) fee schedule.

- RBRVS methodology:

$$[(RVU_w \times GPCO_w) + (RVU_p \times GPCIp) + (RVU_m \times GPCIm)] \times 49.90$$

- Current fee schedules are located on our website.

<http://medicaidalaska.com>



Unlisted Codes

- If unlisted code is billed, reimbursement will be 50% of billed charges, if approved.
- Written explanation for the use of the unlisted code must be attached to claim submission.



Independent Laboratory Services Reimbursement

- All laboratory services reimbursed at lesser of billed charges or the Medicare established fee schedule.
- Current Procedural Terminology (CPT) modifiers
 - Modifier -TC – Technical component
 - Modifier -26 – Professional component
 - Unmodified – Global service



Claim Billing Options

- 837P electronic transaction
 - Must have Provider Information Submission Agreement (PISA) and Billing Agent Information Submission Agreement (BAISA), if applicable, on file
 - Must have software that supports electronic transactions
 - Refer to the Implementation Guides (IG) at <http://www.wpc-edi.com>
 - Refer to Companion Guide for Alaska Medical Assistance specific information at <http://medicaidalaska.com>
 - Must have successfully tested for the 837 transaction
- Professional claim form



Claim Billing Options

- Providers may bill electronically using PayerPath[®] or their own practice management software.
 - PayerPath[®] claims are submitted via the internet.
 - Free, internet-based, claims submission system
 - Immediate claims editing
 - Correction prior to submission
 - Patient re-bill demographics
 - Export files from practice management systems to PayerPath[®], eliminating the need of “double entry”





Electronic Claims Attachments for HIPAA Covered Entities

- Paperwork (PWK) segment supplemental claim information
 - PWK 01 Report type codes
 - PWK 02 Report transmission code
 - FX - by fax is only acceptable mode
 - PWK 05 Identification code qualifier
 - AC - Attachment control number
 - PWK 06 Identification code
 - Attachment control number generated by provider/submitter



Attachment Fax Cover Sheet


A  Company

ACS is now a Xerox company

ATTACHMENT FAX COVER SHEET
P.O. Box 240808 • ANCHORAGE, ALASKA 99524-0808
TELEPHONE: (907) 644-6800 or (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 (Professional) 837I (Institutional) 837D (Dental)

Transportation/Accommodation or Other Noncovered Entity
(Include the recipient ID number on each page faxed)



Unique Attachment Control Number(s):

Note: 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. 05/10


A  Company

Claim Billing Options

- Professional paper claim forms
 - Instructions are on the ACS website.
<http://medicaidalaska.com>
 - Complete all required fields and other fields as applicable.
 - Do not fold or crease claims.
 - Fill in handwritten claims neatly and accurately.



Claim Billing Options

- Professional paper claim forms
 - Keep names, numbers, and codes within the designated boxes and lines.
 - Make corrections carefully. Correction fluid or tape may be used as long as the corrected information is readable.
 - Include a return address on all claims and envelopes.



Claim Billing Options

- Professional paper claim forms
 - Use appropriate, current coding (procedure, diagnosis).
 - Include attachments as required:
Explanation of Benefits (EOB), medical justification, proof of timely filing documentation, etc.



Deficit Reduction Act of 2005

- Alaska Medicaid program requirements to comply with the Deficit Reduction Act (DRA) Drug Rebate rule began April 1, 2008.
- Both HCPC and NDC code information will be required for **specific** drugs administered in office and outpatient settings.
- Alaska Medicaid has published a list of HCPC codes that will be edited for NDC information.
 - <http://medicaidalaska.com>



Drugs Administered in the Office or Outpatient Setting

- Before April 1, 2008
 - Identified on 837P and CMS-1500 claims by HCPCS codes
Usually "J" codes
 - Identified on 837I and UB-04 claims by revenue codes



National Drug Codes

- Alaska Medicaid will pay claims submitted for these drugs only if the manufacturer participates in the Drug Rebate Program.
- Rebateable drug list is available on the CMS website.
 - http://cms.hhs.gov/MedicaidDrugRebateProgram/09_DrugProdData.asp



National Drug Codes

- Affected provider types
 - Physicians and physician groups
 - Podiatrists and podiatry groups
 - Nurse practitioners and nurse midwives
 - Outpatient hospitals
 - Family planning clinics



National Drug Codes: Pricing

- Payment for physician administered drugs will be based on NDC code and NDC quantity.
- Exception:
 - Payments currently based on per diem rates or a percentage of your charges



National Drug Codes: Claims Data

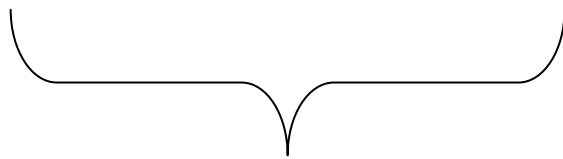
- Include on your claims:
 - NDC number
 - NDC units of measurement
 - Numeric quantity
 - Corresponding HCPCS values and units



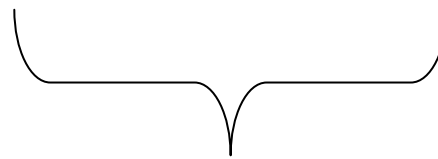
National Drug Codes

NDC consists of 11 digits in three sections

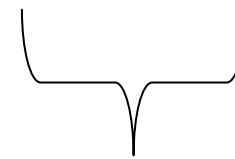
XXXXXX-XXXX-XX



Manufacturer



Product



Package Size



A **xerox** Company

National Drug Codes

Example:

- Product label indicates: 54225-1798-29
- Submit on claim as: 54225179829

- Product label indicates: 452-72-89
- Submit on claim as: 00452007289

- Product label indicates: 45-6-9
- How would you submit this on a claim?





National Drug Codes

The correct answer is 00045000609



National Drug Codes

- Unit of measurement qualifiers
 - NDC billing unit standard
 - UN = Unit
 - ML = Milliliter
 - GR = Gram
 - F2 = International unit

National Drug Code Reporting Electronic Claims

- 837P
 - Loop 2410:
 - Field CTP04 – Enter quantity
 - Field CTP05 – Enter unit of measure
 - Example: CTP****2*UN~
 - Field LIN02 – Enter qualifier N4
 - Field LIN03 – Enter NDC without hyphens
 - Example: LIN**N4*1234567891~
 - HCPCS information will continue to be entered in Loop 2400, Field SV1.



National Drug Code: Completing the Professional Claim Form

- Professional claim forms

- Enter NDC information in the **shaded area** of field 24.

Enter the qualifier N4 immediately followed by the 11-digit NDC code without hyphens in field 24a.

Enter the NDC unit of measure followed by a total quantity field of 9 characters (99999.999) in the shaded area of field 24d.

NDC Code:

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. S CHARGES	G. DAYS OR UNITS	H. EPSON Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER								
N400026064871							UN99999.999						N	1B	12345678901	
10	01	05	10	01	05	11	J1563			13	500.00	20	N	NPI	0123456789	



A xerox Company

National Drug Codes

- Bill the NDC for the actual drug that is administered
- Record the NDC into the patient record



National Drug Codes

- Questions...
 - Provider Inquiry
(800) 770-5650 (Toll free in Alaska), option 1; 1
or
(907) 644-6400, option 1



Federal TPL Waiver

- Alaska Medical Assistance has been granted a Federal TPL Waiver for the following service categories. Therefore, these providers are not required to bill TPL resources:
 - Early periodic screening, diagnosis, & treatment (EPSDT) services
 - Prenatal care services
 - Preventive pediatric services
 - Eye wear (lenses/frames)



Federal TPL Waiver

- Medical Assistance will reimburse up to their “allowed amount” and then seek reimbursement from the TPL resource.
 - Pay and chase
- In some instances, the provider may wish to bill the TPL resource anyway:
 - If the service is covered by the TPL resource
 - If the TPL resource payment exceeds expected Medical Assistance reimbursement



Edits

- All edits are three-digit codes (automated or manual review) with explanations of how the claim was processed.
 - Reduction in payment
 - Denial of service
 - In-process claims awaiting further internal review pending status
 - RTD – additional information requested from the provider



Edits

- The Remittance Advice (RA) includes an Explanation of Benefits (EOB) description page that lists all EOB codes and a brief description of each found within that specific RA.
- Contact ACS Provider Inquiry for clarification as necessary.



ClaimCheck® Editing

- ClaimCheck® is software integrated into the Medicaid Management Information System (MMIS).
 - Includes automatic review of relationship between certain codes
 - Based on billing guidelines found in the CPT manual
- If claims are affected by the software evaluations, a special report will be attached to your RA.
 - ClaimCheck® audit report



ClaimCheck[®] Editing

- Software follows CPT guidelines of the American Medical Association and health care industry standards. When procedures or services are identified during claims processing that exceed clinical or coding guidelines, ClaimCheck[®] will automatically replace or deny the claim.
- Described in affected provider billing manuals.



ClaimCheck[®] Editing

- Types of ClaimCheck[®] editing
 - Visit edits
 - Incidental and mutually exclusive
 - Unbundled/rebundled
 - Preoperative and postoperative editing



ClaimCheck[®] Editing

- Examples of CPT guidelines
 - E/M codes for patients billed on same date of service (DOS) with certain procedures are not reimbursed. The cost of the E/M service is included in the cost of the procedure performed.
Edit 435 – Medical Visit Procedure Billed with Primary Procedure
 - If more than one E/M procedure is billed for same date of service by the same provider, only one will be paid.
Edit 436 – Procedure Rendered More Than One Time on Same Date



ClaimCheck[®] Editing

- Edit 434 – Procedure is Incidental to Primary Procedure
 - Carried out at the same time as a primary procedure, but is clinically integral to the performance of the primary procedure and, therefore, should not be submitted separately
 - Incidental procedure example:
81002, urinalysis, is incidental to 99212, office visit.



ClaimCheck[®] Editing

- Edit 437 - Procedure is Mutually Exclusive to Another Procedure
 - Procedure that by normal practice standards would not be performed on a patient on the same day, therefore, one of the procedures on the claim will not be allowed
 - Mutually exclusive procedure example:
99203, office visit, is mutually exclusive to 99341, home visit.



ClaimCheck® Editing

- Automated voids
 - Paid claims will be compared to claims being processed based on same provider, same recipient, and same date of service. When an invalid relationship is found, an automated void of the previously paid claim may occur or the current claim may deny.
 - The automated, void-associated EOB will appear on the “voided claims” page of the RA. If the total dollar amount of the automated voids exceeds the amount of your paid claims/adjustments, an accounts receivable will be set up. This balance will be collected on future RAs.



ClaimCheck[®] Editing

- ClaimCheck[®] upgraded January 16, 2009
 - New edits
 - Units expansion
 - Review of same services billed by multiple providers
 - Invalid procedure code/modifier combinations



ClaimCheck[®] Editing

- Procedures billed with more than one unit:
 - Edit 464 Line Added for Multiple Unit Procedures
ClaimCheck[®] adds line(s) to determine number of units to reimburse.
 - Edit 474 Multiple Unit Procedures on Single Date of Service
Original claim line is denied.
 - Edit 475 Adjustment Not Allowed on Lines with EOB 464
Adjustments are not allowed for claims with EOB 464.



ClaimCheck[®] Editing

- Procedures billed with modifier -26 or –TC:
 - Edit 466 Multiple Component Billing
Procedure with modifier has paid and same procedure without modifier is received for same recipient and date of service
 - Edit 468 Duplicate Component Billing
Procedure with modifier has been received from two different providers



ClaimCheck[®] Editing

- Other modifiers:
 - Edit 471 Invalid Procedure Code and Modifier Combination
Modifier billed is not valid for the procedure code.



ClaimCheck[®] Editing

- Audit report status code definitions:
 - BCD Bilateral Code, Duplicates Denied
Added to Edit 436
 - DCB Evaluate for Possible Duplicate Component Billing
 - IOS Intensity of Service
 - MAL Can Only be Done X Times in a Person's Lifetime,
Duplicated Denied:
Added to Edit 436



ClaimCheck[®] Editing

- Audit report status code definitions
 - MCB Evaluate for Possible Multiple Component Billing
 - MDO Can Only be Done X Times on a Single Date,
Duplicates Denied
Added to Edit 436
 - MPR Payment Reduced Due to Multiple Procedure Reduction
Added to Edit 972
 - SPL Has Been Denied Due to Multiple Results



ClaimCheck[®] Editing

- Audit report status code definitions
 - UBD Includes Unilateral or Bilateral Performance, Duplicates Denied
Added to Edit 436
 - UDO Modifier Not Appropriate for Procedure
 - UXP Line Added Due to Units Expansion



Common Edits

- Edit 200 Provider Not on File
- Edit 192 Billing Provider NPI not Matched – Multiple Medicaid Identifiers
- Edit 615 Provider License Not Valid on Date of Service
- Edit 355 Attachment Indicator Review Check



Common Edits

- Edit 434 Procedure is Incidental to Primary Procedure
- Edit 500 Document Pend
- Edit 492 NDC Missing/Invalid
- Edit 436 Procedure Rendered More than One Time on Same Date

Common Edits

- Edit 022 Line Billed Charges Missing or Invalid
- Edit 834 Duplicate of Previously Paid Claim



Where To Get Help

Billing/Coverage/Claim Status Questions:

- Provider manual
<http://medicaidalaska.com>
- Provider Inquiry (907) 644-6800, option 1 or (800) 770-5650 (Toll free in Alaska), option 1, 1.

Eligibility Verification:

- EVS system (800) 884-3223 (Toll free in Alaska).
- Provider Inquiry (907) 644-6800, option 1 or (800) 770-5650 (Toll free in Alaska), option 1, 1.
- Recipient Card/Coupon.



Where To Get Help

Electronic Commerce Customer Support/Payerpath:

- ECCS Department ACS (907) 644-6800 # 3 or (800) 770-5650 (Toll free in Alaska) option 1, 4
- Provider Inquiry (907) 644-6800 # 1 or (800) 770-5650 (Toll free in Alaska) option 1, 1

Enrollment Questions:

- Enrollment Department ACS (907) 644-6800 option 2 or (800) 770-5650 (Toll free in Alaska), option 1, 3



Contact Information

Provider Training
Affiliated Computer Services
1835 S. Bragaw St., Suite 200
Anchorage, Alaska 99508

(907) 644-6400

(907) 644-9845 fax

<http://medicaidalaska.com>



Preparing for HIPAA 5010

- Centers for Medicare and Medicaid Services (CMS) Standard
- 5010 Implementation January 1, 2012
- Regulate Electronic Transmission of Healthcare Transactions
- 5010 Transactions Testing



Preparing for ICD-10

- Center for Medicare and Medicaid Services (CMS) Mandate
- Two components
 - ICD-10-CM Diagnosis Codes
 - ICD-10-PCS Institutional Procedure Codes
- Service Date Driven
 - Outpatient Claims
 - Inpatient Claims
- Prepare Now



Resources

- CMS ICD-10 Website
- <http://www.cms.gov/ICD10/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
- <http://medicaidalaska.com>



Resources

- CMS 5010 D.0 Websites
 - <http://www.cms.gov/Versions5010andD0/>
 - <http://www.cms.gov/MFFS5010D0/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
 - <http://medicaidalaska.com>