

ALASKA MEDICAL ASSISTANCE PROGRAM



PROVIDER ENROLLMENT FORM

I. Provider Agreement, continued THIS IS TO CERTIFY THAT THIS PROVIDER AGREES:

3. To comply with policies and procedures in the applicable Alaska Medical Assistance Program Provider Billing Manual(s).

To not bill or require a prepayment by recipients presenting proper identification of eligibility for Medicaid/Denali KidCare and to accept as payment in full the amounts paid in accordance with Alaska statutes, regulations, policy, and program rules; and make no additional charge to the recipient, any member of his or her family, or any other source for supplementation. This provision does not apply for any service or item not covered by Alaska's Medical Assistance programs. For long-term care services under Medicaid/Denali KidCare, the recipient may be assigned a liability for payment of a portion of the cost of care furnished by the facility. For other services requiring recipient cost sharing, the provider shall collect from the recipient the amount of cost sharing in compliance with the provisions of 7 AAC 43.025, 7 AAC 43.052, and 7 AAC 47.220.

If I accept Chronic and Acute Medical Assistance (CAMA) recipients, I agree to not bill or require a prepayment by recipients presenting proper identification of eligibility for CAMA and to accept as payment in full the amounts paid in accordance with Alaska statutes, regulations, policy, and program rules; and make no additional charge to the recipient, any member of his or her family, or any other source for supplementation. This provision does not apply for any service or item not covered by the CAMA program. For other services requiring recipient cost sharing, the provider shall collect from the recipient the amount of cost sharing in compliance with the provisions of 7 AAC 43.025, 7 AAC 43.052, and 7 AAC 47.220.

To bill any third-party resource, in accordance with state and federal rules, regulations, policies, and procedures. Third-party-resources include, but are not limited to, the following categories:

- Private hospital and medical insurance (to include prepaid health plans);
- Disability compensation insurance;
- Worker's compensation (industrial accident);
- CHAMPUS;
- Veterans Administration (VA) benefits;
- Medicare;
- Railroad retirement;
- Estates or probate of deceased Medical Assistance recipients or responsible persons;
- Absent parents (Child Support Enforcement IV-D Program);
- Liable individuals or entities;
- Accidental injury insurance;
- School injury insurance; and
- Other applicable payers.

That the fees or charges for services or items furnished to recipients of Alaska's Medical Assistance programs will not exceed the fees or charges for comparable services or items furnished to individuals not covered under Alaska's Medical Assistance programs. A provider must bill Alaska Medical Assistance the provider's lowest charge (except for Medicare) 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. The provider's lowest charge does not include: (A) any single contract that contains a discounted rate for a service or group of services and the contract does not exceed 20 percent of a provider's annual gross income; (B) a reduced rate for a service or group of services the provider offers to the provider's employees as part of an employee benefit package; or (C) a contract with a federal or state government agency. 7 AAC 43.040.

*Note: If a provider establishes in writing a sliding fee scale based upon income for families and individuals with income equal to or less than 250 percent of the federal poverty level for Alaska, Alaska Medical Assistance will not consider those fees in determining the provider's lowest charge per service.

As the provider or authorized representative, I have received and read this page. _____ / _____
Initials / Date

**ALASKA MEDICAL ASSISTANCE
PROGRAM**



PROVIDER ENROLLMENT FORM

J. Original Signature Required (No photocopies or facsimile signatures will be accepted.)

I understand that I am fully responsible for all health care services provided by myself, my employees and contractors. I further certify that the qualifications and credentials of persons providing and billing for health care services through my practice/business are appropriate and in accordance with Occupational Licensing, Medical Assistance regulations, statutes, and program rules.

I certify that this practice/business is in compliance with all federal and state laws, policies, and rules, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Agreement will be effective from the date finally executed until the date the Agreement is terminated by either party. Either party may terminate the Agreement by providing the other party with 30 days advanced notice of intent to terminate. The Alaska Department of Health and Social Services may immediately terminate the Agreement for cause if the individual provider or the group/entity is excluded from the Medicare or Medicaid programs for any reason, loses its license or certificate, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. The Alaska Department of Health and Social Services may terminate this Agreement without notice if the individual provider or group/entity has not submitted a claim to the Alaska Medical Assistance Program for 18 months.

I attest that I am a citizen or national of the United States, an alien lawfully admitted for permanent residence, or an alien authorized by the Immigration and Naturalization Service to work in the United States. By my signature below, I certify that the information contained in this application and its attachments is true, accurate, and complete, and that I understand and agree to the Provider Agreement.

GROUP/ENTITY PROVIDERS ONLY: *I certify that I have authority to enter into contracts and agreements on behalf of the group or entity requesting enrollment with the Alaska Medical Assistance Program.*

Signature of Provider* or Authorized Representative**
(please use blue ink)

Date

Printed or Typed Name of Person Signing this Agreement

Title

Return to: *Affiliated Computer Services, Inc.
Provider Enrollment Unit
P.O. Box 240808
Anchorage, Alaska 99524-0808*

Telephone Number:
*(907) 644-6800
In-state Toll Free Number (800) 770-5650*

***** *Individuals and sole proprietors must sign the enrollment agreement form.*

*******An authorized representative is the duly appointed official of any business organized under the laws of the state of Alaska or other state, to operate as a corporation, partnership, LLC, joint venture, or similar organization ("entity"), who has the legal authority to enroll the entity in the Alaska Medical Assistance program, to make changes and/or updates to the enrollment status of the entity, and to commit the entity to the terms and conditions set forth in this enrollment application. The authorized representative must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, or direct owner of at least 5% or more of the entity seeking enrollment, or must hold a position of similar status.*

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Evaluation and Management Coding Guidelines (A)

New Patient Office visits (99201-99205) Require 3 out of 3

Office Consultations (99241-99255) Require 3 out of 3 - Consults require documentation of the request indicating the need for the referral; the consulting physician must render & document a sufficient service to meet the code used and a written report must be available to the requesting provider.

	99201/99241	99202-99242	99203/99243	99204/99244	99205/99245
History (HX)	Problem focused (Chief Complaint (CC), brief Hx)	Expanded Problem Focused (CC, brief Hx, problem focused review of Systems (ROS))	Detailed (CC, extensive (ext.) Hx, ext. ROS, past Hx (PH), Social Hx (SH), Family Hx (FH))	Comprehensive (CC, ext. Hx, comp. ROS, comprehensive PH, FH, SH)	Comprehensive (CC, ext. Hx, comprehensive ROS, comp PH, FH, SH)
Physical	Problem focused exam of affected area	Expanded problem focused (exam of affected area and other related systems)	Detailed (extensive exam of affected body and other related systems)	Comprehensive (complete single system or multi-system exam)	Comprehensive (complete single system or multi-system exam)
Medical Decision Making	Straightforward Diagnoses (DX)=1 Data=0-1 Risk=minimal	Straightforward Dx=1 Data=0-1 Risk=minimal	Low Complexity Dx=2 Data=2 Risk=low	Moderate complexity Dx=3 Data=3 Risk=moderate	High complexity Dx=>4 Data=>4 Risk=high

Established Patient Office Visits (99211-99215) Require 2 out of 3

	99211	99212	99213	99214	99215
History	Physician is not required	Problem focused (CC, brief Hx)	Expanded problem focused (CC, brief Hx, problem ROS)	Detailed (CC, ext. Hx, ext. ROS, pertinent PH, FH, SH)	Comprehensive (CC, ext. Hx, comp. ROS, comp PH, FH, SH)
Physical	Physician is not required	Problem focused (exam of affected area)	Expanded problem focused (exam of affected area and other related systems)	Detailed (ext. exam of affected body and other related systems)	Comprehensive (complete single system or multi-system exam)
Medical Decision Making	Physician is not required	Straightforward Dx=1 Data=0-1 Risk=minimal	Low Complexity Dx=2 Data=2 Risk=low	Moderate complexity Dx=3 Data=3 Risk=moderate	High Complexity Dx=>4 Data=>4 Risk=high

Assessments - Require 3 out of 3



Presented below are the “key components” of review with delineation in the various categories for each component. The criteria for the selection of the appropriate CPT-4 code is also provided.

Histories

Problem Focused	Chief complaint and brief history of present problem (1-3)
Expanded Problem Focused	Chief complaint and brief history of present problem focused review of systems (1)
Detailed History	Chief complaint and extended history of present problem, completes extended problem review (2-9) pertinent past, family & social history (1)
Comprehensive History	Chief complaint and extended history of the present problem (>4), conducts a complete system review (10) and requires a complete past, family, and social history (3)

Exams

Problem Focused	Limited to the affected body area or organ (1)
Expanded Problem Focused Exam	Examines the affected body organ and check other related organ systems (2-7)
Detailed Exam	An extended exam of the affected body area and other symptomatic or related organs (2-7)
Comprehensive Exam	Completes multi-system exam or single system specialty examination (8)

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the patient’s presenting problems (s), the diagnostic procedure (s), and/or the possible management options

	Straight Forward	Low	Moderate	High
Number of Diagnoses (Dx)	Minimal (1)	Limited(1-2)	Multiple(3)	Extensive(>4)
Amount of Data to Check (Tests)	Minimal(0-1)	Limited(2)	Moderate(3)	Extensive(>4)
Risk of more serious illness or death	Minimal	Low	Moderate	High

Key for abbreviations:

CC	Chief Complaint	SH	Social History
HPI	Chronological description of the development of the patient’s present illness	PFSH	Past, Family, and/or Social History
ROS	Review of systems		
FH	Family History		



Evaluation and Management Coding Guidelines (B)

	99301 – Annual Assessment	99302 – Major Permanent Change in Status	99303 – Initial Admission or Readmission
History	Detailed (CC, ext. interval Hx & ROS, pertinent PH, FH, SH)	Detailed (CC, ext. interval Hx & ROS, pertinent PH, FH, SH)	Comprehensive (CC, ext. Hx, comp. ROS, comp. PH, FH, SH)
Physical	Comprehensive (complete multi-system exam)	Comprehensive (complete multi-system exam)	Comprehensive (complete multi-system exam)
Medical Decision Making	Straightforward - Low Dx = 1-2 Data = 0-2 Risk = low	Moderate - High Dx = 3->4 Data = 3->4 Risk = moderate to high	Moderate - High Dx = 3->4 Data = 3->4 Risk = Moderate to high

Subsequent Visits – Require 2 out of 3

	99311	99312	99313
History	Problem focused (CC, brief Hx)	Exp. problem focused (CC, brief Hx, problem ROS)	Detailed (CC, ext. Hx, ext. ROS, pertinent PH, SH, FH)
Physical	Problem focused (exam of affected area)	Exp. problem focused (exam of affected area and other related systems)	Detailed (ext. exam of affected area and other related systems)
Medical Decision Making	Straightforward – Low Dx = 1-2 Data = 0-2 Risk = low	Moderate Dx = 3 Data = 3 Risk = moderate	Moderate - High Dx = 3->4 Data = 3->4 Risk = Moderate to high

Discharge Codes

99315	Discharge day management = 30 minutes or less
99316	Discharge day management = more than 30 minutes



Presented below are the “key components” of review with delineation in the various categories or each component. The criteria for the selection of the appropriate CPT-4 code is also provided.

Histories

Problem Focused	Chief complaint and brief history of present problem (1-3)
Expanded Problem Focused	Chief complaint and brief history of present problem focused review of systems (1)
Detailed History	Chief complaint and extended history of present problem, completes extended problem review (2-9) pertinent past, family & social history (1)
Comprehensive History	Chief complaint and extended history of the present problem (>4), conducts a complete system review (10) and requires a complete past, family, and social history (3)

Exams

Problem Focused	Limited to the affected body area or organ (1)
Expanded Problem Focused Exam	Examines the affected body organ and check other related organ systems (2-7)
Detailed Exam	An extended exam of the affected body area and other symptomatic or related organs (2-7)
Comprehensive Exam	Completes multi-system exam or single system specialty examination (8)

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the patient’s presenting problems (s), the diagnostic procedure (s), and/or the possible management options

	Straight Forward	Low	Moderate	High
Number of Diagnoses (Dx)	Minimal (1)	Limited(1-2)	Multiple(3)	Extensive(>4)
Amount of Data to Check (Tests)	Minimal(0-1)	Limited(2)	Moderate(3)	Extensive(>4)
Risk of more serious illness or death	Minimal	Low	Moderate	High

Key for abbreviations:

CC	Chief Complaint	SH	Social History
HPI	Chronological description of the development of the patient’s present illness	PFSH	Past, Family, and/or Social History
ROS	Review of systems		
FH	Family History		

Affiliated Computer Services, Inc.
Surveillance and Utilization Review (SUR)
P.O. Box 240808
Anchorage, AK 99524-0808



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*Fraud Hotline: (800) 256-0930
Fax: (907) 644-8128
Email: SURS-AK@acs-inc.com*

Complaint Form

This is a confidential complaint/report of any suspected abuse/fraud involving the Alaska Medical Assistance Program (State of Alaska Medicaid).

Name of the person or entity suspected of abuse and/or fraud:

This person or entity is a:

- Medicaid Recipient
- Medicaid Provider
- Other

Identifying Information: _____
ID number, date of birth, or other identifying information of suspected person or entity.

Reason for complaint/report: _____

Please continue on back of form if additional space is required

You may remain anonymous; however, we encourage you to provide your name and contact information in the event more information is needed to investigate this report. If you choose to do so, your identity will be kept confidential.

Your name: _____

Your telephone number (or other contact information): _____

Date: _____ Signature: _____

INTERNAL USE ONLY

DATE AND METHOD OF RECEIPT: _____

Case #/Entry Date: _____ Received by: _____ Disposition: _____

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Suspected/Fraud Abuse Form

This is a confidential complaint/report of any suspected abuse/fraud involving the Alaska Medical Assistance Program (State of Alaska Medicaid).

Name of the person or entity suspected of abuse and/or fraud:

This person or entity is a:

- Medicaid Recipient
- Medicaid Provider
- Other

Identifying Information: _____
ID number, date of birth, or other identifying information of suspected person or entity.

Reason for complaint/report: _____

Please continue on back of form if additional space is required

You may remain anonymous; however, we encourage you to provide your name and contact information in the event more information is needed to investigate this report. If you choose to do so, your identity will be kept confidential.

Your name: _____

Your telephone number (or other contact information): _____

Date: _____ Signature: _____

INTERNAL USE ONLY		
DATE AND METHOD OF RECEIPT: _____		
Case #/Entry Date: _____	Received by: _____	Disposition: _____

