



A **xerox**  Company

Long-Term Care Facilities

ACS is now a Xerox company

Overview

- Medicaid enrollment requirements
- Provider participation requirements
- Recipient eligibility



A **xerox**  Company

Overview, cont.

- LTC services
- Prior authorization
- Billing
- Edits



A **xerox**  Company

Medicaid Enrollment Requirements

An enrolled provider with a current provider agreement on file with Alaska Medicaid may provide and be reimbursed for covered, long-term care facility services rendered to eligible recipients.



A **xerox**  Company

Medicaid Enrollment Requirements, cont.

- Provider agreement
 - Follow procedures that are consistent with guidance in the applicable *Alaska Medicaid Provider Billing Manual*
 - Comply with applicable state and federal Medicaid law
 - Cooperate in reports, surveys, reviews or audits conducted by the Division

Medicaid Enrollment Requirements, cont.

- Record keeping/Record request requirements
 - 7 AAC 105.230 Requirements for provider records
 - 7 AAC 105.240 Request for records
<http://www.legis.state.ak.us/cgi-bin/folioisa.dll/aac>



A **xerox**  Company

Provider Participation Requirements

- Written acceptance policies
- Monitor admissions
- Prompt notification of patient transfers



A **xerox**  Company

Provider Participation Requirements, cont.

- Out-of-state providers must:
 - Meet licensing requirements of their own state
 - Be enrolled in their own state's Medicaid program
 - Be enrolled in Alaska's Medicaid program



A **xerox**  Company

Provider Participation Requirements, cont.

- Skilled nursing facilities

- Compliance with federal certification requirements

Certified by the Division for the United States Department of Health and Human Services

- Level of care
- Current provider agreement



A **xerox**  Company

Provider Participation Requirements, cont.

- Skilled nursing facilities, cont.
 - Meet recipient's need for skilled nursing or structured rehabilitation for an unstable condition
 - Services ordered by and under the direction of a licensed physician
 - Provided either directly by or under supervision of qualified technical or professional personnel
 - On premises at the time of service



A **xerox**  Company

Provider Participation Requirements, cont.

- Intermediate care facilities
 - Compliance with federal certification requirements
 - Certified by the Division
 - Level of care
 - Current provider agreement on file

Provider Participation Requirements, cont.

- Intermediate care facilities, cont.
 - Meet recipient's need for intermediate nursing services or therapy for a stable condition
 - Ordered by and under direction of a licensed physician



A **xerox**  Company

Recipient Eligibility

- Section I of the billing manual
 - Eligibility verification
 - Eligibility codes



A **xerox**  Company

Before Rendering Services

- Verify:
 - Recipient information
 - Based on recipient's eligibility code
 - Based on the recipient's age
 - Provider information
 - Based on the provider's credentials
 - Based on list of covered services in the provider billing manual



A **xerox**  Company

Before Rendering Services, cont.

- All long-term care services require prior authorization.
- Verify that prior authorization (PA) has been obtained.
 - Authorization is requested by the facility or hospital on a Long-Term Care Authorization form (AK-LTC-1).
 - AK-LTC-1 is submitted to Division of Senior and Disabilities Services (DSDS).
 - Request PA for continuous flow oxygen on AK-PA form.

Before Rendering Services, cont.

- Prior authorization requirements, procedures and forms are included in provider billing manuals.
 - List of covered services

Tips for Successful PA Submission

- Verify correct address to submit PA request.
- Check billing manual to determine what documentation is required for request.
- Fill out request accurately and completely.

Attachments to the PA Request

- Oxygen saturation level or arterial blood gas (ABG) on room air
 - Less than 90
- Doctor's prescription or doctor's orders



A **xerox**  Company

Most Common Errors on PA Requests

- No date of service (DOS) indicated
- Invalid procedure codes/revenue codes
- Missing attachments
- Insufficient details provided



A **xerox**  Company

Most Common Errors on PA Requests, cont.

- Request for recipient who is ineligible
- Request for retroactive services that do not meet criteria
- Request for service that does not require PA

What Happens After I Request an Authorization?

- Faxed or mailed requests are received in the PA Department of Affiliated Computer Services (ACS).
 - ACS then:
 - Tracks and manages all PAs
 - Verifies eligibility
 - Reviews history of prior services
 - Conducts medical review



A **xerox**  Company

What Happens After I Request an Authorization? (continued)

- Authorization is approved, denied or pended (if additional information is needed).
- Copy of PA is forwarded to provider.



A **xerox**  Company

Prior Authorization Form

(1st Half of Form)

AFFIX LABEL HERE
AFFIX LABEL HERE

CONTROL NUMBER * FOR ACS USE ONLY

STATE OF ALASKA HEALTH AND SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE
DO NOT USE THIS FORM TO REQUEST LONG TERM CARE PLACEMENT

PRIOR AUTHORIZATION REQUEST

SEQUENCE NUMBER									
P	33026								
FOR ACS USE									
20. HCP: YOUR REQUEST IS:									
<input type="checkbox"/> APPROVED AS REQUESTED									
<input type="checkbox"/> APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)									
<table border="1"> <tr> <td colspan="2">PRIOR AUTHORIZATION NUMBER</td> </tr> <tr> <td>FROM</td> <td>TO</td> </tr> <tr> <td>DATE</td> <td>DATE</td> </tr> <tr> <td>MM/DD/YY</td> <td>MM/DD/YY</td> </tr> </table>		PRIOR AUTHORIZATION NUMBER		FROM	TO	DATE	DATE	MM/DD/YY	MM/DD/YY
PRIOR AUTHORIZATION NUMBER									
FROM	TO								
DATE	DATE								
MM/DD/YY	MM/DD/YY								
AUTHORIZATION IS VALID FOR SERVICES PROVIDED									
<input type="checkbox"/> DENIED									
BY _____									
AUTHORIZING AGENT									
21. AGENT NUMBER	22. DATE								
	MM/DD/YY								

(PLEASE TYPE) FOR HEALTH CARE PROFESSIONAL (HCP) USE		
1. HCP PHONE NO. (907) 555-1234	2. HCP IDENTIFICATION NO. MD1234	3. REQUEST IS RETROACTIVE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
4. HCP NAME AND ADDRESS PLEASE TYPE YOUR NAME AND ADDRESS HERE Ms. Jane Doe ABC Physician Center 123 Main Street Anywhere, AK 99911		
5. RECIPIENT NAME (LAST, FIRST, MI) Jones, James L.		6. RECIPIENT ID NO. 0601000000
7. STREET ADDRESS 111 Happy Street	8. SEX M	9. DATE OF BIRTH
	10. AGE 24	
11. CITY, STATE, ZIP CODE	12. PHONE NUMBER	

Prior Authorization Form

(2nd Half of Form)

11. CITY, STATE, ZIP CODE Little River, AK 99911		12. PHONE NUMBER (907) 554-6789		MM/DD/YY					
13. DIAGNOSIS AND MEDICAL JUSTIFICATION:		14. PRIMARY ICD-9-CM DIAGNOSIS CODE XXX.XX		23. COMMENTS / EXPLANATION 					
ICD-9 Codes Narrative Description									
DOS 6/1/04 – 9/1/04									
	15. PROCEDURE/ DRUG CODE	M O D.	16. SPECIFIC SERVICES REQUESTED	17. REQUESTED UNIT/QTY	18. CHARGES	AUTHORIZED		26. APPROVED UNIT / QTY	27. APPROVED AMOUNT
						24. YES	25. NO		
1	270		CONTINUOUS FLOW OXYGEN	54 cu. ft.	\$54.00				
2									
3									
4									
5									
6									
19. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.									
SIGNATURE OF PHYSICIAN OR HEALTH CARE PROFESSIONAL						TITLE		DATE	

Long-Term Care Services

- Covered for recipients who need:
 - Supervised care services of a certified and licensed:
 - Skilled nursing facility (SNF)
or
 - Intermediate care facility (ICF)



A **xerox**  Company

Long-Term Care Services, cont.

- Skilled nursing services
 - Observation
 - Assessment
 - Treatment
 - Initiation of ordered medical procedures
 - Until condition improves to the point of stabilization



A **xerox**  Company

Long-Term Care Services, cont.

- Intermediate nursing services

- Observation

- Assessment

- Treatment

- Emphasis on maintenance or care when patient is nearing recovery and discharge

- Therapy may be included.

- Provided by an aide or orderly under the supervision of licensed nursing personnel or therapist



A **xerox**  Company

LTC Admission

- Authorization for long-term care facility
 - New admission
 - Transfer
 - Continuing placement



A **xerox**  Company

LTC Admission and Level of Care

- AK-LTC-1 authorization form
 - Information required:
 - Medical reason for continued stay
 - Support for level of care decision
 - Plan of care for treatment ordered by attending physician
 - Recipient's diagnoses, symptoms, complaints and complications
 - Description of functional level of recipient
 - Written objectives



A **xerox**  Company

LTC Admission and Level of Care, cont.

- AK-LTC-1 authorization form, cont.
 - Information included:
 - Orders for medications and treatments
 - Restorative and habilitative services
 - Therapies, diet, activities, social services
 - Special procedures to meet objectives
 - Plans for continuing care
 - Review and necessary modifications
 - Reasons why alternative placement is not feasible or appropriate
 - Plan for discharge

LTC Admission and Level of Care, cont.

- AK-LTC-2 consent form for initial authorization
 - Indicates that the patient (or legal representative) was involved in his/her own planning and would like to go to a nursing home
- MI/MR supplement assessment, level I form for initial authorization
 - Used to identify mental illnesses or mental retardation



A **xerox**  Company

LTC Admission and Level of Care, cont.

- Authorization forms for LTC
 - Completed with full knowledge and concurrence of:
 - Recipient or legal guardian
 - Representative payee
- Submit forms to and receive authorization from DSDS before admission.



A **xerox**  Company

LTC Admission and Level of Care, cont.

- If placement is from an acute care facility:
 - Preliminary evaluation to establish need for LTC from:
 - Attending physician
 - Director of nursing
 - Licensed therapist
 - Other professional involved with recipient's care
 - Submit evaluation with AK-LTC-1 to DSDS
 - Within one week of admission



A **xerox**  Company

Level of Care Decision

- Complete and submit AK-LTC-1 to DSDS.
 - Input from interdisciplinary team
 - Decision made within ten days
 - Approve placement
 - DSDS may request additional information
 - Support for level of care decision
- Upon disapproval, facility has 30 days to discharge recipient.



A **xerox**  Company

Level of Care Decision, cont.

- Submit AK-LTC-1 to:
Division of Senior & Disabilities Services
3601 C Street, Suite 310
Anchorage, Alaska 99503-5954
(907) 269-3666

First Name.Last Name@alaska.gov



A **xerox**  Company

LTC Admission and Level of Care

- Facility must have written policies that:
 - Monitor admissions to ensure it has the capability to treat recipients who are admitted
 - Notify DSDS if unable to provide appropriate care for a recipient
 - Arrange for prompt transfer of recipient to facility that can meet the recipient's needs



A **xerox**  Company

LTC Admission and Level of Care, cont.

- DSDS approves care:
 - Considers type of care
 - Qualifications of rendering provider
 - Stability of recipient's overall condition
 - Authorizes level of care and length of stay
- If level of care is denied, DSDS sends written notice to:
 - Facility
 - Recipient and/or recipient's legal representative.



A **xerox**  Company

Structured Rehabilitation Services

- Require physician orders
- Service provided at least five days per week
 - On-going assessment of structured rehabilitation needs and potentials
 - Therapeutic exercises or activities
 - Gait evaluation and treatment
 - Range-of-motion exercises



A **xerox**  Company

Structured Rehabilitation Services, cont.

- Maintenance therapy
- Ultra-sound, short-wave, and microwave therapy treatments
- Hot pack treatments, infra-red treatments, and paraffin baths
- Services of a communications specialist, speech pathologist or audiologist



A **xerox**  Company

LTC Reauthorization

- Requests submitted to DSDS
 - Precise statement of the medical reason for continued stay
 - Status of the rehabilitation and/or discharge plan
 - Complete both parts A & B of AK-LTC-1 form.
 - SNF level of care
 - Submit reauthorization request one month prior to end of current authorization.
 - ICF level of care
 - Submit reauthorization request one month prior to end of current authorization.

LTC Reauthorization, cont.

- If recipient no longer needs nursing facility care:
 - Within 30 days, arrange for discharge or alternative placement
 - At the end of 30-day period, the Division will terminate payment.



A **xerox**  Company

Level of Care Change

- Change in level of care within the same facility
 - Send written notice to the division.
 - Submit a current "Request for Nursing Home Authorization."
 - ❖ No later than one week following transfer



A **xerox**  Company

Transfer of Recipients

- Transfer to a different level of care within the same facility
 - Submit current “Request for Nursing Home Authorization” no later than one week following transfer.
- Transfer to another facility
 - Submit written notice 10 days prior to transfer to:
 - Recipient and, where appropriate:
 - Family or guardian
 - Attending physician
 - DSDS
 - Medical practice review section of the facility

Depending on whether the facility or the Division is proposing the transfer

Discharge of Recipients

- Notice given to:
 - Recipient or family/guardian
 - Attending physician
 - Regional office
 - Medical practice review section
If the facility proposes discharge
 - Facility
If the Division proposes discharge



A **xerox**  Company

Days Chargeable

- Alaska Medical Assistance reimburses for:
 - Day of admission
- Alaska Medical Assistance does not reimburse for:
 - Day of discharge, including
 - Level of care change
 - Transfer
 - Death



A **xerox**  Company

Absence from Facility

- LTC facility submits written request for any leave of absence that exceeds 12 days.
- Alaska Medical Assistance will not pay for more than 12 days leave of absence within a 12-month period per recipient without written prior authorization.
- More than 12 **consecutive** days, leave of absence requires written prior authorization.



A **xerox**  Company

Absence from Facility, cont.

- “Twelve months” starts on date of admission or anniversary of admission.
- Record in the facility’s records:
 - All absences
 - Times of departure and return
 - Purpose for the leave
- When a recipient is absent from a facility because of hospitalization, payment will not be made to reserve the recipient’s bed.



A **xerox**  Company

Non-Covered Items/Services

- Examples of items/services **not included** in the all-inclusive rate:
 - Prescribed legend drugs and biologicals
 - Physician services
 - Except routine annual physical exams
 - Dental services
 - Personal items paid for by personal funds



A **xerox**  Company

Non-Covered Items/Services, cont.

- Examples of items/services **not included** in the all-inclusive rate:
 - X-ray and laboratory procedures provided in or out of the facility
 - Essential transportation for recipients to and from sources of medical care
 - Payment directly to the providers
 - Non-periodic, heavy use of oxygen

Claims Submission

- 837P electronic claim
 - Companion guide
<http://medicaidalaska.com>
 - Implementation guide
<http://www.wpc-edi.com>
- Professional paper claim form



A **xerox**  Company

Revenue Code 270

- Billing for revenue code 270, when it includes continuous flow oxygen:
 - 7 AAC 140.580
 - Periodic oxygen is included in the all-inclusive rate.
 - Non-emergency, continuous flow oxygen is **not** included in the all-inclusive rate.
 - Prior authorization request (AK-PA) form
 - Attach physician orders, physician notes or nursing notes



A **xerox**  Company

Revenue Code 270, cont.

- Continuous flow oxygen:
 - Payment is at facility's cost.
 - With prior authorization, billed as a separate line item, one month at a time, using revenue code 270.
 - PA number must be on the claim in FL 63 (treatment authorization codes).
 - Enter the number of liters/bottles used.
 - Metered amount of oxygen given to patient and dates used must be listed on an attachment to the claim form.
 - Cost for professional services and supplies are covered in the all-inclusive per diem rate and cannot be billed separately.
 - ❖ Revenue code 270 is also used for medical supplies.



A **xerox**  Company

Rates of Payment

- Rates for facilities in Alaska are determined by Office of Rate Review.
 - Billings may not exceed rates to general public.
- Payment for out-of-state facilities is established by Medicaid state agency in state where facility is located.
 - Payment may not exceed the maximum rate established for Alaska facilities.



A **xerox**  Company

All-Inclusive Rate

- Examples of items/services **included** in the all-inclusive rate*:
 - Periodic oxygen
 - Rehabilitative nursing care
 - Non-physician consultation and training of patients and staff

*List all applicable revenue codes on claim form

All-Inclusive Rate, cont.

- Examples of items/services **included** in the all-inclusive rate:
 - Direct patient care services
 - All transportation
 - Routine annual physical exams



A **xerox**  Company

Billing for Changes in Level of Care

- Claims for more than one level of care (LOC) during the same calendar month must be billed on two separate claim forms:
 - One claim represents the discharge from the “old” LOC.
Do not bill as facility discharge.
 - Second claim represents the admission to the “new” LOC.



A **xerox**  Company

Billing for Changes in Level of Care, cont.

- The sum of the dates spanned between the two claim forms should total the number of long-term care days in the month.
- The institutional claim instructions apply.



A **xerox**  Company

Billing for Changes in Level of Care, cont.

- Key claim fields for accurate claim processing:
 - FL 6: Statement covers period = from and through dates
 - FL 17: Patient status
 - FL 39-41: Value codes and amounts
 - 80 – Covered days, 81 – non-covered days
 - 34 – LTC patient liability amount
 - FL 42: Revenue code
 - Note: The “through” date becomes the discharge date from this level of care.



A **xerox**  Company

Billing for Changes in Level of Care, cont.

- Key claim fields for accurate claim processing:
 - FL 6: Statement covers period = from and through dates
 - FL 12: Admission date
 - FL 15: Admission source
 - FL 17: Patient status
 - FL 39-41: Value codes and amounts
 - 80 – Covered days, 81 – non-covered days
 - 34 – LTC patient liability amount
 - FL 42: Revenue code
 - Note: Enter the “from” date to match the admit date of the new level of care.

Tips for Billing Leave of Absence Days

- Bill appropriate number of covered or non-covered days.
 - Sum of covered days plus non-covered days = total days (FL39-41).
 - Total days must = the number of days spanned in the statement covers period (FL6).
 - Sum of covered days plus non-covered days must also = the accommodation units (units associated with accommodation revenue codes) reported in service unit (FL 46).



A **xerox**  Company

Tips for Billing Leave of Absence Days, cont.

- To check entries for covered and non-covered days, consider the patient's status (FL 39-41) on the last day in the billing period.
 - Continuing patient:
The "through" date is counted on both sides.
 - Discharged, transferred or deceased patient:
The "through" date is not counted.

Tips for Billing Leave of Absence Days, cont.

- Example for a continuing patient:
 - The days spanned for a claim “from” 07/01/08 “through” 07/06/08 are six days. (Count the calendar days beginning with the “from” date including the “through” date.) The sum of covered plus non-covered days must then equal six.



A **xerox**  Company

Tips for Billing Leave of Absence Days, cont.

- Example for a discharged patient:
 - The days spanned for a claim “from” 07/01/08 “through” 07/06/08 are five days. (Count the calendar days beginning with the “from” date but do not count the “through” date.) The sum of covered plus non-covered days must then equal five.



A **xerox**  Company

Tips for Billing Leave of Absence Days, cont.

- Bill appropriate revenue code (FL 42) and revenue code description (FL 43).
 - 185 for acute care/leave of absence (LOA) days (non-covered days)
 - 182 for LOA days in excess of the 12 authorized social leave days per 12-month period
- Total charges (FL 47)
- Non-covered charges (FL 48), if billing for LOA days in excess of the 12 authorized
- Complete all other required fields.

Type of Bill Code

- Form Locator 4:
 - First digit is a leading zero.
 - Second digit is the type of facility:
1=hospital, 2=SNF, 6=ICF
 - Third digit is bill classification:
1=inpatient, 5=ICF, 8=Hospital swing or administrative wait bed
 - Fourth digit defines frequency of the bill:
1=admit thru discharge claim
2=interim billing, first claim
3=interim billing, continuing claim
4=interim billing, last claim



A **xerox**  Company

Condition Codes

FL 18-28 Condition codes:

- Enter ML for nursing home patient.
- Required

1		2		3a PAT CNTL #		4 TYPE OF BILL	
				b. MED REC #			
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM THROUGH			
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE		11 SEX	12 DATE	13 HR	14 TYPE	15 SPC	16 DHR
				18 19 20 21		22 23 24	
				25 26 27 28		29 AGDT 30 STATE	
31 OCCURRENCE DATE	32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE	38 OCCURRENCE CODE
39 VALUE CODES AMOUNT				40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a				b		c	
d				e		f	
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV DATE	
						46 SERV UNITS	
						47 TOTAL CHARGE	
						48 NON-COVERED CHARGES	
						49	

FL 18-28 Condition Codes:
ML indicates patient is in a nursing home.



A xerox Company

Billing Tips

- Avoid split billing since our system will automatically take the patient liability on both claims.
- Exception: A change in the level of care within the same facility must be split billed.
- If the patient liability is taken out twice in one month, submit an adjustment or contact Provider Inquiry for assistance.



A **xerox**  Company

Billing Tips, cont.

Reporting patient's status (FL 17) as discharge or transfer will automatically end the authorized segment for that period. No other claims received during the original authorized period will be paid.



A **xerox**  Company

Billing Tips, cont.

- FL 17 – Status Codes
 - 01 = Discharged to home or self care (routine discharge)
 - 02 = Discharged/transferred to another short-term general hospital
 - 03 = Discharged/transferred to SNF
 - 04 = Discharged/transferred to ICF
 - 05 = Discharged/transferred to another type of institution
 - 06 = Discharged/transferred to home under care of organized home health service organization
 - 07 = Left against medical advice
 - 20 = Expired
 - 30 = Still patient



A **xerox**  Company

Billing Tips, cont.

Submit all other bills for the authorized segment and allow them to successfully process before submitting the discharge claim.



A **xerox**  Company

Payments

- Medicaid payment constitutes payment in full.
- Additional payments must be refunded or credited to Medicaid.
 - Contributions or donations have a direct effect on recipient's eligibility.



A **xerox**  Company

Patient Liability

- Division of Public Assistance Income Credit Notice
- Report LTC patient liability in FL 39 using code 34 for the month of the service billed.
- If amount entered on claim exceeds amount on the eligibility file, the larger amount will be deducted.
- No deduction from the month of the patient's admission to or discharge from institutionalization.

Medicare Coinsurance

- Alaska Medicaid will pay on behalf of eligible recipients who are also qualified Medicare Beneficiaries.
 - Coinsurance established under Part A Medicare.
- Once Medicare benefits are exhausted:
 - Alaska Medicaid may pay the Medicaid rate established for care in that particular facility.



A **xerox**  Company

Medicare Crossover Claims

- Coordination of Benefits (COB) agreement:
 - National standard requirement implemented by the Centers for Medicare and Medicaid Services
 - Provides automatic claim coordination of benefits (crossover) service from Medicare to Medicaid
 - Affects claims submitted for Dual Eligibles – those who are eligible for both Medicare and Medicaid



A **xerox**  Company

Advantages of Coordination of Benefits

- Streamlined claims process:
 - Increased accuracy of processed claims
 - Increased number of claims which successfully cross over from Medicare to Medicaid
 - Faster payment of claims
 - Reduction in the number of provider generated, separately submitted claims to Medicaid as the secondary payer



A **xerox**  Company

Medicare Crossover Format

Refer to the ACS website for instructions and examples.

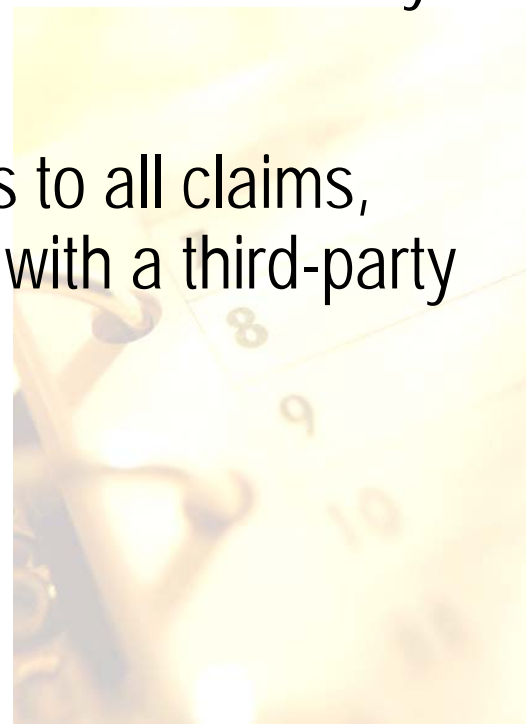
<http://medicaidalaska.com>



A **xerox**  Company

Timely Filing

- All claims must be filed **within 12 months** of the date you provided services to the patient.
- The 12-month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier.



A **xerox**  Company

Edits of Claims

- Three-digit codes
- Explanation of Benefits (EOB) in Remittance Advice (RA)
- Contact ACS Provider Inquiry



A **xerox**  Company

Long Term Care Services Common Edits

Refer to Common Edits Handout for the most common edits



Edit 200:
Edit 500:
Edit 231:



rox Company

Summary

- Providers must be enrolled.
- Claims must be submitted within 12 months from the date of service.
- Eligibility must be verified.
- For assistance:
 - Refer to your billing manual.
 - Call ACS Provider Inquiry.

Where to Get Help

- **Billing/Coverage/Claim status questions**
 - Provider manual and fee schedules
<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



A **xerox**  Company

Where to Get Help, cont.

- **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*



A **xerox**  Company

Training Information

Provider Training

Affiliated Computer Services, Inc.

1835 S. Bragaw St., Suite 200

Anchorage, Alaska 99508

Phone: (907) 644-6800

Fax: (907) 644-9845

<http://medicaidalaska.com>



A **xerox**  Company