



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Payerpath Changes

Overview of 5010 changes



[Title slide only.]



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Welcome



Thank you for attending this webinar session on 5010 changes to Payerpath. [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.



Overview

- **Effective January 1, 2012**
- Changing from 4010 to 5010
- Alaska-specific information
- Impacts on Payerpath



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 this federally-mandated HIPAA change. By law, all HIPAA-covered entities must convert from the current version 4010 electronic transaction standard to the new version 5010. HIPAA-covered entities are our trading partners, which includes providers, clearinghouses (like Payerpath), and health plans. Anyone who submits claims in the HIPAA-format must follow the transaction rules. Payerpath makes that easy for you to do.

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-specific and impacts Payerpath. Information related to specific transaction changes, such as the 837 Professional, Dental and Institutional (837P/D/I) are addressed in separate training modules.



Why Change to 5010?

- New version federally mandated
- Improves standards for administrative simplification
- Corrects problems in 4010
- Creates better access to health insurance
- Limits fraud and abuse
- Reduces administrative costs
- Supports ICD-10 (October 2013)



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 is the acronym for the American National Standards Institute, originally developed standards referred to as 4010. CMS mandated the ANSI 4010 standards in 2003. 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.

Now 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. ICD-10 is the new version of the diagnosis code set.

Payerpath is making these changes so you can still send your claims electronically.



Learning Objectives

- Identify changes to Payerpath
- Discover available resources



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 as it relates to Payerpath. Most of the requirements we will discuss are unique to Payerpath's interactions with Alaska Medical Assistance.



A Look at a 5010 Transaction

```
GS*HC*100020*77200*20061207*16265868*90000  
0201*X*0005010X224A2~ST*837*627484322*0005  
010X224A2~BHT*0019*00*A74322*200090123*040  
1*CH~NM1*41*2*HOSPITAL*****46*70160~PER*IC*BI  
LLINGOFFICE*TE*8001234567~NM1*40*2*AKMEDIC  
AID*****46*77200~HL*1**20*1~PRV*BI*PXC*OOODO  
OOOOX~NM1*85*2*HOSPITAL*****XX*1234567890~  
N3*1 MOOSELANE~N4* ANCHORAGE*AK*99502290  
3~REF*EI*123456789~HL*2*1*22*0~SBR*P*18*00123
```

Are you daunted by what you see on the slide ? You don't need to be. We didn't put it here to make you nervous. We just wanted you to see a partial example of claim information coding in the HIPAA 5010 transaction format which makes your claims process.

As Payerpath users, you're lucky because you don't have to worry about coding. The claim information you key into Payerpath is converted into the appropriate electronic claim format. The work to convert what you enter into what you see on the screen is accomplished by Payerpath – or other software vendors and programmers. After an entry is coded, Alaska Medical Assistance can receive and track your claims and payments. On top of all that, Payerpath makes sure your claims meet federally-mandated standards for transmitting information electronically.

Today you'll learn about important changes that impact Payerpath because of 5010 implementation. For instance, you'll learn if there are new or deleted codes and new or modified fields. Most of the 5010 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 when you use Payerpath.



Important Payerpath Highlights

- Payerpath will look, act, and perform as before
- Interface, navigation, and menu are not changing
- New fields have been added
- Longer fields if the number of characters increased
- “Rebill” considerations



But before we go any further in the training, we want to let you know that from a Payerpath user’s point of view the claim forms and submission process will seem to be almost the same. The way you access Payerpath and navigate through the menus is not changing. The screens still have the same look and feel. The interface is not changing. The navigation options and menu picks are not changing. In fact, the workflow and run and save edits are the same.

However, there are some new required fields and some of the values that you used to enter have changed. Most of the changes pertain to fields that are accessed by clicking the Electronic Fields link. The major difference providers will notice are a handful of new fields at the line levels. You may also notice that some of the fields throughout Payerpath are longer. That’s because the number of characters you can enter was increased.

There are also some special considerations if you use the “Rebill” function. The “Rebill” option on Payerpath uses the last claim submitted for that particular recipient as a base for the new claim. If the claim was submitted before January 1, 2012, it would have been built using 4010 standards. If you use “Rebill” after January 1, the 4010 formatted claim will attempt to process using 5010 standards which will result in processing errors. Because of this, you will need to review the claim the first time it is submitted for a recipient. After a claim is successfully submitted, everything will be in accordance with the 5010 standards, the 5010 information will be saved on that particular recipient’s claim and “Rebill” will work as it does today.



Loops, Segments, and Elements

- Loops are made up of segments
- Some segments may repeat
- Elements are individual data

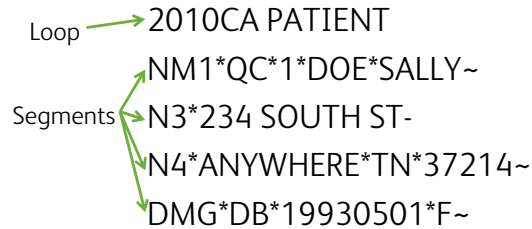


Even though Payerpath handles the details of the coding of your claims in the appropriate format for Alaska Medical Assistance to process, there is still some basic terminology you should know in case you need to talk with Payerpath, ACS, or Alaska Medical Assistance about a 5010 transaction related issue. Let's start with a quick review of loops, segments and elements. These terms refer to the different components of electronic claim transactions.

Even though you may not notice this in Payerpath, information hierarchies exist within each transaction. These hierarchies have a basic loop, segment and element structure. Loops are the highest level of information. Segments provide more specific information within a loop. Within segments, there are elements – also known as data fields – and they show the claim details.



Example of Loops, Segments, and Elements



On the screen, you see an example of loops, segments, and elements. You won't see this in Payerpath but it lets you know how they work.

The 2010 CA Patient Loop has patient information. This loop is the highest level of information about the patient. Segments within the patient loop break out patient information, like their name, address, and birthday. Elements within the patient name segment – such as first name, last name, middle initial, and name suffix – allow for reporting the most specific information. As you can see, there are 4 segments with this loop: NM1, N3, N4, and DMG. There are many elements within each of these segments. They are separated by an asterisk. The end of a segment is signified by a terminator, usually a tilde (~).

What does the Patient Loop and its related segments and elements mean to Payerpath users? Everything that goes into the Patient Loop is what goes into the patient information section on the professional claim billing form in Payerpath – or boxes 2, 3 and 5.



Required Information

- Required **must** be in transaction
 - Example: Patient Last Name field
 - 2100 CA NM103 or first field in Box 2



2 PATIENTS.name (Last, First, MI)

[Redacted] [Redacted] [Redacted]

The image shows a screenshot of a data entry field. The field is labeled "2 PATIENTS.name (Last, First, MI)". The input area contains three redacted fields, each represented by a red rectangle. The first redacted field is highlighted with a green border.

Throughout this webinar, you will also hear us refer to information that is required or situational. On this slide, we'll go over required information.

If something is required, you must include it. In Payerpath, some information is always required. Examples of required information are the Alaska Medicaid provider ID to identify the biller, the Alaska Medicaid recipient ID number to identify the patient and the procedure code to identify the service being billed.



Situational Information

- Situational **may** be in transaction
 - Example: Patient First Name field
 - 2100 CA NM104 or second field in Box 2



- Example: Patient Middle Initial field
 - 2100 CA NM105 or third field in Box 2



If something is situational, sometimes you need to include it. You include situational information only if the situation applies. Examples of situational rules are procedure code modifiers that may be needed to define a procedure code and prior authorization numbers when Alaska Medical Assistance requires a prior authorization for the service billed.

It is important for us to stress that a required segment may have both required and situational fields. For instance, the Patient loop we discussed in slide 6 requires you to enter the patient last name, but the patient first name is considered situational. In this case, if the person has a first name, you must enter it. But the middle initial is always optional.

In just a moment, we'll show you how to learn if fields are required or situational.



Codes or Qualifiers?

- Codes stand alone and represent information
- Qualifiers identify types of information in other fields
- Codes and qualifiers are paired

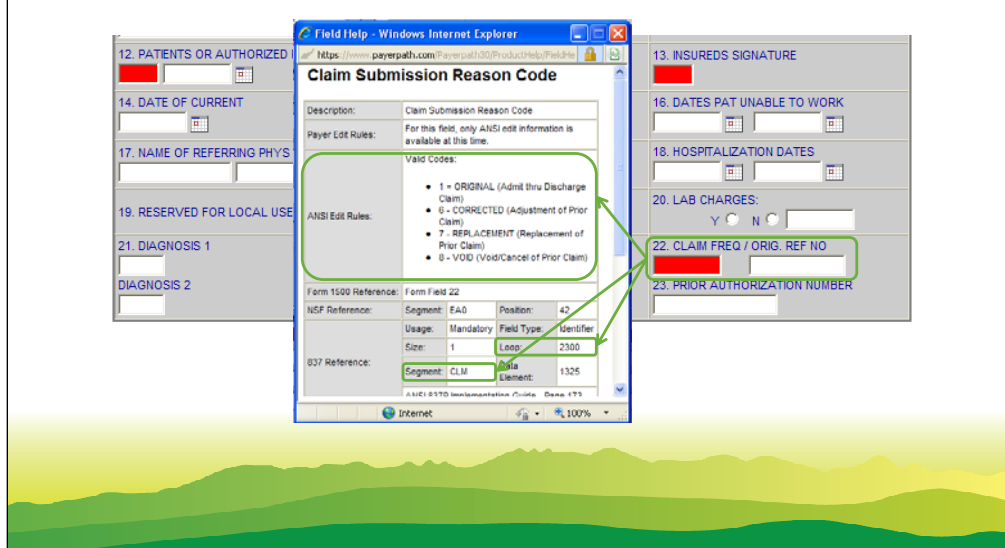
The last thing we need to go over is the difference between codes and qualifiers. They both are used to report claim details, and you already use both in Payerpath.

A code stands on its own and represents something. For instance, the numeric code 8 means “void” and does not introduce something else. Other examples of claim codes are place of service codes, procedure codes and diagnosis codes.

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. The new qualifier PXC introduces the taxonomy code.

Both codes and qualifiers help make up fields or elements.

Getting More Information



Now let's take a look at where you can find information about loops, segments, and elements. In Payerpath, when you hover over some section titles, you can see that information along with what data can be entered, such as valid codes, qualifiers, and number of characters.

For instance, if you are submitting a claim and need to know information about the claim frequency, hover your mouse over the title of that section. A hand will appear. Click the title. The Field Help box appears. In this box, you can see the valid codes. These codes are entered in the field on the claim. If you need information about the hierarchy we talked about, you can see what the loop is and what the segment is.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Information about Payerpath



[Title slide only.]



Claim Transactions Using Payerpath

- Allows providers to submit electronic claims:
 - 1500 form
 - UB-04 form
 - ADA Dental form
 - Specified by ANSI and required by HIPAA



Now we are ready to go over some of the changes that are specific to submitting electronic claims to Alaska Medical Assistance if you use Payerpath. This online claim program is used by a wide variety of Alaska Medical Assistance provider types, such as MD's, ANP's, health professional groups, DME suppliers, ambulatory surgery centers, dental providers and transportation providers, among many others. In this part of the training, we will discuss what you need to know to submit your claim on Payerpath whether it is a professional, institutional, dental, and transportation claim.

Remember that ANSI dictates the electronic claim transaction format, but Payerpath makes sure that their program meets those standards. To be compliant with the 5010 format, Payerpath modified certain fields and added other fields to accommodate the 5010 data requirements. Claims submitted via Payerpath go to ACS who processes them on behalf of Alaska Medical Assistance. As we mentioned earlier, there are many 5010 changes, but we'll just go over the handful of Payerpath-related changes.

Red and White Fields in Payerpath

- Red fields indicate you **must** enter valid data
- White fields indicate you **may** need to enter valid data

The image shows a screenshot of a claim form with 11 numbered fields. Fields 1, 2, 4, 7, and 8 are highlighted with a red background, indicating they are required. Fields 3, 5, 6, 9, 10, and 11 are highlighted with a white background, indicating they are optional. The fields are: 1. PATIENT'S name (Last, First, MI), 2. PATIENT'S ADDRESS (No., Street), 3. PATIENT'S BIRTHDATE / SEX, 4. INSURED'S NAME (L, F, M), 5. PATIENT STATUS, 6. PATIENT RELATIONSHIP, 7. INSURED'S ADDRESS (No., Street), 8. OTHER INSURED'S NAME (L, F, M), 9. EMPLOYMENT / STUDENT STATUS, 10. CONDITION RELATED TO, and 11. IIS POLICY GROUP OR FECA #.

Before we go on, we would like to remind you that any field that is red in your claim form is required. You must enter valid data in it. In the small chance you see a field that is now red which had not been before January 1, 2012, that means it became required to meet 5010 standards.

If you see white fields, they are situational. You enter information in those fields when it applies to the recipient's or provider's situation.



Electronic Fields in Payerpath

- Are situational fields
- Sometimes require you to enter valid data

Electronic Claim Information

| | |
|--------------------------------|-----------------------|
| ▶ Ambulance | Display Charge Fields |
| ▶ Billing Provider | Display Charge Fields |
| Provider Blue Shield Number | <input type="text"/> |
| Provider Champus Number | <input type="text"/> |
| Provider Taxonomy Code | <input type="text"/> |
| Billing Taxonomy Code | <input type="text"/> |
| Provider Entity Type Qualifier | 2 |
| ▶ Codes | Display Charge Fields |

https://www.payerpath.com/payt Internet

On a related note, the fields in the Electronic Fields section which are accessed by clicking on the link in the Webpage Dialogue box, are always situational. As we discussed earlier, you may need to enter information here if the situation applies.

For instance, you are required to put the billing taxonomy in Electronic Fields under the Billing Provider section. On the screen, you can see where you enter them. Put them in the Billing Taxonomy Code field.



Universal 5010 Changes Impacting Payerpath

- Field sizes increased
- Use of billing provider identifiers clarified
- Billing address must be a street address
- Billing address zip code must be 9 digits (zip+4)
- Example of 9 digit zip code: 995020769



Let's start reviewing changes to Payerpath by reviewing some of changes that apply to all parts of 5010. Although we don't need to 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. The changes you are about to see impact all types of claim transactions, including those coming from Payerpath. For the most detailed information about specific claim changes and not just Payerpath changes, you will want to take our other 5010 trainings. At the end of this presentation, you will see what course are available.

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 respectively. Certain identifiers such as medical records 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.

According to the 5010 standards, any time you enter the billing address it must be a physical address. If you enter a post office box, your transaction will be rejected. This is a very important change and is one 5010 change that impacts all providers regardless of the type of claim transaction they submit.

The same is true for the zip code field. You must enter a 9 digit zip code, which is the 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.



Submitting Diagnosis Codes

- Required on professional, institutional, and transportation claims
- Structured for use of ICD-9 or ICD-10 codes
- Look for more info at <http://medicaidalaska.com>

If you submit professional, institutional, or transportation claims using Payerpath, you are now required to submit diagnosis codes. This is one of the most important changes, so we will come back to it later in the training.

This change means some providers who have not previously submitted a diagnosis on a claim will now be required to submit one. Claims submitted electronically without a diagnosis code will be rejected and will not be forwarded to Alaska Medical Assistance for processing. 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 and accommodation providers and Home and Community Based service providers.

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.

As we all make this transition, Alaska Medical Assistance will offer guidance to those providers who are now required to submit a diagnosis code about which diagnosis codes is appropriate to use for their transaction. Please look for guidance on this topic in your RA messages, in the ACS monthly newsletter, and on the 5010 New Alerts website page which can be found by access the website on this slide, selecting HIPAA 5010 and then selecting 5010 News Alerts.

Some of you are familiar with entering diagnosis codes, and some of you are not. Either way, let's clarify where you enter them. The next three slides show you what fields you use to enter diagnosis codes.



Entering Diagnosis Codes on Professional Claims

- Enter up to 4 diagnosis codes on the claim form

| | |
|-----------------------------------------|-------------------------------------|
| 21. DIAGNOSIS 1 <input type="text"/> | DIAGNOSIS 3 <input type="text"/> |
| DIAGNOSIS 2 <input type="text"/> | DIAGNOSIS 4 <input type="text"/> |

- Can have up to 8 diagnosis codes total
- If applicable, put them in the Codes section

| | | |
|------------------|----------------------|-----------------------|
| Billing Provider | | Display Charge Fields |
| Codes | | Display Charge Fields |
| Diagnosis Code 5 | <input type="text"/> | |
| Diagnosis Code 6 | <input type="text"/> | |
| Diagnosis Code 7 | <input type="text"/> | |
| Diagnosis Code 8 | <input type="text"/> | |

If you submit professional claims, you can enter up to 4 codes on the main page of the form in field 21. For some claims, you may need to enter up to 8 diagnosis codes. Where do you enter the other diagnosis codes? If you need to enter more diagnosis codes, enter additional codes in the Electronic Fields section under Codes. Entering extra codes is a new feature of the professional claim.

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 diagnosis. At a minimum, a primary diagnosis is required, otherwise the claim transaction will reject. We will go over entering diagnosis codes and diagnosis code pointers in depth later in this presentation.



Entering Diagnosis Codes on Institutional Claims

- Enter up to 11 diagnosis codes on the claim form

| 67 Prin Diag | 68 Code | 69 Code | 70 Code | 71 Code | 72 Code | 73 Code | 74 Code | 75 Code | 76 Adm Diag | 77 ECode |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

- Can have up to 26 diagnosis codes total
- If applicable, put them in the Codes section

| Claim Pricing Repricing | | Display Charge Fields |
|-------------------------|----------------------|-----------------------|
| ▼ Codes | | Display Charge Fields |
| Diagnosis Code10 | <input type="text"/> | |
| Diagnosis Code11 | <input type="text"/> | |
| Diagnosis Code12 | <input type="text"/> | |
| Diagnosis Code13 | <input type="text"/> | |

If you submit institutional claims, you are already used to submitting diagnosis codes. As you know, you can enter up to 11 codes on the main page of the form in fields 67 - 77. In fields 67 – 75, be sure to rank them in descending order – from primary to secondary to tertiary, etc. Field 76 is the admitting code, and field 77 is the e-code. For some claims, you may need to enter more diagnosis codes. Where do you enter the other diagnosis codes? You can enter 15 more diagnosis codes in the Electronic Fields section under Codes.

As always, Alaska Medical Assistance requires diagnosis codes on institutional claims. Enter all appropriate diagnosis codes, including the primary diagnosis code which you put in field 67. Only the primary diagnosis code in field 67 and the secondary diagnosis code in field 68 are used in processing.



Entering Diagnosis Codes on Transportation Claims

- Enter at least 1 diagnosis code on the claim form



| | |
|-----------------|-------------|
| 21. DIAGNOSIS 1 | DIAGNOSIS 3 |
| DIAGNOSIS 2 | DIAGNOSIS 4 |

- Can have up to 4 diagnosis codes total

According to 5010 standards, if you submit transportation claim, you must enter at least 1 diagnosis code in Box 21 under the Diagnosis 1 field for your claim to process. This change impacts all enrolled personal care agencies and HCBS providers (regardless of covered agency or atypical status). If you do not submit a code, you will not be paid.

You may wonder what code to submit. Don't worry, later in the webinar, you will learn what codes to enter if you submit transportation claims on Payerpath.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Professional Claims Submitted via Payerpath



[Title slide only.]



Summary of New Fields on Professional Claims

| Section | Details |
|------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| Facility | Contains a Service Facility Contact Phone field |
| Electronic Charge Line Information | When "Coordination of Benefits – Additional Adjustments" is selected, a Remaining Patient Liability field is available |
| Electronic Charge Line Information | When "Coordination of Benefits – Additional Adjustments" is selected, a Remaining Patient Liability field is available |

The information you see on this slide is a brief summary of the new fields in the professional claim form on Payerpath. The professional claim is like the 837P transaction or the 1500 form. All of these new fields are in the Electronic Fields, which means they are all situational.

Now you can enter a service facility contact phone number in the Facility section.

In the Electronic Charge Line Information, you have new fields for information pertaining to ambulance pick-ups and drop-offs and remaining patient liability.

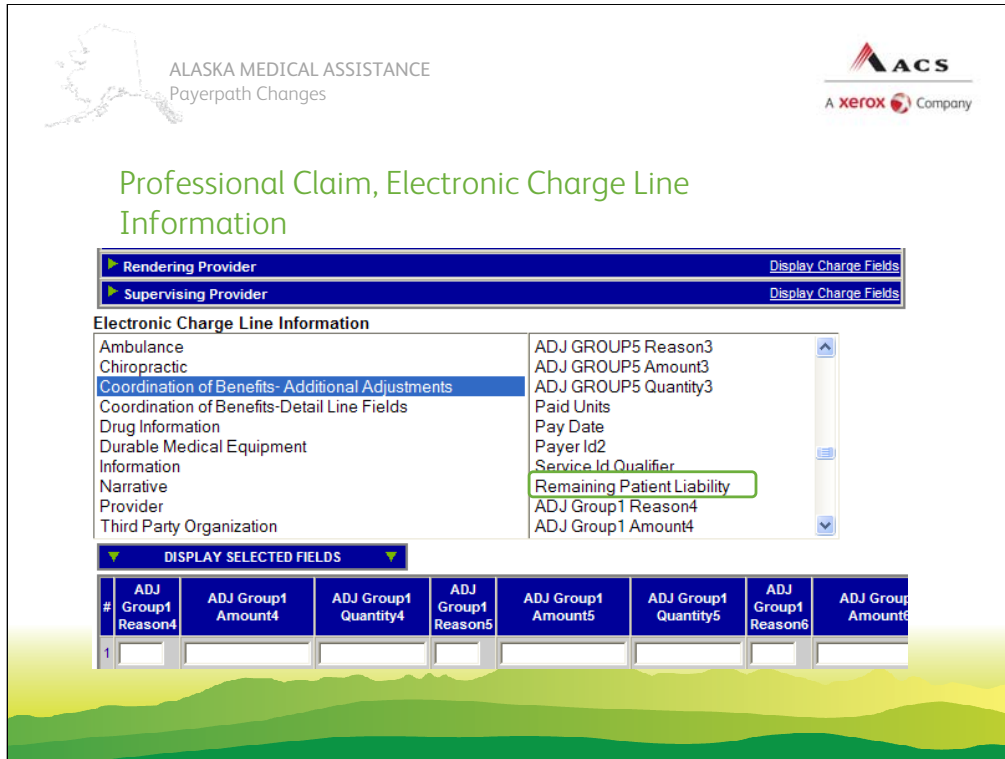
Now that we've seen a summary of the changes, let's look at each one of them specifically as they appear in Payerpath.



Professional Claim, Facility Section

| | |
|-------------------------------------------|---------------------------------------|
| ▶ Coordination of Benefits-Other Payer C | Display Charge Fields |
| ▼ Facility | Display Charge Fields |
| Service Facility Phone Number | <input type="text"/> |
| Facility/Laboratory Street Address Line 2 | <input type="text"/> |
| Facility/Lab Id Number | <input type="text"/> |
| Location Identifier | <input type="checkbox"/> |
| Facility Id Qualifier | <input type="checkbox"/> |
| Facility Tax Id | <input type="text"/> |
| Facility Tax Id Qualifier | <input type="checkbox"/> |
| ▶ Information | Display Charge Fields |

If you click the Electronic Fields link, you will be redirected to a page with this information. If you need to add facility information, now you can include the Service Facility Phone Number.



Finally if you have entered charges at the bottom of the screen, you will see the Electronic Charge Line Information. Now, there are two new sets of information you can provide.

First, if you select Ambulance and click Display Selected Fields, there are eleven new pick up and drop off fields available to you. They include:

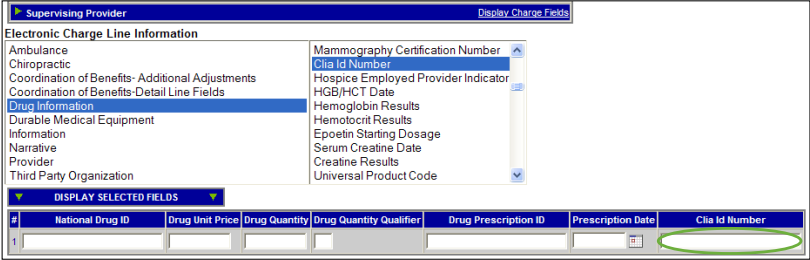
- Ambulance Pick-up Address 1
- Ambulance Pick-up Address 2
- Ambulance Pick-up City
- Ambulance Pick-up State
- Ambulance Pick-up Zip
- Ambulance Drop-off Name
- Ambulance Drop-off Address 1
- Ambulance Drop-off Address 2
- Ambulance Drop-off City
- Ambulance Drop-off State
- Ambulance Drop-off Zip

Second, if you select Coordination of Benefits – Additional Adjustments and click Display Selected Fields, there is one new field called the Remaining Patient Liability field.



Reporting Referring Providers and CLIA#

- Referring Provider in field 17
- CLIA# in Electronic Charge Line Information



| # | National Drug ID | Drug Unit Price | Drug Quantity | Drug Quantity Qualifier | Drug Prescription ID | Prescription Date | CLIA ID Number |
|---|------------------|-----------------|---------------|-------------------------|----------------------|-------------------|----------------|
| 1 | | | | | | | |

There are a few other things we want to remind you of, if you submit professional claims on Payerpath. You will see these reminders on this slide and the next three slides.

Referring provider information has changed to require that the referring provider be an individual. If you need to report a referring provider, put the first and last name of the individual who is an enrolled provider – not an entity – in field 17. The first box is for the last name. The second box is for the first name. The third box is for the middle initial.

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. If the provider has a CLIA# for lab services, you need to enter it in the Electronic Charge Line Information section. To do that, select Drug Information. Click Display Selected Fields. Then find CLIA ID number in the menu to the right. When you click CLIA ID number, it will bring up a row with fields. Enter the CLIA ID number in the last field titled CLIA ID number.



Entering New Condition Codes

- 8 new condition codes
- Find definition of values in NUBC manual
- Manual posted on www.nubc.org

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. Those codes are defined in the manual from the National Uniform Billing Committee, which is also known as NUBC. You can access the NUBC manual on their website.

The information on where these condition codes are entered in Payerpath will be forthcoming.

Riding in Ambulances

- Number of patients riding in ambulance in Electronic Charge Line Information

Supervising Provider Display Charge Fields

Electronic Charge Line Information

| | |
|--------------------------------------------------|-----------------------------|
| Ambulance | Ambulance Drop-off Name |
| Chiropractic | Ambulance Drop-off Address1 |
| Coordination of Benefits- Additional Adjustments | Ambulance Drop-off Address2 |
| Coordination of Benefits-Detail Line Fields | Ambulance Drop-off City |
| Drug Information | Ambulance Drop-off State |
| Durable Medical Equipment | Ambulance Drop-off Zip |
| Information | Purpose Of Round Trip |
| Narrative | Purpose Of Stretcher |
| Provider | Patient Count |
| Third Party Organization | Ambulance Condition Code 1 |

| Purpose Of Stretcher | Patient Count | Ambulance Condition Code 1 | Ambulance Condition Code 2 | Ambulance Condition Code 3 | Ambulance Condition Code 4 | Ambulance Condition Code 5 |
|----------------------|---------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| | | | | | | |

Alaska Medical Assistance also needs you to report how many patients rode in an ambulance. You enter the number of patients in the Electronic Charge Line Information section in the Electronic Fields. Pick Ambulance from the list on the left and click Display Selected Fields. Then find Patient Count in the menu on the right. Click it and a row appears below. To the far right, you will see a field with the column heading Patient Count. You will need to scroll over to see this field. Enter the number of the patients riding in the ambulance here.



Anesthesia-Related Changes

- Time reported in total number of minutes
- Reporting anesthesia as units is no longer permitted
- Processes the same as 4010

| | From Date | To Date | POS | TOS | HCPCS | Mod1 | Mod2 | Diag code | Charges | Units | FP | EMG | COB | Reserved | NPI | Del |
|---|------------|------------|-----|-----|-------|------|------|-----------|---------|-------|----|-----|-----|----------|-----|-----|
| 1 | 01/01/2012 | 01/01/2012 | 11 | | 01860 | | | | \$1.00 | 1 | | | | | | |
| 2 | 01/01/2012 | 01/01/2012 | 11 | | 01999 | | | | | 30 | | | | | | |
| 3 | | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | |

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.

The methodology remains the same. Anesthesia billing will still consist of a two line transaction. Please continue to send the anesthesia base code plus the time unit procedure code of 01999. Under 4010, if you billed the 01999 with three units, now with 5010, you bill the 01999 with 30 units.

You enter the total number of anesthesia minutes in the Units column on the professional claim form in Payerpath.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Institutional Claims Submitted via Payerpath



[Title slide only.]



Summary of New Fields on Institutional Claims

| Section | Details |
|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| Codes | Contains additional fields for Diagnosis Codes, Other Procedure Codes, Other Procedure Dates, Present on Admission, and External Causes of Injury Codes |
| Referring Provider | Has fields for Referring Provider First Name and Referring Provider Middle Name |
| Rendering Provider | Has fields for Rendering Provider First Name and Rendering Provider Middle Name |
| Electronic Charge Line Information | When "Provider" is selected, 9 referring and rendering provider fields are available |

The institutional claim is like the 837I transaction or the UB-04 form. The information you see on this slide is a brief summary of the new fields in the institutional claim form on Payerpath. These changes are in the Electronic Fields so they are always situational.

In the Codes section, there are new fields for diagnosis codes 14 through 25, other procedure codes 13 through 25, other procedure dates 13 through 25, present on admission codes 14 through 25 (which we encourage you to send), and external causes of injury codes 2 through 12.

Now you can also enter the referring and receiving provider's first name and middle name in the Referring Provider section and the Receiving Provider section.

Finally, if you select Provider in the list under the Electronic Charge Line Information section, you can enter information into the nine new fields for first and last name, IDs or NPIs, and qualifiers.

Now that we've seen a summary of the changes, let's look at each one of them specifically as they appear in Payerpath.



Institutional Claim, Codes Section

| | |
|---------------------------|-----------------------|
| ▶ Claim Pricing Repricing | Display Charge Fields |
| ▼ Codes | Display Charge Fields |
| Other Procedure Code 13 | <input type="text"/> |
| Other Procedure Date 13 | <input type="text"/> |
| Other Procedure Code 14 | <input type="text"/> |
| Other Procedure Date 14 | <input type="text"/> |

While you are in the institutional claim form, if you click the Electronic Fields link, you will be redirected to a page with this information. If you need to add codes, you now have several new options. You will have to scroll down on the page to see them all. On the screen is an example of four of them. The new code fields are:

- Diagnosis Code 14 through Diagnosis Code 25
- Other Procedure Code 13 through Other Procedure Code 25
- Other Procedure Date 13 through Other Procedure Date 25
- Present on Admission 14 through Present on Admission 25. Don't forget, if you have a present on admission code, you should send it. We'll show you what codes to use on the next slide.
- External Cause of Injury (E-Code) 2 through External Cause of Injury (E-Code) 12



Present on Admission 837I Changes

| POA Value | Details |
|-----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Y | Diagnosis present at time of inpatient admission |
| N | Diagnosis not present at time of inpatient admission |
| U | Documentation insufficient to determine if condition was present at the time of inpatient admission |
| W | Affirms that the hospital has determined that, based on data and clinical judgment, it is not possible to document when the onset of the condition occurred. |



A very important change in institutional claim is that there is now a location for reporting a Present on Admission (POA) indicator. This indicator communicates to the payer whether the associated diagnosis code was present when the patient was admitted to the facility. The POA is required on hospital admission for principal and other diagnosis codes. The chart on your screen specifies the valid 5010 POA values. Be sure to include the value Y, N, U or W on institutional inpatient hospital claims.



Institutional Claim, Referring Provider Section

| | | |
|--------------------------------|----------------------|---------------------------------------|
| ▶ Payer C Additional Fields | | Display Charge Fields |
| ▼ Referring Provider | | Display Charge Fields |
| Referring Provider First Name | <input type="text"/> | |
| Referring Provider Middle Name | <input type="text"/> | |
| Referring Provider Last Name | <input type="text"/> | |

Toward the bottom of the Electronic Fields list, you will see the Referring Provider section. 5010 allows you to enter the referring provider's first name and middle name now. Why are these boxes here? Because the referring provider must be an individual – not an entity – which means you need to put their first name and middle initial, if you know it. As usual, you must put the referring individual provider's last name too.



Institutional Claim, Rendering Provider Section

| | |
|--------------------------------|---------------------------------------|
| ▶ Payer C Additional Fields | Display Charge Fields |
| ▶ Referring Provider | Display Charge Fields |
| ▼ Rendering Provider | Display Charge Fields |
| Rendering Provider First Name | <input type="text"/> |
| Rendering Provider Middle Name | <input type="text"/> |
| Rendering Provider Last Name | <input type="text"/> |

Underneath the Referring Provider section, you can see the Rendering Provider section. You can enter their first name and middle name now too.



Institutional Claim, Electronic Charge Line Information

▶ Referring Provider [Display Charge Fields](#)

▶ Rendering Provider [Display Charge Fields](#)

Electronic Charge Line Information

Charge Reports
Coordination of Benefits- Additional Adjustments
Coordination of Benefits-Detail Fields General
Coordination of Benefits-Detail Line Fields
Information
Parenteral Nutrition Therapy
Provider
Third Party Organization

Referring Provider First Name
Referring Provider Last Name
Referring Provider ID
Referring Provider ID Qualifier
Rendering Provider First Name
Rendering Provider Last Name
Rendering Provider ID NPI
Rendering Provider ID
Rendering Provider ID Qualifier
Attending Provider Qualifier

▼ DISPLAY SELECTED FIELDS ▼

| # | Reason Code 1 | Referring Provider First Name | Referring Provider Last Name | Referring Provider ID | Referring Provider ID Qualifier |
|---|---------------|-------------------------------|------------------------------|-----------------------|---------------------------------|
| 1 | | | | | |

As with all claim types, at the bottom of the Electronic Fields list, there is the Electronic Charge Line Information. If you select Provider and then click on the Display Selected Fields, you will see several new provider fields. They include:

- Referring Provider First Name
- Referring Provider Last Name
- Referring Provider ID
- Referring Provider ID Qualifier
- Rendering Provider First Name
- Rendering Provider Last Name
- Rendering Provider ID NPI
- Rendering Provider ID
- Rendering Provider ID Qualifier



Institutional Claim, Covered and Non-covered Days

The screenshot shows a medical claim form with several sections. A green circle highlights field 7 (CD) and field 8 (LUCD). Another green circle highlights fields 39 (Value Code), 40 (Value Code), and 41 (Value Code) in the 'Larger Representative Item' section. A blue 'X' is placed over the highlighted fields 7 and 8.

| Code | Description |
|------|------------------|
| 80 | Covered Days |
| 81 | Non-covered Days |

Submitting the correct covered and not-covered days information on inpatient hospital, nursing facility and long term care facility claims is critical. The fields where that information is entered has changed on Payerpath. You used to enter the number of covered days in field 7 and the number of non-covered days in Field 8. Now you need to use fields 39, 40 and 41. The system disregards any data that is entered in Fields 7 and 8.

You also need to enter a value code to indicate whether the number of days is covered or non-covered. The value code you enter is 80 for covered days and 81 for non-covered days. The number of days goes into the column that is labeled "Amount". As an example, if the claim is for 25 covered days and 10 non-covered days, you would enter 80 as the value code in Field 39 and 25 as the amount. Then you would enter 81 as the value code in Field 40 and 10 in the amount space.

The number of days you enter will display as dollars. For example, if you enter 25 days, it will look like \$25.00. The system will only transmit the whole number, not a dollar amount, and process the claim as 25 days.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Transportation Claims Submitted via Payerpath



[Title slide only.]



Summary of Changes to Transportation Claims

- Continue submitting transportation claims as usual
- Enter a diagnosis code on every claim
- Enter a diagnosis code pointer on every claim
- Enter a POS code on every claim



The transportation claim, which is like the 837P transaction or parts of the 1500 form, is for atypical providers who provide transportation and accommodation services. This claim is undergoing only three changes, and one of them we mentioned earlier. But we are pointing it out again because it is very important.

The first thing you need to know is that you must now enter a diagnosis code. Related to that, you must also enter a diagnosis code pointer. Finally, you need to enter a place of service code on every claim.

Now that we've told you about these changes, we are going to show them to you on the next slide.



Entering Data in Transportation Claims

| | From Date | To Date | POS | TOS | HCPCS | Mod1 | Mod2 | Diag code | Charges | Units | FP | EMG | COB | Reserved | Del |
|---|-----------|---------|-----|-----|-------|------|------|-----------|---------|-------|----|-----|-----|----------|-----|
| 1 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |

Based on 5010 rules, you must now enter a diagnosis code for every claim you submit. To enter the diagnosis code, when you open the claim form, go down to Box 21. You can enter up to 4 diagnosis codes, but most likely you will only need to enter one code in the Diagnosis 1 field.

Place of Service (POS) is now a required field so you also need to enter a place of service code on every claim. It is the box in the POS column. The three transportation-related POS codes you need to use are:

- 41 for Ambulance – Land
- 42 for Ambulance – Air or Water
- 99 for Other Place of Service

Transportation and accommodation providers may use the 99 Place of Service code if the ambulance codes do not apply.

If authorized transportation is included within the waiver plan of care, continue to bill as you do today with a Place of Service code of 12.

Since you have entered the diagnosis code, you also need to enter a diagnosis code pointer. You must always put a 1 in the box in the Diag column.



Diagnosis Codes for Transportation Claims

| Provider Type | Provider Description | ICD-9 Code | ICD-9 Description |
|----------------------------------------------------------|-------------------------------|------------|--------------------------------------------------------------|
| i.e., TR####, TX####, AC####, HM####, HO#### | Taxi Services and Hotel/Motel | V630 | Residence remote from hospital or other health care facility |

Since you do not have access to the recipient's medical records, we have designated diagnosis codes for you to use on your claims. You must enter the code that matches what type of provider you are. There is one code for you and it goes in field 21 in the transportation claim.

On the this slide, you can see the diagnosis code you need to use if your are a taxi services or accommodation provider. As you can see, you need to use V630 in the Diagnosis 1 box. Don't forget to enter a 1 in the box under the Diag column with the dates and charges.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Claims Submitted by Atypical and Miscellaneous Provider Types via Payerpath



[Title slide only.]



Summary of Changes to Atypical and Miscellaneous Provider Types

- Continue submitting transportation claims as usual
- Enter a diagnosis code on every claim
- Enter a diagnosis code pointer on every claim



If you are billing for an atypical provider – like home and community based services, residential living services, pre-maternal home, or personal care agency – you already know that you use the professional form. The form you used in 4010 looks the same as 5010, but you need to enter two new pieces of information, and one of them we mentioned earlier. But we are pointing it out again because it is very important.

For your claim to process, you must enter a diagnosis code and a diagnosis code pointer.

Now that we've told you about these changes, we are going to show them to you on the next slide.

Entering Data for Atypical and Miscellaneous Provider Types

The screenshot displays a claim form interface. At the top, there are three main input sections: '21. DIAGNOSIS 1' (with a sub-field 'DIAGNOSIS 2'), 'DIAGNOSIS 3' (with a sub-field 'DIAGNOSIS 4'), and '22. CLAIM FREQ / ORIG. REF NO' (with a sub-field '23. PRIOR AUTHORIZATION NUMBER'). Below these is a table with the following columns: 'From Date', 'To Date', 'POS TOS HCPCS Mod1 Mod2', 'Diag code', 'Charges', 'Units', 'FP', 'EMG COB Reserved', 'NPI', and 'Del'. The 'Diag code' column is highlighted with a green box, and a '1' is entered in the first row of this column. The table has six rows, with the first row containing red bars in the 'From Date', 'To Date', 'Charges', and 'Units' columns.

Based on 5010 rules, you must now enter a diagnosis code for every claim you submit. To enter the diagnosis code, when you open the claim form, go down to Box 21. You can enter up to 4 diagnosis codes, but most likely you will only need to enter one code in the Diagnosis 1 field.

Since you have entered the diagnosis code, you also need to enter a diagnosis code pointer. You must always put a 1 in the box in the Diag column.



Diagnosis Codes for Atypical and Miscellaneous Provider Types

| Provider Type | Provider Description | ICD-9 Code | ICD-9 Description |
|---------------|-------------------------------------------|------------|------------------------------------------|
| i.e., HC##### | Home and Community Based Agency (HCB) | 78099 | Other general symptoms |
| i.e., RL##### | Residential Supported Living Arrangements | V606 | Person living in residential institution |
| i.e., EM##### | Environmental Modifications | V601 | Inadequate housing |
| i.e., BR##### | Behavioral Rehabilitation | V606 | Person living in residential institution |
| i.e., MS##### | Lifeline Waiver | 78099 | Other general symptoms |

For your claims to process, you need to include a valid diagnosis code on the claim. If you have the recipient's diagnosis code, then a valid ICD-9 code to report that condition can be submitted. If you do not have a valid diagnosis code, Alaska Medical Assistance has provided valid codes for you to use. If you use these codes, you must enter the code that matches what type of provider you are. Any time you enter a diagnosis code, it must go in field 21 in the Payerpath claim entry form.

On this slide and the next you are going to see the codes you can use if you do not have the recipient's diagnosis code. Here, you can see the diagnosis codes for Home and Community Based Agencies, Residential Supported Living Arrangements, Environmental Modifications, Behavioral Rehabilitation and Lifeline Waiver providers.



Diagnosis Codes for Atypical and Miscellaneous Provider Types, Continued

| Provider Type | Provider Description | ICD-9 Code | ICD-9 Description |
|------------------------------|-----------------------|------------|-------------------------------------|
| i.e., CMG#### | Care Coordination | 78099 | Other general symptoms |
| i.e., AC####, HM####, HO#### | Pre-Maternal Home | V222 | Pregnancy state, incidental |
| i.e., PCG#### | Personal Care Agency | 7999 | Other unknown and unspecified cause |
| i.e., SB#### | School Based Services | 78099 | Other General Symptoms |

On the this slide, you can see the diagnosis code you need to use if your are a provider who is billing for Care Coordination, Pre-Maternal Home, Personal Care Agency or School Based Services.

Be sure to enter your diagnosis code in Box 21 so that your claim processes and you are paid. If other codes become available, they will be published on medicaidalaska.com and in your RA messages.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Dental Claims Submitted via Payerpath



[Title slide only.]



Changes to Dental Claims Coming

- Continue submitting dental claims as usual
- Claim form and Electronic Fields will be updated TBD
- Different way to handle the dental claim procedure count
- Can submit a valid diagnosis code



The dental claim is just like the 837D transaction and the ADA Dental claim. Payerpath has not released or implemented the changes to this claim yet. Until you hear differently, you need to continue submitting dental claims just like you do using 4010 standards. When those changes are available, you will see them in your claim form.

Here are a few things you can expect, though, because of 5010 rules. First, Payerpath is giving you a different way of handling dental claim procedure counts. Second, you now have the option to submit diagnosis codes. Submission of a diagnosis code on a dental claim is situational. If you choose to submit a diagnosis code on a dental claim, it must be a valid diagnosis code for the date of service.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Payerpath Rebill Function



[Title slide only.]



Rebill Function Considerations

- Pre-populates information
- Information differences between 4010 and 5010
- Using Rebill after January 1, 2012

Payerpath has a rebill function that simplifies claims submission by pre-populating certain fields with information that was previously submitted for a recipient.

If you use a claim submitted prior to January 1, 2012 as the base claim for your rebill function you will need to update fields to 5010 standards in order for the claim to be accepted.

For example, if addresses are P.O. Boxes, they will need to be updated to reflect a physical address. Zip codes will need to be updated to include the +4 extension. Make sure you have a diagnosis code and pointer as well as a valid place of service code for transportation claims. A present on admission code is required for institutional claims. All referring providers must be an individual and not an entity.

This only needs to be done the first time you submit a claim using the base of a claim originally submitted prior to January 1, 2012. After that, the information will be saved according to 5010 standards for future use.

Claims that are entered from scratch without using the rebill function will automatically use the valid 5010 values.

Correcting Patient Signature Source

The screenshot displays the Payerpath web application interface. The main form is titled "Payer A" and includes fields for "Payer Responsibility A", "Insurance Type Code A", "Source of Payment Code A" (set to "MC-MEDICAID"), "Payer Identification Number A", "Patient Signature Source", "Champus Sponsor Status", "Champus Sponsor Branch", "Champus Sponsor Grade", and "Remaining Patient Liability". The "Patient Signature Source" field is highlighted with a red border and contains a red error message: "INVALID CODE". A pop-up window titled "Form Navigation - Webpage Dialog" is open, showing "Errors for NAME" and "Pat Acct: xxx###". Below the error message, it lists "Patient Signature Source - INVALID CODE" and provides navigation options: "Save and Run Edits", "Back To Form", "Back To List", "Previous Claim", and "Next Claim". The browser address bar shows "https://www.payerpath.com/".

This screen shows an error with the Patient Signature Source. This is an example of where the valid value changed. For 4010 it was a "B" but the new code for 5010 is a "P" or blank.

New claims generated via Payerpath will default to the "P" value. However, if you use a claim submitted prior to January 1, 2012 as the base claim for a Rebill, you will need to change this value on the Electronic Fields screen. Claims containing the previous value of "B" and associated descriptive text in this field will receive an "Invalid Code" error prior to submission. This must be corrected for the claim to be accepted for processing.

Correcting Primary Payer Facility ID Qualifier

The screenshot displays a web-based form for Alaska Medical Assistance. The form is titled "Correcting Primary Payer Facility ID Qualifier". It contains several sections, including "Coordination of Benefits" and "Facility". The "Facility" section is expanded, showing fields for Facility Name, Address, City, State, ZIP Code, and Facility ID Number. The "Primary Payer Facility ID Qualifier" field is highlighted in green and contains the value "1D". A red error message is displayed next to this field, indicating an "INVALID CODE" error. A pop-up window titled "Form Navigation - Webpage Dialog" is also visible, showing the error message and navigation options.

This screen shows an error with the Primary Payer Facility ID Qualifier. This is an example of where the valid value changed on an institutional claim. For 4010 it was a "1D" but the new code for 5010 is a "G2".

Just as we saw on the previous slide with the Patient Signature Source, new claims generated via Payerpath will default to the "G2" value. However, if you use a claim submitted prior to January 1, 2012 as the base claim for a Rebill, you will need to change this value on the Electronic Fields screen. Claims containing the previous value of "1D" in this field will receive an "Invalid Code" error prior to submission. This must be corrected for the claim to be accepted for processing.

All of the valid codes for 5010 can be found in the Companion Guides published on www.medicaidalaska.com.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Payerpath Webinar Wrap-Up



[Title slide only.]

ALASKA MEDICAL ASSISTANCE
Payerpath Changes

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Alaska-Specific Resources

- Alaska Medical Assistance 5010 Companion Guides at http://medicaidalaska.com/providers/hipaa/hipaa5010_Companion_Guides.shtml
- ASC x12 TR3s at <http://store.x12.org/store/>
- ACS Payerpath Introductory Training
 - Call EMC department at 907-644-6800, option 3
- ACS 5010 News Alerts at http://medicaidalaska.com/providers/hipaa/hipaa5010_news.shtml

Now that we've reviewed the changes to Payerpath, you may want more resources. There are four things we recommend.

You may want to get the Companion Guides we provide which gives you information exclusive to Alaska Medical Assistance. The link to get them is located on the slide. They are available free of charge for you to review and print. If you need more information about the Companion Guides, please refer to the 5010 Companion Guide webinar. For Payerpath or other software vendors and clearinghouses, these Companion Guides serve as a supplement to the TR3s, which are Technical Report Type 3s.

On that note, you should be aware that TR3s are available for you to purchase. They are the technical detail manuals written by ANSI and used by software coders and clearinghouses. You can buy them from the website listed in the slide.

Another option is you to take the Payerpath introductory training ACS offers. To find out about this training, call ACS's Electronic Media Claim Department, known as EMC, by dialing 907-644-6800 and selecting option 3.

Finally, remember to check for the most up-to-date information at medicaidalaska.com. Simply click the link on the screen or select the HIPAA 5010 tab from the Alaska Medicaid home page.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Questions?

- Ask a subject matter expert
- Email AKHIPAASupport@acs-inc.com
- Call
 - Toll-free at 855-226-9391
 - Local Alaska number at 907-644-6831
- Go to <http://medicaidalaska.com>
- Subscribe to the RSS feed

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.



Other 5010 Courses

- Companion Guides and Testing Requirements
- 837P Professional Claim Transaction
- 837P Atypical Professional Claim Transaction
- 837I Institutional Claim Transaction
- 837D Dental Claim Transaction
- 270/271 Eligibility Benefit Inquiry and Response Transactions
- 835 Claim Payment Advice Transaction

As we've gone through the changes in Payerpath and as we've taken your questions, you may have realized that you would like to learn more about 5010. For instance, you may need to learn more about your particular kind of claim transaction.

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.



ALASKA MEDICAL ASSISTANCE
Payerpath Changes



Thank You



Thank you for attending 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.