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**November '05**



First Health Services, in conjunction with the Division of Health Care Services, publishes this monthly newsletter that offers providers useful information, monthly reminders, and tips on how to make billing easier.

November Holiday Closures						
■ = State Offices Closed						
■ = State & FHSC Offices Closed						
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## How does it affect Medicare Part D Alaska Medical Assistance (Medicaid) Recipients?

Part D is the newest program in Medicare. In 2003, the federal Medicare Prescription Drug, Improvement and Modernization Act created the program to cut drug expenses for those enrolled. Since then, some people have purchased Medicare drug discount cards to reduce prescription costs until Part D begins.

Starting January 1, 2006, the new Medicare prescription drug coverage will be available to all people with Medicare, regardless of income, health status, or how they currently pay for prescription drugs. Medicare part D will cover brand name and generic drugs. The discount cards will be phased out by May 15, 2006.

All but three of the plans offered in Alaska have a mail order option to help people, particularly those living in rural areas, purchase medicines they need.

There may be many Medicare drug plans from which to choose and these plans may vary in different areas. The Medicare drug plans may vary in which prescription drugs are covered (each will have its own formulary or tiering), how much the patient has to pay (co-pays may vary), and which pharmacies can be used (all plans are linked with at least one pharmacy). Insurance companies and other private companies will work with Medicare to offer these Medicare drug plans. It is important for people to understand the type of coverage they have now and to choose a Medicare plan that

suits their needs. Medicaid is the state-run program that pays for health care costs for people with limited income and resources. It may be called something other than Medicaid in some states.

Medicare is the federal health insurance program for the aged and disabled, people age 65 or older, people under 65 with certain disabilities, and people with ESRD {end stage renal disease} of all ages. People with Medicare and full Medicaid coverage (known as dual eligibility) need to be aware of the change in their drug coverage from Medicaid to Medicare. They will be notified that as of December 31, 2005, their Medicaid will no longer be creditable coverage for prescription drugs, however; Medicaid will pay the premium for Medicare part D. These individuals will automatically be enrolled in a Medicare plan if they don't join by the end of the year. The notice will include information about which prescription plan Medicare will enroll them in, their costs in the plan, and questions and answers about Medicare prescription coverage. Auto-enrollment applies only to those who are already enrolled in Medicare with full Medicaid benefits.

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A handbook **Medicare and You 2006** includes information about the specific drug plans available in different areas. It will be mailed in October 2005 to people with Medicare. Individuals should choose a Medicare drug plan that works for them. Remember, if dual eligibles don't join a plan by December 31, 2005, they will be auto-enrolled in a plan chosen by Medicare.

If you know someone with questions about the changes in prescription drug coverage, direct them to read the handbook or visit [www.medicare.gov](http://www.medicare.gov), or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. They may also call their State Health Insurance Program (SHIP) for free personalized health insurance counseling.

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## IHS/Tribal Claims Correction Worksheet

IHS/Tribal providers are encouraged to return the Tribal Claims Correction Pend Worksheet in a timely manner to speed up the processing of their claims. The worksheet is an intervention tool to facilitate claims resolution and payment. The Tribal Claims Coordinator provides detailed instruction to fix errors identified by a three digit explanation code. The Coordinator gives the provider 14 days to return the corrected worksheet. If there is no response to the worksheet, the claims is placed in RTD status or denied. The worksheet may be faxed or mailed. If mailed, allow enough time for the worksheet to reach the Coordinator within the 14 day limit.

# PROVIDER TRAINING

Providers and billing staff are encouraged to attend training. There is no charge to attend, as training is sponsored under contract with the State of Alaska, Department of Health and Social Services, Division of Health Care Services. All participants should bring their provider billing manual(s).

Because of limited space, you are encouraged to register early; registration for each class will close one week prior to the date of the class. Only registered attendees (with a confirmed registration) are guaranteed a seat; those without a confirmed registration may be turned away. If registration requests exceed the available seats, additional sessions may be offered.

Register for classes in one of the following ways:

- Complete the online registration form on the First Health Services Website at <http://alaska.fhsc.com>
- Complete the registration form found in the Alaska Medicaid Training Schedule and fax to First Health Services at 907-644-5900 or mail to P.O. Box 240808, Anchorage, Alaska 99524-0808

After your registration is received and processed by First Health Services, you will receive a confirmation for the classes in which you are enrolled.

## TRAINING SCHEDULE

OCTOBER - DECEMBER 05  
IS NOW AVAILABLE

The training schedule through December 2005 is now available on First Health Services' Website at <http://alaska.fhsc.com>. If you would like an electronic version sent to you, please contact the FHSC training unit at [anctraining@fhsc.com](mailto:anctraining@fhsc.com). If you prefer a paper copy of the schedule, please contact the First Health Services Provider Inquiry Unit at 907-644-6800 or 1-800-770-5650 (toll free in Alaska).

### TRAINING EMAIL AND FAX NUMBER

Medicaid's training email address ([anctraining@fhsc.com](mailto:anctraining@fhsc.com)) is provided for your convenience to send in your questions and comments regarding training offered by FHSC, and to submit completed training registration forms.

Training also provides a fax number (907-644-5900) for your convenience in sending in registration forms or correspondence to FHSC's training department. Remember, our professional staff is ready to assist you, whatever your training needs may be.

Please do not send sensitive or confidential information via email, as this is not a securely protected environment.

## NOVEMBER

<b>11/04/05</b>	Physicians/Osteopaths/ANPs	10:00 am – 12:00 pm
<b>11/08/05</b>	Physicians/Osteopaths/ANPs	<b>Fairbanks</b> 10:00 am – 12:00 pm
<b>11/09/05</b>	Transportation & Accommodation Medical Justification for Travel Attachments	<b>Fairbanks</b> 8:00 am – 11:00 am 11:15 am – 12:15 pm 1:00 pm – 4:00 pm
<b>11/15/05</b>	Waivers Services	<b>Anchorage</b> 8:30 am – 10:30 am
<b>11/18/05</b>	Waivers Services	<b>Teleconference</b> 8:30 am – 10:30 am
<b>11/21/05</b>	Introduction to Alaska Medicaid Eligibility Completing Claim Forms: UB-92 Completing Claim Forms: CMS-1500 Medicare Crossovers	<b>Anchorage</b> 8:30 am – 11:30 am 11:30 am – 12:30 pm 1:30 pm – 2:15 pm 2:30 pm – 3:15 pm 3:30 pm – 4:15 pm
<b>11/22/05</b>	Remittance Advice RTDs Appeals Prior Authorizations (PAs)	<b>Anchorage</b> 8:30 am – 9:30 am 9:45 am – 11:45 am 1:00 pm – 2:00 pm 2:15 pm – 3:15 pm
<b>11/30/05</b>	Physicians/Osteopaths/ANPs Top 10 Edits	<b>Juneau</b> 10:00 am – 12:00 pm 1:00 pm – 3:00 pm

## **WEEKEND PA BEGINS 10/29/05**

FHSC's Prior Authorization Unit has hired a representative to assist you with your after-hours emergency travel needs. The hours for weekend assistance will be:

Saturday - 8-5PM

Sunday - 12-4PM

## **IN QUEUE TIME**

Please listen carefully to FHSC's Prior Authorization and Provider Inquiry Unit telephone message. The system has recently been updated. Information has been provided that will assist you in expediting your call.

## **ERASE PHI Before Discarding Old Hard Drives**

Remember, when throwing away old computers, be sure to erase the hard drives. PHI can be obtained by anyone searching the hard drive unless it has been properly erased. Protect both your organization's reputation and your patients' PHI by double checking that all data stored on your computer is destroyed - - before you send your hard drives to the trash pile.

## **NATIONAL PROVIDER IDENTIFIER**

The National Plan and Provider Enumeration System (NPPES) collects identifying information on health care providers and assigns each a unique National Provider Identifier (NPI). If you need an NPI, you can apply online by going to <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>. The estimated time to complete the NPI application form is approximately 20 minutes. If you would like a paper application, please call 1-800-465-3203.

*Health care providers are required by law to apply for a National Provider Identifier (NPI). For the latest NPI information, visit [www.cms.hhs.gov/hipaa/hipaa2](http://www.cms.hhs.gov/hipaa/hipaa2)*

## *Bits n' Pieces of information to assist you...*

FHSC is not able to image receipts that are small. Please copy small receipts onto a 8.5 x 11 sheet of paper before mailing in for better imaging. This process will assist FHSC in processing your claims in a more timely manner.

## **New Pharmacy Enrollment Process**

The First Health Services enrollment process for Pharmacy providers has changed. This includes providers who dispense medications (such as Physicians and NPs who use the Point of Sale billing mechanism). Effective immediately, the original signed Provider Information Submission Agreement (PISA) is a requirement for enrollment, in addition to the existing enrollment requirements for pharmacy and dispensing providers.

For more information on this process, please call Provider Enrollment at (907) 644-6800 or (1-800-770-5650, toll-free, in-state).

## **ATTENTION:**

When a claim is being rebilled, it is not necessary to mail the claim to the attention of a specific person. This may cause a delay in the processing of the claim and could possibly cause a missed cycle, or timely filing (depending on how close to timely filing the specific claim is being submitted).

[The 835 \(Electronic RA\)](#) registration form and other information can be found on FHSC's Website at <https://alaska.fhsc.com>. Choose HIPAA, then choose Agreements. The form is located near the bottom of the page.

Providers need to obtain a Submitter ID in order to directly receive an 835, otherwise the Billing Agent is able to receive it on the providers' behalf.

If you have further questions regarding the 835, please call the HIPAA support hotline at (907) 644-6800, option 3, or 1-800-770-5650 (toll-free in Alaska), option 4.

# First Level Appeals - When and How.

A provider may request a review of an Alaska Medical Assistance claim or decision when a claim has been denied or reduced. Providers may also dispute the recovery of an overpayment by Alaska Medical Assistance, denial for enrollment issues (sent to DHCS, Division of Health Care Services), or disputes related to hospital admission or length of stay (contact Qualis Health).

First level appeals must be in writing and received within 60 days of the claim disposition date (the date of the Remittance Advice [RA]), or within the timely filing period for that date of service.

There are three levels of appeals which are discussed in detail in Section III of the Billing Manuals. You must follow the proper sequence when submitting a request for an appeal level review.

Prior to submitting a first level appeal, follow these steps in determining whether or not an appeal is warranted:

- Has the claim paid, but listed on a different RA?
- Was it denied, and if so, why?
- If the claim was denied, can it be corrected and resubmitted?
- Review the claim itself for accuracy.
- Are all names, ID numbers, procedure codes (and modifiers), and diagnoses correct?
- Check the claim's history to verify whether the claim had been previously submitted?
- Did it ever go into RTD status?
- Have you requested to have the claim adjusted or should you be doing so now?
- Is the recipient's eligibility current?
- Is your provider enrollment current?

Many first level appeals are delayed due to an incomplete request. First Health Services Corp (FHSC) suggests using our

Appeals form (*see sample form*), which will help ensure that you have submitted all of the necessary information for FHSC to complete the first level appeal review process. Remember to include (1) medical records; (2) the medical provider's name, ID number, and contact information; (3) the recipient's name and ID number; (4) the date of service and the procedure codes (and applicable modifiers) related to the appeal; (5) copy of the claim denial or payment notice (the RA) which shows how the claim adjudicated; (6) an original paper claim for the service denied or reduced (that can be submitted after review is completed); and (7) summarize the reason you are appealing on the form, including the provider contact logs and other relevant documentation support this claim. Remember, any Claim Check® denials will require medical notes for review.

Remember, many claims which have been denied may be corrected and resubmitted. Claim Check® denials, however, require an appeal. Appealing such claims does not guarantee they will be paid.

*Don't forget to include*

- Appeal Form
- RA (Remittance Advice)
- Original paper claim for denied service
- Supporting Documents

Mail First Level Appeals to:  
 FHSC  
 Attn: Appeals  
 P.O. Box 240808  
 Anchorage, AK 99524

P.O. Box 240808  
 Anchorage, AK 99524  
 (907) 544-6800  
 www.fhsc.com



### Provider Appeals Form

Pre -Appeal  First Level Appeal

**Provider Information**

Provider Name: \_\_\_\_\_  
 Provider ID No.: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_  
 Contact Telephone No.: \_\_\_\_\_

**Recipient Information**

Recipient Name: \_\_\_\_\_  
 Recipient ID No.: \_\_\_\_\_  
 Date of Service Related to this Appeal: \_\_\_\_\_  
 Service(s) or Procedure(s) Related to this Appeal: \_\_\_\_\_

**Reason for Request** (i.e., medical justification, timely filing, etc.)

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