



June 2006

Alaska Medical Assistance Newsletter

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First Health Services, in conjunction with the Department of Health & Social Services, publishes this monthly newsletter to offer providers useful information, monthly reminders, and tips on how to make billing easier.

Attention Providers: New Medicare Crossover Process

June 2006

				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

FHSC and State of Alaska offices will be closed on Tuesday, July 4, 2006 in observance of Independence Day.

Updates...

The following has been updated and is available to you on the FHSC website:

- School Based Services billing manual
- DME, Prosthetics, Orthotics & Supplies Fee Schedule
- Home Infusion Therapy Fee Schedule Addendum

What is the purpose of this notice?

The Centers for Medicare & Medicaid Services (CMS) is implementing a new crossover process, the **Coordination of Benefits Agreement (COBA)**. The crossover process is the method by which claims and payment information are electronically transmitted from Medicare as the primary payer to a secondary payer, such as Medicaid, thus reducing the need for the healthcare provider to submit the same claim information to Medicaid. This notice provides guidance for your participation in the new COBA crossover claims process.

Why did I receive this notice?

YOU, an enrolled Medicare and Medicaid provider, are subject to the new COBA claims process.

What is COBA?

The new COBA process is a national standard requirement between Centers for Medicare & Medicaid Services (CMS) and other health insurance organizations, including Medicaid. COBA provides an automatic claim coordination of benefits, or crossover service, from Medicare to Medicaid and other health insurance organizations, or trading partners.

Note: This notice pertains only to Alaska Medicaid as the secondary payer.

Additional information about COBA is available on the CMS Website at: http://www.cms.hhs.gov/COBAgreement/01_overview.asp

What claims are affected by COBA?

The new COBA process affects claims that you bill to Medicare for Dual Eligibles – those who are eligible for both Medicare AND Medicaid.

What is the purpose of COBA?

CMS implemented COBA in order to better serve providers through the streamlining of the claims crossover process. COBA provides significant advantages and improvements for you, including:

- Increased accuracy of processed claims
- Increase in the number of claims which successfully crossover from Medicare to Medicaid
- Faster payment of claims
- Reduction in the number of separately submitted claims to Medicaid as the secondary payer

****** Appeals******

When sending in an appeal, ensure that what you are sending is complete. Include a copy of the claim, and any necessary attachments, such as medical records/documentation. If you receive a letter from FHSC that your appeal is incomplete, please respond to the letter as soon as possible to expedite your appeal.

How will COBA work?

CMS will transfer claim crossover functions from individual Medicare contractors (intermediaries and carriers) to a single national claims crossover contractor. This **Coordination of Benefits Contractor (COBC)** is Group Health Incorporated (GHI).

When is COBA effective?

Effective July 3, 2006, claims you submit to Medicare for Dual Eligibles will electronically crossover to Medicaid via the COBC. When you correctly file a claim for a Dual Eligible, the new COBA crossover process will be largely transparent to you.

What do I need to do?

To fully realize the benefits of COBA, you will need to include your Medicaid Billing Provider ID and Medicaid Servicing (Rendering) or Attending Provider ID on claims submitted to Medicare for Dual Eligibles for claims submitted on or after July 3, 2006.

To specify your Medicaid billing and servicing or attending provider IDs on your claim to Medicare:

- Professional claims:
 - The Medicaid Billing Provider ID is entered in the 2010AA Loop
 - The Medicaid Servicing Provider ID is entered in the 2330E or 2420A Loop
- Institutional claims:
 - The Medicaid Billing Provider ID is entered in the 2010AA Loop
 - The Medicaid Attending Provider ID is entered in the 2330D or 2420A Loop

There is no change in the fields you currently use to bill Medicare. These are additional fields to identify your Medicaid provider numbers. Refer to the attached table for specific information regarding the 837 transaction and loops.

What else do I need to be aware of?

The month of July 2006 will be a transitional month; therefore you can expect to see some crossover claims that have processed through both the new COBA process and through the former process. Due to this transition, CMS has advised that the possibility of processing duplicate claims exists. For this reason, please pay particular attention to your 835 transaction or Remittance Advice statement.

Be sure to watch for additional information that will arrive soon regarding COBA. Please submit any questions or comments to FHSC via facsimile, (907) 644-8126, or by mail to:

First Health Services Corporation
Attention: Provider Inquiry
P.O. Box 240808
Anchorage, Alaska 99524-0808

April - December 2006
 Training Schedule is available
 on FHSC's Website at
[http://alaska.fhsc.com/training/
 providerTraining.asp](http://alaska.fhsc.com/training/providerTraining.asp)

NEW MEDICARE CROSSOVER PROCESS

837 Instructions: Billing Medicare for Dual Eligibles

Effective with Claims Filed to Medicare on and after July 3, 2006

PROFESSIONAL CLAIMS BILLED TO MEDICARE

Medicaid Provider ID	X12 Loop ID	Description	837P
The Medicaid Billing Provider ID is entered in this field:	2010AA	Billing Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Billing Provider ID
The Medicaid Servicing Provider ID is entered in this field:	2330E	Rendering Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Rendering Provider ID
When the rendering provider for this claim line is different from the other claim lines, the Medicaid Servicing Provider ID is entered in this field:	2420A	Rendering Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Rendering Provider ID

INSTITUTIONAL CLAIMS BILLED TO MEDICARE

Medicaid Provider ID	X12 Loop ID	Description	837I
The Medicaid Billing Provider ID is entered in this field:	2010AA	Billing Provider Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Medicaid Billing Provider ID
The Medicaid Provider ID for the Attending provider is entered in this field:	2330D	Attending Physician Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Attending Provider Medicaid ID
When the attending provider is different from the from the attending provider for the rest of the claim, the Attending Provider Medicare ID is entered in this field:	2420A	Attending Physician Secondary Identification	Segment: REF01
			Field Value: 1D
			Segment: REF02
			Field Value: enter your Attending Physician Secondary Identifier

Hospital Services

Alaska Medical Assistance will reimburse an enrolled hospital provider for services rendered to an eligible Medical Assistance recipient. Hospital services are reimbursed at a per diem rate established by the Medicaid Rate Advisory Commission, per 7 AAC 43.670 - 7 AAC 43.709; based on the rate that was effective at the time service was provided.

To receive payment from Alaska Medical Assistance, providers must comply with licensing requirements under AS 18.20 and 7 AAC 12 (exception for tribal facilities 7AAC 43.365); comply with 7 AAC 43; have a plan of utilization review approved by the Department of Health and Social Services (DHSS); and comply with PA (Prior Authorization) requirements.

Claims may be submitted electronically (HIPAA compliant 837 I claim; contact FHSCs ECCS coordinator for testing, (907) 644-6800 or (800) 770-5650) or on paper using the UB-92 claim form. Instructions for claim submission are in section I of the hospitals billing manual.

- Use national codes sets, revenue codes, in field 42
- HCPCS codes are used for diagnostic laboratory procedures

For further information on electronic billing please review the National Uniform Billing Committee (NUBC) manual, which can be accessed at www.nubc.org or by calling (317) 422-3390, as well as the Alaska Trading Partner Companion Guide 837 Institutional, <http://alaska.fhsc.com>.

If you are filing paper claims (UB-92), use the NUBC manual in conjunction with the Alaska Medical Assistance billing manual. Be sure to complete all required fields, and send all required attachments with your claims.

Resubmission Turnaround Documents (RTDs)

Resubmission Turnaround Documents are worksheets that you can correct errors or omissions on your claim. An RTD requires action on your part within 90 days. Corrections must be received at First Health by the date indicated on the RTD or the claim will be denied.

After making corrections, sign and date the RTD and return it to:

First Health Services
PO Box 240729
Anchorage, AK 99534-0729

or FAX to (907) 644-8122

The RTD worksheet is not intended for provider questions or comments. Please direct your questions to FHSC's Provider Inquiry Unit at (907) 644-6800, option 1.

National Provider ID Number (NPI) The deadline for providers completing electronic transactions to begin using NPI exclusively is May 23, 2007. If you do not yet have an NPI, you can apply online at <https://nppes.cms.hhs.gov/NPPE/StaticForward.do?forward=static.instructions>.

The estimated time to complete the NPI application is 20 minutes. If you prefer a paper application, please call (800) 465-3203.

For the latest NPI information, visit www.cms.hhs.gov/hipaa/hipaa2

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 manuals.

Because of limited space, you are encouraged to register early; registration for each class will close one day 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 in the Alaska Medical Assistance Training Schedule and fax to First Health Services at (907) 644-9845 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 Email and Fax Numbers

The Alaska Medical Assistance training email address (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. For Indian Health Services (IHS) training information, the training email address is ihs@fhsc.com.

Training also provides a fax number ((907) 644-9845) 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 secure method of sending confidential information.

June Schedule

06/13/06 (Teleconference) *Rescheduled from 5/2/06* 📧

Physicians/Osteopaths/ANPs 10:00 a.m. – 12:00 p.m.

06/14/06 (Anchorage)

Vision 10:00 a.m. – 12:00 p.m.

Eyewear from Rochester Optical 1:00 p.m. – 3:30 p.m.

06/20/06 (Palmer)

Intro to Alaska Medical Assistance 8:30 a.m. – 12:00 p.m.

Eligibility 2:00 p.m. – 3:15 p.m.

Prior Authorization 3:30 p.m. – 5:00 p.m.

UPDATED CMN FORM

The Certificate of Medical Necessity Form was revised on February 3, 2006. The revised form consists of two pages that must be submitted together for hearing services and items, durable medical equipment and supplies, respiratory therapy assessment visit services, prosthetics and orthotics, and home infusion therapy services that require prior authorization, effective with the new regulations for these services beginning on January 11, 2006. The form is posted on FHSCs website at <http://alaska.fhsc.com> under Provider Updates. If you have any questions, please contact FHSCs Provider Inquiry Unit at (907) 644-6800 or (800) 770-5650 (in-state, toll-free).

06/21/06 (Palmer)	
Remittance Advice	8:30 a.m. – 10:30 a.m.
Resubmission Turnaround Documents (RTDs)	10:45 a.m. – 12:00 p.m.
Appeals	2:00 p.m. – 3:30 p.m.
06/22/06 (Palmer)	
Adjustments & Voids	8:30 a.m. – 10:00 a.m.
Transportation & Accommodation	10:15 a.m. – 12:15 p.m.
6/27/06 (Anchorage) <i>Rescheduled from 6/07/06</i>	
Outpatient Therapies	10:00 a.m. – 12:00 p.m.
6/30/06 (Teleconference)	
Outpatient Therapies	10:00 a.m. – 12:00 p.m.

Care Coordination (Alaska)

Care Coordinator News

Care Coordination in Alaska is a service that works hand-in-hand with constituents looking for solutions to effectively and efficiently link children to levels of care appropriate to their clinical needs. Care Coordinators provide information regarding adequate resources to achieve the best possible outcomes for Alaska’s children with special needs.

We are currently updating the Website with more comprehensive resources for providers to enhance the level of care for Alaska’s youth. Watch for changes on the Care Coordinator Website at <http://alaska.fhsc.com/LookUp/CareCoordination.asp>.

If you have additional questions, please call or email:

Lyn Tashea, LPC

(907) 644-8119

lyntashea@fhsc.com

Carmel Nelson, LMSW, CDCII

(907) 644-8118

carmelnelson@firsthealth.com

Inpatient Behavioral Health Medicaid Program Provider Training

Attention: All Clinicians, case managers, administrative staff of enrolled Alaska Medicaid providers, Acute Inpatient and Residential Psychiatric Treatment Services staff

First Health Services is under contract with the State of Alaska’s Division of Behavioral Health (DBH) to perform prior authorization and utilization management of inpatient and residential psychiatric treatment services. These services are primarily provided to eligible Alaska Medicaid recipients under the age of 21.

Two training opportunities are **still available** this summer by First Health Services. The purpose of this training is to educate providers on the prior authorization and utilization management policies and procedures of the State, along with a thorough review of policy changes.

One-day training sessions will be held in the cities of Fairbanks (Session II) and Juneau (Session III) in June.

Session II

(Limited to 40
participants)

Fairbanks - June 21, 2006

Aspen Hotel, (907) 457-2288 or (888) 595-2151
Fairbanks, Alaska 99901

Session III

(Limited to 40
participants)

Juneau - June 23, 2006

Aspen Hotel, (907) 790-6435 or (888) 559-9846
Juneau, Alaska 99801

Pre-registration is mandatory. You may register for sessions on the First Health Services website at <http://alaska.fhsc.com>; choose **Training**, then **Online Registration**. You will receive an instant response that you are registered for your chosen session.

Due to limited seating, we cannot guarantee a seat if you are not registered. If you are unable to access the FHSC website to obtain the registration information, please contact **Lyn Tashea at (907) 644-6800 or (800) 770-5650** (toll-free in Alaska).

Electronic Billing

Unique Identification Numbers

Reminder to providers that submit claims electronically: Fax attachments to claims the same day that you submit your claims. Enter a unique identification number of your choosing on each page of the attachment. Enter the unique identification number in the appropriate field on your claim form, and write the unique identification number on fax cover sheet. First Health uses this unique identification number to match attachments to your claims. For more information, go to our website <http://alaska.fhsc.com> and click the HIPAA drop menu; then choose Companion Guide.

National Provider Identifiers (NPIs)

Centers for Medicare & Medicaid Services (CMS) has the capability for health industry organizations to submit health care providers' applications for National Provider Identifiers via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider's NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format.

EFI is an alternative to health care providers having to apply for their NPIs via the web-based or paper application process. After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers. Interested health industry organizations should avail themselves of the EFI materials available from the CMS NPI page (www.cms.hhs.gov/NationalProvIdentStand/) and from the NPPES page (<https://nppes.cms.hhs.gov>) before downloading and completing the Certification Statement (available at <https://nppes.cms.hhs.gov>) and registering as EFI Organizations. A completed Certification Statement must be approved by CMS before an interested health industry organization can participate in EFI.

CMS has released three new educational products on the National Provider Identifier.

“Guidance for Organization Health Care Providers Who Apply for National Provider Identifiers (NPIs) for Their Health Care Provider Employees” Tip Sheet.

This contains helpful information for organization health care providers who wish to apply for NPIs, or submit updates using the NPPES web-based process, on behalf of their employed health care providers.

“Tips for Health Care Professionals – Preparing Your Office Staff for NPI” Tip Sheet. This provides basic steps to prepare your office staff, and your business, for NPI implementation.

“NPI Overview” PowerPoint Presentation. This contains basic information on the NPI that is suitable for self education, as well as training purposes.

Also visit the Educational Resources page on the CMS NPI website at:

http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp to view these new products.

SUR (Surveillance Utilization Review)

Care Management Program (CMP)

As of April 1, 2006, the Care Management Program (formerly the Lock-in program) became active and is open to new referrals. If you have further questions or comments please contact a Care Management Program Coordinator at

(907) 644-6842.

First Health Services will be contacting providers looking for those willing to participate in the program. Watch the newsletter for upcoming information regarding CMP.

Provider Records Requirements and Retention

A provider shall maintain records necessary to support the care and services for which payment is requested, and must retain those records for **at least seven years** from the date services were provided. Be aware that some professional standards require record retention for longer periods of time. Records shall include:

- Patient information for each service provided, including the recipient receiving treatment; specific services provided; extent of service; date of each service; and individual who provided each service;
- Financial information for each service provided, including date of each service and charge; each payment source pursued; date and amount of all debit and credit billing actions; and amounts billed and paid;
- Clinical information pertinent to each service provided (according to applicable professional standards, applicable state and federal laws, applicable Alaska Medical Assistance provider billing manuals, and any pertinent contracts) to a patient for which services have been billed to Medical Assistance, identify the recipient's diagnosis; the medical need; each service, prescription, supply, or plan of care prescribed by the provider - including therapeutic services; and annotated case notes, dated and be signed or initialed by the individual who provided each service.

Request for Records

At the request of a Department of Health and Social Services representative, an authorized federal representative, or another authorized representative, including an employee of the Department of Law, **a provider shall provide records free of charge**, including financial, clinical, and other records, which relate to the provision of goods or services on behalf of a recipient. A provider who maintains records in an electronic format shall ensure that the data is readily accessible.

Adjustments/Voids/and Refunds

Remember that claims with incorrect provider or recipient identification numbers cannot be adjusted. They must be voided. When the void finishes processing, resubmit the claim with the correct identification number.

If you send in a refund check for an overpayment, please send in a completed adjustment form so we know where to apply the refund.