



July 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.

New Medicare Crossover Process

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 COVA crossover claims process.

Enrolled Medicare and Medicaid providers are subject to the new COBA claims process.

The new COBA process is a national standard requirement between 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. This 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

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

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

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).

Effective July 3, 2006, claims submitted 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.

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9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

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

<http://alaska.fhsc.com>

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

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 transactions and loops.

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.

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, AK 99524-0808

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

*******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.

Institutional Claims Billed to Medicare

Medicaid Provider ID	X12 Loop ID	Description	837I
The Medicaid Billing Provider ID is entered in the 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 rendering provider for this claim line is different from the other claim lines, the Medicaid Servicing Provider 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

Outpatient Therapies Billing

When billing for multiple time increment codes for the same date of service, the total number of units that can be billed is constrained by the total time spent **face to face** with the patient. For example, performing 97530 for 24 minutes and 97140 for 23 minutes would be a total of 47 minutes with the patient which allows for the billing of 3 units (see chart below). In this case you would bill 97530 for 2 units (the code with the most time) and 97140 for 1 unit.

UNITS	TIME
1	8-23 minutes
2	23-38 minutes
3	38-53 minutes
4	53-68 minutes
5	68-83 minutes
6	83-98 minutes
7	98-113 minutes
8	113-128 minutes

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

**April - December 2006
Training Schedule** is available
on FHSCs Website.

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 FHSCs 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.

July Training Schedule

07/05/06 (Anchorage, 1835 S Bragaw, 3rd floor)

Dental Services 9:00 a.m. – 11:00 a.m.

07/06/06 (Teleconference)

Care Management Services 2:00 p.m. – 3:30 p.m.

07/20/06 (Anchorage, 1835 S Bragaw, 3rd floor)

Transportation 1:00 p.m. – 3:00 p.m.

07/25/06 (Central Peninsula General Hospital, 250 Hospital Place, Soldotna)

Redoubt and Spur Conference Room

Introduction to 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.

07/26/06 (Central Peninsula General Hospital, 250 Hospital Place, Soldotna)

Redoubt and Spur Conference Room	
Remittance Advice	8:30 a.m. – 10:30 a.m.
Resubmission Turnaround	10:45 a.m. – 12:00 p.m.
Documents (RTDs)	
Appeals	2:00 p.m. – 3:30 p.m.

07/27/06 (Soldotna, Central Peninsula General Hospital, 250 Hospital Place)

Redoubt and Spur Conference Room	
Adjustments & Voids	8:30 a.m. – 10:00 a.m.
Transportation & Accommodation	10:15 a.m. – 12:15 p.m.

Electronic Billing

Providers have the option to bill electronically. You must have successfully tested for HIPAA compliant electronic transactions and have practice management software that supports the transactions and have an information submission agreement on file with us. Contact First Health Services EMC/HIPAA coordinator or the First Health Services website <http://alaska.fhsc.com> for more information.

Be aware that any information entered in the “comments”, “narrative”, or “supporting documentation” field on your electronic claim form will cause the claim to pend for review. Some providers, for example, DME providers must enter information in this field for the claim to process. However, if you are entering extraneous information in this field your claim will stop to review. An example of extraneous information in this field would be a procedure code description when the description is not needed.

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.

National Provider ID Number (NPI) The deadline for providers submitting 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/NPPES/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.

When applying for your NPI, CMS urges you to include your provider identification numbers, not only for Medicare, but for all payors. Of reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to NPI.

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

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)

The Care Management Program (formerly the Lock In Program) has been actively placing qualified Medicaid recipients into this program since April 1, 2006. Under new regulations we are required to request and review the medical records of these selected recipients. Your medical records department may have already received a record request if the recipient is one of your patients. Thank you for your prompt attention to these requests.

We would also like to thank the providers who are currently acting as primary care providers for one or more recipients in the Care Management Program. The continuity of care that you are providing for these patients is commendable. We will be contacting other providers in the near future and encouraging them to help us with this program as well.

If you have a patient that you think would benefit from the Care Management Program please contact us a (907) 644-6842 so that we may accept and research your referral.

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 and Voids

Only *paid* claims may be adjusted or voided; denied claims may be corrected and resubmitted. Allow up to three weeks for an adjustment or void to process before submitting a corrected claim.

There are two ways to refund an overpayment to Medical Assistance:

1. Send a completed adjustment/void form(s) *without* a refund check. The funds will be collected from future payments and will appear on future remittance advice statements.
2. Send a completed adjustment/void form(s) *with* a refund check attached for the refund to be applied to the corresponding claim(s) only.

Important Reminder: Send adjustment/void form(s) and refund check together

- If Medical Assistance receives the adjustment/void form(s) and refund check separately, the funds will be collected from future payments **and** the refund check will be deposited and reported as a refund only **without** being applied to the corresponding claims, therefore processing the refund amount twice.