



August 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 Requirements for Medicaid/Denali KidCare Recipients

Beginning August 1, 2006, U.S. citizens applying for or renewing benefits for Medicaid including Long-Term Care and Denali KidCare will need to provide proof of U.S. citizenship and identity. This is due to a change in federal law, the Deficit Reduction Act (DRA), which took effect on July 1, 2006. For most citizens, this means providing a birth certificate and some form of identification. This new requirement does not apply to individuals who are receiving SSI or Medicare beneficiaries. The Social Security Administration (SSA) has completed the citizenship and identity verification for them.

The new law may cause delays in eligibility determination. This is a reminder that you should request to see and photocopy the recipient's Medicaid coupon or Denali KidCare card **prior to rendering the service**. If recipients do not have their Medicaid coupon or Denali KidCare card with them, be sure to verify eligibility using the Eligibility Verification System (EVS) at (800) 884-3223 or call provider inquiry at (907) 644-6800, option 1 or (800) 770-5650, option 1,1. If the patient is not eligible, please refer Medicaid patients to their local Division of Public Assistance office, or have them call (888) 804-6330 and press 5 for a listing of office numbers. Refer Denali KidCare patients to the Denali KidCare office at (888) 318-8890.

New Medicare Crossover Process

The Centers for Medicare & Medicaid Services (CMS) implemented 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 article provides guidance for your participation in the new COBA 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

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Updates...

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

- 2006 Hearing Services Fee Schedule

IN BRIEF...

To ensure a successful COBA crossover claim, remember to

- Update your Medicare number with FHSC's Provider Enrollment unit
- Enter you Medicaid Provider ID number in the appropriate fields (see chart on this page)
- Update your provider file by sending FHSC your "Welcome to Medicare" letter
- Send in a recent (within past three months) RA with your Medicare EOB/MRN with a note for us to update your Medicare number.

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 transferred 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.

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. (See the chart below.)

July 2006 was a transitional month; therefore some crossover claims may 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.

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
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

Resubmission Turnaround Document (RTD)

Claims that are in Resubmission Turnaround Document (RTD) status on the in-process page of your Remittance Advice (RA) require some response from you as the provider. Use the worksheet from the back of the RA when the claim went into RTD status to correct incomplete information or to attach additional information by the deadline on the worksheet. Sign and date the worksheet as it is an amendment of your original claim. Send in only the RTD worksheet with any attachments, as applicable. Your claim will not process until you respond and may be holding up the rest of your claim lines. You are given 90 days to send your corrected RTD worksheet to First Health. If no response is received from you after 60 days, a 2nd notice letter is generated. You have 30 days from the receipt of the letter to respond. Remember, the deadline does not change. If no response is received by the deadline, the claim will deny for Edit 076 – RTD filing limit exceeded. If you receive the 076 denial, it is now too late to send in the corrected RTD worksheet. You must resubmit a **corrected** claim. You may need to backtrack 90 days to find the RA in which the claim went into RTD status to determine the reason for the RTD so that the appropriate corrections can be made.

Do not attempt to make an adjustment to a claim or to add a claim line to the RTD. RTDs are an opportunity for you to correct a claim so that it can continue to process.

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

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.

August Training Schedule

Anchorage

08/08/06

Introduction 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.

08/09/06

Remittance Advice	8:30 a.m. – 10:30 a.m.
Resubmission Turnaround Documents (RTD)	10:45 a.m. – 12:00 p.m.
Appeals	2:00 p.m. – 3:30 p.m.

08/10/06

Adjustments and Voids	8:30 a.m. – 10:00 a.m.
Transportation & Accommodations	10:15 a.m. – 12:15 p.m.

08/16/06

Inpatient/Outpatient Hospital Services	1:00 p.m. – 3:00 p.m.
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08/23/06

Durable Medical Equipment	1:00 p.m. – 4:00 p.m.
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Teleconference

8/14/06

Remittance Advice	1:00 p.m. – 3:00 p.m.
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08/17/06

Inpatient/Outpatient Hospital Services	1:00 p.m. – 3:00 p.m.
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08/24/06

Durable Medical Equipment	1:00 p.m. – 4:00 p.m.
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08/29/06

Pharmacy Services	9:00 a.m. – 11:00 a.m.
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08/27/06

Long Term Care Services	1:00 p.m. – 2:00 p.m.
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I.H.S/Tribal Specific August Training Schedule

Fairbanks

(Fairbanks Imaging Center in the Fairbanks Memorial Hospital, 1650 Cowles Street)

08/16/06

Introduction (Alaska Medicaid, Enrollment)	8:30 a.m. – 10:00 a.m.
Billing Manual Overview	10:00 a.m. – 11:00 a.m.
How to Complete Forms	11:00 a.m. – 12:00 p.m.
Lunch Break	12:00 p.m. – 1:15 p.m.
Inpatient/Outpatient Hospital (CHAP/S)	1:15 p.m. – 3:15 p.m.
Remittance Advice & RTDs	3:30 p.m. – 4:30 p.m.

8/17/06

Correction Worksheets/Resubmission Turnaround Documents (RTDs)	8:30 a.m. – 9:30 a.m.
Dental Health Aids (Dental Billing)	9:30 a.m. – 11:30 a.m.
Appeals, Recipient Hot Line	11:30 a.m. – 12:00 p.m.
Lunch Break	12:00 p.m. – 1:15 p.m.
Transportation & Accommodation	1:15 p.m. – 2:00 p.m.
Teleconference/Interface	2:00 p.m. – 3:30 p.m.
Questions & Answers	3:30 p.m. – 4:30 p.m.

Nome

(Norton Sound Medical Clinic, 306 W. 5th Avenue)

08/30/06

Introduction (Alaska Medicaid, Enrollment)	8:30 a.m. – 10:00 a.m.
Billing Manual Overview	10:00 a.m. – 11:00 a.m.
How to Complete Forms	11:00 a.m. – 12:00 p.m.
Lunch Break	12:00 p.m. – 1:15 p.m.
Inpatient/Outpatient Hospital (CHAP/S)	1:15 p.m. – 3:15 p.m.
Remittance Advice & RTDs	3:30 p.m. – 4:30 p.m.

8/31/06

Correction Worksheets/Resubmission Turnaround Documents (RTDs)	8:30 a.m. – 9:30 a.m.
Dental Health Aids (Dental Billing)	9:30 a.m. – 11:30 a.m.
Appeals, Recipient Hot Line	11:30 a.m. – 12:00 p.m.
Lunch Break	12:00 p.m. – 1:15 p.m.
Transportation & Accommodation	1:15 p.m. – 2:00 p.m.
Teleconference/Interface	2:00 p.m. – 3:30 p.m.
Questions & Answers	3:30 p.m. – 4:30 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

NPI: Get It. Share It. Use It.

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. When 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

Getting an NPI is free – not having one can be costly.

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.

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.

New NPI Information

As the industry transitions to NPI compliance, remember that there is **no charge** to get an NPI. Providers can apply online for their NPI, free of charge, by visiting <https://nppes.cms.hhs.gov> or by calling (800) 465-3203 to request a paper application. The CMS NPI page, located at www.cms.hhs.gov/NationalProviderStand/ is the only source for official CMS education and information on the NPI initiative; all products located on this site are free of charge.

CMS continues to urge providers to include your current provider identification numbers on your NPI applications, not only for Medicare, but for all payors. If reporting a Medicaid number, include the associated State name. If you have already applied for your NPI, CMS asks you to go back into the NPPES and update your information with your provider identification number. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

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.

Remember to write your Prior Authorization number on your claims for reimbursement if the service(s) required prior authorization and you did obtain the authorization. Services that require prior authorization are indicated in your billing manual or fee schedule.

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.