



September 2006

Alaska Medical Assistance Newsletter

Volume 1, Number 9

First Health Services Corp.
1835 S. Bragaw St., Suite 200
Anchorage, AK 99508-3469
<http://alaska.fhsc.com>
(800) 770-5650
(907) 644-6800

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

September 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

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.

FHSC and the State of Alaska offices will be closed on Monday, September 4, 2006 in observance of Labor Day.

Updates...

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

- 2006 Hearing Services Fee Schedule
- Targeted Case Management Services for the Infant Learning Program Billing Manual (TCM-ILP)

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, you must verify eligibility using the 1) Eligibility Verification System (EVS) at (800) 884-3223, or 2) call the Provider Inquiry Unit 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.

Payment for Mental Health Crossover Claims

After further clarification from CMS, effective immediately; payment will be made on the mental health claims for the crossover portion of the patient responsibility. If you have claims that were previously denied, please resubmit your claims for the additional payment.

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.

April - December 2006 Training Schedule is available on FHSC's Website at <http://alaska.fhsc.com>. Choose **Training**, and then choose **Schedule**.

The National Uniform Billing Committee (NUBC) approved the UB-04 as the replacement for the UB-92 at its February 2005 meeting. Submitters (health care providers such as hospitals, skilled nursing facilities, hospice, and other institutional claim filers) can use the UB-04 beginning March 1, 2007; however, there will be a transitional period between March 1, 2007 and May 22, 2007 where the UB-04 or the UB-92 can be used. Starting May 23, 2007 all institutional paper claims must use the UB-04; the UB-92 will no longer be acceptable after this date. For more information visit the NUBC Website at: <http://www.nubc.org/>

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.

September Training Schedule

Friday, September 8, 2006, Teleconference

TPL Avoidance	2:00 PM – 3:00 PM
---------------	-------------------

Wednesday, September 13, 2006, Teleconference

School-based Services	1:00 PM – 2:00 PM
-----------------------	-------------------

Friday, September 15, 2006, Teleconference

Mental Health/Substance Abuse	1:00 PM – 4:00 PM
-------------------------------	-------------------

Tuesday, September 19, 2006, Anchorage

Introduction to Alaska Medical Assistance	8:30 AM – 12:00 PM
Eligibility	2:00 PM – 3:15 PM
Prior Authorization	3:30 PM - 5:00 PM

Note: Anchorage training sessions are held in FHSC's Training room located at 1835 S. Bragaw St., on the 3rd floor.

Wednesday, September 20, 2006, Anchorage

Remittance Advice	8:30 AM – 10:30 AM
Resubmission Turnaround Documents (RTD)	10:45 AM – 12:00 PM
Appeals	2:00 PM – 3:30 PM

Thursday, September 21, 2006, Anchorage

Adjustments and Voids	8:30 AM – 10:00 AM
Transportation and Accommodation	10:15 AM – 12:15 PM

Thursday, September 28, 2006, Teleconference

Dental	2:00 PM – 4:00 PM
--------	-------------------

Electronic Billing

Providers have the option to bill electronically. You must have successfully tested for HIPAA compliant electronic transactions, have practice management software that supports the transactions, and have an information submission agreement on file with FHSC. You may contact FHSC's EMC/HIPAA coordinator or visit FHSC's website at <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 claim attachments 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 the fax cover sheet. FHSC uses this unique identification number to match claim attachments. For more information, go to FHSC's website (<http://alaska.fhsc.com>), choose the **HIPAA** menu, and then choose **Companion Guide**.

NPI: 8 Months & Counting.

September 23rd marks 8 months remaining until the National Provider Identifier (NPI) compliance date. Do you have your NPI yet?

The Centers for Medicare & Medicaid Services (CMS) would like to announce the following:

CMS will host a national **NPI Roundtable**, open to **all** health care professionals, on **Tuesday, September 26th from 2:00-3:30PM ET**. To participate, you may call **1-877-203-0044**, pass code **4795739**.

Reminder...

When requesting TPL avoidance, remember to continue to bill your claim(s) with an EOB that has a valid denial for that benefit year until you are notified by FHSC that your TPL avoidance has been approved by the state. Do not hold claims.

You do not have to bill each claim to the TPL as long as you have a denial for that benefit year.

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.

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

CMS will address common questions related to Medicare's guidance on Subparts. While CMS will only address questions from a Medicare perspective, this information may be helpful to all providers.

Think You Don't Need an NPI? Think Again.

- Even those providers who do not bill for services may need to disclose their NPI number to those providers who do (e.g., physicians who order lab tests or refer patients for diagnostic testing must be identified on the lab's or testing facility's claims).
- Even if you plan to retire in April, but know that some of your claims will not be submitted until after the May 23rd compliance date, you still need an NPI. Without the NPI, those claims may be adversely affected, with payment delayed or possibly even denied.

Reminder to Supply Legacy Identifiers on NPI Application

- CMS continues to urge providers to include legacy identifiers on their NPI applications. This will help all health plans, including Medicare, to get ready for May 23, 2007. If reporting a Medicaid legacy number, include the associated State name. If providers have already been assigned NPI numbers, CMS asks them to consider going back into the NPPES and updating their information with their legacy identifiers if they did not include those identifiers when they applied for NPI numbers. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

As always, more information and education on the NPI can be found at <http://www.cms.hhs.gov/NationalProidentStand> on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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.

Medicare DME, Orthotics and Supply Suppliers

The Centers for Medicare and Medicaid Services (CMS) will be linking Medicare provider numbers with NPI numbers.

As mentioned in the paper entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA," **Medicare DME suppliers are required to obtain an NPI for every location.** The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the supplier may have.

The requirement for Medicare DME suppliers to obtain NPI numbers for every practice location applies also to those Medicare DME suppliers who do not send electronic claims to Medicare. Federal regulations require the unique enumeration of

COBA:

To ensure successful COBA crossover claims remember to update your Medicare number with our Provider Enrollment unit and to enter your Medicaid Provider ID number in the appropriate fields on your Medicare claims. You can update your provider file by sending us your "Welcome to Medicare" letter or by sending in an RA with your Medicare EOB/MRN from within the past three months with a note for us to update your Medicare number in our provider files. Be sure to also indicate your Medicaid Provider identification number so we can update the correct provider file.

every location of a Medicare DME supplier regardless of how claims are submitted. (Again, sole proprietors are eligible for only one NPI.) Failure to comply with this requirement may result in delayed processing or the rejection of Medicare claims.

For more information on Medicare Subpart Expectations, please visit the Medicare Subpart Guidance Paper at:

<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf>

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.

Inpatient Providers

The newly revised Alaska Provider Information form is now available on FHSC's website at <http://alaska.fhsc.com>. Choose **Providers**, then choose **Behavioral Health**, then choose **Information**; the form is listed on the bottom of the page.

For your convenience, the form may be filled out online. Once completed, you may print the form and fax, mail, or email it to FHSC. The fax number is (907) 644-5998. The email address is lyntashea@fhsc.com. The mailing address is: First Health Services Corporation, Attention: Lyn Tashea, PO Box 240808, Anchorage, AK 99524-0808.

If you have further questions please contact Lyn Tashea at (907) 644-6800 or (800) 770-5650 (in state, toll-free).

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.

Reminder 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.

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.

Vaccine Update

The Alaska Division of Public Health's Vaccines for Children (VFC) Program provides most vaccine products, free of charge, to Alaska's healthcare providers for administration to Alaska residents. This program does not, however, currently offer

NEW DRUG CHANTRIX

The new drug Chantix® (Varenicline) is now available for Medicaid reimbursement through pharmacies for tobacco cessation. It is available for a ninety day course of treatment when a recipient wants to quit, is receiving counseling and is not receiving a Nicotine Replacement Therapy. Chantix requires prior-authorization (PA) by prescribers from the First Health Map Desk by calling 1-800-331-4475. The PA form is available on First Health Services' Website at <http://alaska.fhsc.com/providers/updates/provupdates.asp> and selecting Tobacco Cessation Prior Authorization Request.

the two newly licensed vaccines that have recently become available:

- Human Papillomavirus (PPV) vaccine
- Rotavirus vaccine

[IHS Clinics, Family Planning Clinics, Advanced Nurse Practitioners, Physicians](#) Medicaid/DKC will reimburse IHS clinics, family planning clinics, advanced nurse practitioners and physicians for these two vaccines when they are given to Medicaid/DKC-eligible recipients until such time that they are made available through Public Health's Vaccines for Children (VFC) Program.

Medicaid will reimburse up to \$142.50 per dose plus an administration fee for Gardasil(r), the Merck HPV vaccine. Reimbursement coverage is limited to eligible female recipients 9 through 20 years of age. The CPT code is 90649.

Medicaid also will reimburse up to \$79.69 plus an administration fee for RotaTeq(r), Merck's oral rotavirus vaccine. RotaTeq(r) is licensed only for infants 6-32 weeks of age. The CPT code is 90680.

[Rural Health Clinics \(RHC\), Federally Qualified Health Centers \(FQHC\)](#)

In the case of RHC/FQHC providers, the department realizes that providing these new vaccines will result in increased cost, however, additional reimbursement for these new program costs can be considered only if a request for rate adjustment is made by the provider in accordance with 7 AAC 43.860 (j). The department's Office of Rate Review will consider requests that meet these regulatory requirements which state, in part, that the adjustment request must be made in writing and must include an analysis demonstrating that providing these vaccines will result in increased per visit cost of more than two and one-half percent.

Providers are encouraged to thoroughly review 7 AAC 43.860 (j) prior to requesting an adjustment.

Hearing Services Providers

When billing for hearing devices using HCPC codes for binaural hearing aids, submit on the claim using one line indicating (1) in the unit field. Binaural relates to both ears. Claims billed for binaural HCPC codes using one line indicating (2) in the unit field are incorrect. Claims billed for binaural HCPC codes using two lines indicating a RT modifier for the right ear and a LT modifier for the left ear with a (1) in the unit field per line are incorrect.

When billing for postage cost reimbursement, use HCPC code V5299 which requires prior authorization. See regulation 7 AAC 43.927(i) for delivery and dispensing expenses reimbursement requirements. The claim must be submitted with the approved prior authorization number and postage invoice corresponding with the billed charge.

When billing for labor and repair cost reimbursement, use HCPC code V5014 for the repair cost attaching the manufacturer's invoice corresponding with the charge amount and HCPC code L7520 for the labor cost including the time spent in 15 minute increments. See regulation 7 AAC 43.927 (j) for labor and repair reimbursement requirements. Please remember to itemize billed charges when necessary and attach supporting documentation when required.

If you have questions, call the Provider Inquiry Unit at (907) 644-6800 locally or (800) 770-5650 selecting option 1 for Providers and option 1 again for Inquiry.