

Alaska Medical Assistance Provider Billing Manual



Section I: Physician, Advanced Nurse Practitioner & Physician Assistant Services Policies and Procedures

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About This Manual

The Department of Health and Social Services (DHSS) is the state agency designated to administer the Alaska Medical Assistance Program, which includes:

- Medicaid
- Denali KidCare (DKC)
- Chronic and Acute Medical Assistance (CAMA)

Unless otherwise specified, references to the Alaska Medical Assistance Program, or Alaska Medical Assistance mean Medicaid, Denali KidCare, and CAMA. References to Alaska Medicaid, or Medicaid, mean only Medicaid and Denali KidCare.

Section I: Physician | Advanced Nurse Practitioner | Physician Assistant: Services, Policies and Procedures is to be used by enrolled physicians, advanced nurse practitioners and physician assistants in conjunction with:

- [Section II: Professional Claims Management](#)
- [Section III: General Program Information](#)

Updates to this manual will be necessary from time to time as federal and state medical assistance regulations are adopted. As updates are made, each affected segment of the manual will be annotated with the date of the change. Providers will be informed of these updates by remittance advice messages and announcements on the Alaska Medicaid website, <http://medicaidalaska.com>. Previously published manuals are available upon request.

Thank you for your participation in the Alaska Medical Assistance Program and for the services you provide.

Updated 06/12

Provider Enrollment

The following enrollment information is specific to physicians, advanced nurse practitioners and physician assistants. For general enrollment instructions and guidelines, refer to [Section III: General Program Information](#).

[Provider Participation Requirements for Physicians](#)

[Provider Participation Requirements for Advanced Nurse Practitioners](#)

[Provider Participation Requirements for Physician Assistants](#)

[Locum Tenens](#)

[Health Professional Group Enrollment](#)

Provider Participation Requirements and Responsibilities

Provider Participation Requirements for Physicians

In addition to the general conditions for participation identified in [Section III: General Program Information](#),

- Individuals who have an active license from the Alaska Division of Occupational Licensing to practice medicine or osteopathy may enroll with Alaska Medical Assistance.
- Enrolled physicians may receive reimbursement for covered medical services provided to eligible recipients.
- Physicians who wish to enroll as part of a professional group must first enroll individually. For additional information, refer to [Health Professional Group Enrollment](#) in this section.
- In order to receive reimbursement for laboratory services performed in a physician-owned laboratory, the provider must submit a copy of the lab's Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or certificate of registration. For guidelines for performing these services, refer to Laboratory Services in this section.
- Enrolling physicians must complete, sign, and submit a [Physician Provider Addendum](#), available at <http://medicaidalaska.com/providers/Enrollment.shtml>.

Updated 05/13

Provider Participation Requirements for Advanced Nurse Practitioners

In addition to the general conditions for participation identified in [Section III: General Program Information](#),

- Individuals who have an active license from the Alaska Division of Occupational Licensing to practice as an advanced nurse practitioner (ANP) of any specialty may enroll in the Alaska Medical Assistance Program.
- Enrolled, independently practicing ANPs may receive reimbursement for covered medical services provided to eligible recipients.
- ANPs who wish to enroll as part of a professional group must first enroll individually. For additional information, refer to [Health Professional Group Enrollment](#) in this section.
- In order to receive reimbursement for laboratory services performed in a physician-owned laboratory, the provider must submit a copy of the lab's Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or certificate of registration. For guidelines for performing these services, refer to [Laboratory Services](#) in this section.

Updated 05/13

Provider Participation Requirements for Physician Assistants

In addition to the general conditions for participation identified in [Section III: General Program Information](#),

- Individuals who have an active license from the Alaska Division of Occupational Licensing to practice as a physician assistant (PA) may enroll in the Alaska Medical Assistance Program.
- Enrolled PAs must be supervised by a physician who is currently enrolled with Alaska Medical Assistance.
- Enrolled PAs must be affiliated with a health professional group as a rendering-only provider.
 - Services rendered by an enrolled PA must be billed by the health professional group identifying the PA as the rendering provider; PAs may not bill directly for services.
 - Payment for the physician assistant will be made to the health professional group; the PA cannot be paid directly.
- Enrolling PAs must complete, sign, and submit a [Physician Assistant Provider Addendum](#), available through the Provider Enrollment Portal at <https://enroll.medicaidalaska.com>.
 - The addendum must include the name and NPI for the PA's supervising physician.
 - Each time the physician assistant's supervising physician changes, the PA must submit to Xerox an updated addendum and copy of the occupational license reflecting the new supervising physician.

Updated 05/13

Provider Participation Requirements for Dispensing Physicians, Advanced Nurse Practitioners and Physician Assistants

In addition to the general conditions for participation identified in [Section III: General Program Information](#), enrolled physicians, advanced nurse practitioners and physician assistants may also enroll with Alaska Medical Assistance as dispensing providers.

The enrolling dispensing physician, advanced nurse practitioner or physician assistant must submit:

- Proof of active licensure as a pharmacist or retail pharmacy,
- An active Drug Enforcement Agency (DEA) license, and
- A completed, signed [Dispensing Provider Addendum](#), available through the Provider Enrollment Portal at <https://enroll.medicaidalaska.com>.

To be eligible for a dispensing fee a dispensing provider must meet the following two requirements:

- The dispensing provider's practice location must be 45 miles from a retail pharmacy.
- The dispensing provider must not be a covered entity under 42 U.S.C.256b or purchasing outpatient medications under either the 340b program (section 602) or Federal Supply Schedule pricing (section 603).

Updated 05/13

Locum Tenens

A provider who is practicing under a temporary or locum tenens permit, license, or authorization, and who is substituting for another provider, being evaluated for permanent employment, or temporarily employed by a facility while it attempts to fill a vacant position must enroll with Alaska Medical Assistance as required to be reimbursed for services rendered.

To be reimbursed for services rendered, a provider practicing as a locum tenens must:

- Obtain a license or permit through Alaska's Division of Occupational Licensing.
- Enroll as a provider in Alaska Medicaid and obtain a Medicaid Contract ID.
- Enrolled locum tenens may receive reimbursement for covered medical services provided to eligible recipients.

Enrollment will be approved only for the period on the license or permit.

Alaska permits only medical and osteopathic physicians, advanced nurse practitioners, physician assistants, chiropractors, nurses, certified registered nurse anesthetists and nurse midwives to be a locum tenens. Plan ahead, as the process usually takes eight weeks to receive the permit. To apply for a permit, contact the Alaska Department of Commerce, Community, and Economic Development's [Division of Corporations, Business and Professional Licensing](#) (<http://commerce.alaska.gov/occ>).

Updated 06/12

Health Professional Group Enrollment

In addition to the general conditions for participation identified in [Section III: General Program Information](#),

- Each member of a health professional group must first enroll individually with the Alaska Medical Assistance Program.
- The following providers may **enroll** as part of a health professional group **and bill directly for services**:
 - **Physician**
 - Chiropractor
 - **Advanced nurse practitioner, including nurse midwife**
 - Podiatrist-Chiropracist
 - Audiologist
 - Direct-entry midwife
 - Occupational therapist
 - Psychologist
 - Optician
 - Optometrist
 - Physical therapist
 - Speech language pathologist
 - Certified registered nurse anesthetist
- Other providers may enroll as part of a health professional group as a rendering provider but may not bill directly for services. Instead, payment for services will be made through the health professional group. These providers include:
 - **Physician assistant**
 - Occupational therapy assistant
 - Physical therapy assistant
 - Speech language pathology assistant
 - Community Health Aid/Practitioner (CHA/P)

A physician assistant must be enrolled under the supervision of an enrolled physician (refer to [Provider Participation Requirements for Physician Assistants](#)); however the supervising physician is not required to be a member of the same health professional group as the physician assistant.

A supervising provider of the same discipline must be enrolled as part of a group before an occupational therapy assistant, physical therapy assistant or speech language pathology assistant may enroll with the group.

Billing Services in a Health Professional Group

Members of a health professional group must bill their services under the group, except when performing services outside the group as part of another practice or job.

Updated 11/06/13

Recipient Eligibility

All references to recipient mean an individual who is eligible for and receiving assistance under the Alaska Medical Assistance Program.

Eligibility Codes

The Department will pay an enrolled physician, advanced nurse practitioner or physician assistant's supervisor or group for covered services provided to a recipient who is eligible for Alaska Medical Assistance under one of the following eligibility codes:

Eligibility Codes: Physician/Advanced Nurse Practitioner/Physician Assistant Services	
Code	Category
10	Public Health Service (IHS, AANHS and TRICARE, formerly CHAMPUS)
11	Pregnant Woman (Alaska Healthy Baby Program)
15	Incapacity/Pregnancy Determination
19	Waiver Determination
20	No Other Eligibility Codes Apply
21	Chronic and Acute Medical Assistance (CAMA) Coverage Only
24	300 percent Institutionalized
25	Disability and Blindness Exams
30	Adult Disabled, Waiver Only
31	Adult Disabled, Waiver Medical
34	Adult Disabled, Waiver Adult Public Assistance (APA)/Qualified Medicare Beneficiary (QMB)
40	Older Alaskan, Waiver Only
41	Older Alaskan, Waiver Medical
44	Older Alaskan, Waiver APA/QMB
50	Under 21
51	Juvenile Court Ordered Custody of Health & Social Services
52	Transitional Medical Assistance
53	Illegal Alien/Unqualified Alien Emergency Coverage
54	Disabled/Supplemental Security Income (SSI) Child
60	Residential Psychiatric Treatment Center (RPTC) Waiver, 300 percent
61	RPTC Waiver
62	RPTC Waiver, Pregnancy Services
64	RPTC Waiver, APA/QMB
67	QMB Only - Eligible Only for Medical Assistance Payment of Medicare Deductible and Coinsurance for Medicare-Covered Services
69	APA/QMB - Dual Eligibility
70	Individuals with Intellectual and Developmental Disabilities, Waiver Only
71	Individuals with Intellectual and Developmental Disabilities, Waiver Medical
74	Individuals with Intellectual and Developmental Disabilities, Waiver APA/QMB
80	Children with Medically Complex Conditions, Waiver Only
81	Children with Medically Complex Conditions, Waiver Medical

Updated 06/12

Service Authorization

Certain services, procedures and medications covered by Alaska Medical Assistance require service authorization (SA). Refer to [Medicaid-Covered Services](#) in this section for service authorization requirements for specific services and [Section II: Professional Claims Management](#) of this manual for information about requesting and obtaining SA.

Updated 02/13

Physician, Advanced Nurse Practitioner and Physician Assistant Services

Alaska Medical Assistance reimburses enrolled providers for medically necessary services for eligible recipients when delivered, ordered or prescribed by a provider within the scope of the provider's license or certification.

Services rendered based on a prescription, order or referral are reimbursable only if the prescribing, ordering or referring provider is enrolled as an Alaska Medical Assistance provider.

Updated 06/12

Travel for Medical Care

Alaska Medicaid covers out-of-area and local transportation and out-of-area accommodation services when travel is required to receive non-emergent, medically necessary services.

For additional information about non-emergency transportation, including how to request service authorization, refer to [Section III: General Program Information](#).

Updated 04/13

Medicaid-Covered Services

Anesthesia

Anesthesia services are covered when administered by an anesthesiologist or a certified registered nurse anesthetist and billed in accordance with the current edition of the *American Society of Anesthesiologists (ASA) Relative Value Guide*.

Alaska Medical Assistance reimburses for anesthesiology services at the lesser of billed charges or a calculation based on the ASA procedure base unit value and time. The current reimbursement for each procedure base unit value is \$42.90. The current reimbursement amount for each time unit (one time unit = 10 minutes) is \$36.00 (\$3.60 per minute).

Updated 06/12

Behavioral Health Screening and Services

Alaska Medicaid reimburses enrolled physicians for medically necessary and appropriate mental health services only if the physician directly renders these services.

Psychiatrist – Alaska Medicaid requires that the physician must be a psychiatrist to provide mental health services in a licensed and certified psychiatric hospital or facility, a general acute care hospital, a long term care facility, or an intermediate care facility for the intellectually and developmentally disabled (ICF/IDD).

Psychotherapy – Alaska Medicaid requires service authorization (SA) for outpatient psychotherapy services when services for a recipient exceed 10 hours in a state fiscal year. Alaska Medicaid does not reimburse physicians for group psychotherapy provided to a recipient in an inpatient psychiatric hospital facility or an acute care hospital facility offering psychiatric services.

DC:0-3R

Alaska Medicaid supports using the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised* (DC:0-3R) by enrolled primary care providers. Using the DC:0-3R aids efforts to report the mental health and developmental disorder diagnoses for young children up to five years of age. The [DC:0-3R](http://www.zerotothree.org/estore) may be ordered from <http://www.zerotothree.org/estore>.

Although not required, using the DC:0-3R will help primary health care practitioners and mental health clinicians accurately report diagnoses for infants and toddlers experiencing mental health and/or developmental disorders. Clinical records must support the given diagnosis through assessment processes.

When submitting claims for services rendered, Alaska Medicaid requires providers to report diagnosis codes using ICD-9-CM code set. A crosswalk between DC:0-3R and ICD-9-CM is available at <http://medicaidalaska.com/providers/provupdates.shtml>.

Screening and Brief Intervention Services

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for emergency intervention with at-risk substance users before more severe consequences occur.

Providers eligible to provide and bill for these services include:

- Physicians
- Advanced nurse practitioners
- Physician Assistants
- EPSDT screeners
- Rural health clinics/Federally qualified health clinics
- Community health aides/practitioners
- Tribal clinics
- Community behavioral health clinics
- Mental health physician clinics

Use SBIRT services to target Medicaid recipients with nondependent substance abuse. Alaska Medicaid encourages providers to incorporate SBIRT services into normal practice routines because early, brief intervention can:

- Decrease the frequency and severity of drug and alcohol use
- Reduce the risk of trauma
- Increase the percentage of patients who enter specialized substance abuse treatment

The Substance Abuse and Mental Health Services Association ([SAMHSA](http://www.samhsa.gov)) provides screening instruments and tools for providers on their website <http://www.samhsa.gov>.

To bill SBIRT services, use the appropriate CPT code:

- 99408 Audit/dast 15-30 min
- 99409 Audit/dast over 30 min

For additional information about SBIRT services, refer to the [Mental Health Physician Clinic](#) or [Community Behavioral Health Manual](#). Additionally, providers may contact the [Provider Inquiry Unit](#) for billing and payment inquiries or the [Division of Behavioral Health](#) for policy questions.

Updated 05/13

Chiropractic Services

A physician may provide covered chiropractic manipulations for recipients who are under 21 years of age. Additionally, a physician may provide covered chiropractic manipulations to adult Medicaid recipients who are also enrolled in Medicare. Alaska Medicaid limits coverage to one chiropractic X-ray exam and 12 spinal manipulations during a calendar year.

All chiropractic services for children under six years of age require service authorization (SA). To request SA, use the [Service Authorization Request Form \(AK-SA\)](#) available at <http://medicaidalaska.com/providers/forms.shtml>. Providers must attach the referral to the form. For instructions on completing the AK-SA, refer to [Section II: Professional Claims Management](#).

For additional information, refer to the [Chiropractic Services Billing Manual](#).

Updated 05/13

Durable Medical Equipment and Specialized Medical Equipment

Durable Medical Equipment

Alaska Medicaid covers medically necessary and appropriate durable medical equipment (DME) when prescribed by a physician, advanced nurse practitioner or physician assistant.

For DME items that require service authorization (SA), a Certificate of Medical Necessity ([CMN](#)) must be completed. To request SA, use the [Service Authorization Request Form \(AK-SA\)](#). The CMN and AK-SA are available at <http://medicaidalaska.com/providers/forms.shtml>. For instructions on completing the AK-SA, refer to [Section II: Professional Claims Management](#).

- The CMN may be used for most DME, supplies, prosthetics and orthotics, audiology equipment, or hearing aids.
- Quantities requested should be appropriate for a 30-day period. Orders in excess of a 30-day supply require written medical justification, otherwise the SA may be denied.
- The [Certificate of Medical Necessity – Incontinence Supplies](#) may be used only for incontinence treatment.

For additional information, refer to the [Durable Medical Equipment Billing Manual](#).

Updated 05/13

Specialized Medical Equipment

Home and community-based waiver recipients may be eligible to receive specialized medical equipment (SME) when ordered by a physician. SME authorization requests are submitted as amendments to the recipient's plan of care.

For additional information, refer to the [Home and Community-Based Waiver Services Billing Manual](#).

Completing the Certificate of Medical Necessity

The [CMN](#) is comprised of four sections. The attending physician, advanced nurse practitioner or physician assistant acting within the scope of his or her license should fill out the following sections:

- Demographic information
- Section A: Clinical Information
- Section B: Clinical Assessment of Need for Prescribed Services or Item(s) and Plan and the ordering provider's attestation and signature

The provider supplying the DME/SME must fill out the following sections:

- Demographic information
- Section C: Requested Services or Items
- Section D: Supplier Attestation, Signature, and Date

Updated 02/13

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Alaska Medicaid provides coverage for EPSDT services so that eligible children ages birth through the last day of the month of the individual's 21st birthday may have the opportunity for optimum health status through regular, periodic, preventive health services, and the early detection and treatment of disease. Providers should screen children for any physical health, mental health, or developmental problem that a provider suspects.

All comprehensive medical screenings should comply with the minimum recommendations found in the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care, available at http://brightfutures.aap.org/clinical_practice.html. These guidelines replace the Alaska Periodicity Schedule for Child and Adolescent Health Screening standards.

For additional information, refer to the [EPSDT Provider Billing Manual](#).

Updated 06/12

Fluoride Varnish Application

Refer to [Oral Evaluation](#).

Human Growth Hormone

Alaska Medicaid limits growth hormone treatment to children (under age 21) diagnosed by a board certified pediatric endocrinologist.

Alaska Medicaid requires pharmacists to obtain service authorization (SA) for this service. The prescribing provider should send or make the diagnosis information available to the pharmacy in order to expedite the authorization process. The [Human Growth Hormone Authorization Request](#) as well as a list of all drugs requiring SA is available at http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/authorization_hcs.aspx.

Updated 02/13

Infant Formulas and Medical Foods

When a recipient under age five is diagnosed with a medical condition that requires a formula other than a Women, Infants and Children (WIC) "contract" formula, service authorization (SA) is required and an Enteral Nutrition Prescription Request Form ([ENPR](#)) must be completed by a physician or other health care provider who is enrolled with Alaska Medical Assistance and licensed to write prescriptions. The ENPR is available at <http://dhss.alaska.gov/dpa/Pages/nutri/default.aspx>.

Updated 02/13

Laboratory Services

Alaska Medical Assistance requires that all laboratory services for recipients are medically necessary and ordered by appropriately licensed professionals. Services and procedures may be provided off-site by an independent laboratory or at a physician-owned laboratory, subject to all legal requirements.

- Alaska Medical Assistance does not reimburse the handling and/or conveyance of a specimen for transfer from the physician's office or from the patient in other than the physician's office to a laboratory. Alaska Medical Assistance considers these procedures to be incidental to the other services performed for the patient.
- Laboratory services for which the Centers for Medicare and Medicaid Services (CMS) has established a payment rate are reimbursed by Alaska Medical Assistance at the CMS rate.
- Laboratory services for which CMS has assigned RVUs are reimbursed by Alaska Medical Assistance using the Resource-Based Relative Value System (RBRVS) methodology.
- Routine venipuncture performed with a surgical or laboratory procedure is considered incidental to that procedure and is not reimbursed separately.
- When a provider interprets a diagnostic laboratory test performed off-site, the provider should bill only for the professional component of the laboratory service by using the appropriate modifier.

For additional information, refer to the [Laboratory Services Billing Manual](#).

Independent Laboratory

The provider may bill only for the professional component of a diagnostic lab test when performed by an independent laboratory.

Physician-Owned Laboratory

All laboratories must have one of the following to legally perform laboratory services:

- A Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver (for those tests deemed "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result") or
- A CLIA certificate of registration
- A copy of the CLIA certificate must be on file with Xerox (refer to [Provider Participation Requirements and Responsibilities](#)). Alaska Medical Assistance reimburses providers who have the appropriate CLIA certificate for diagnostic lab services rendered to eligible recipients when performed in their own laboratory.

CLIA Waived Laboratory Services

When billing for CLIA-waived laboratory services, a QW modifier is required. For a current list of CLIA-waive laboratory test, refer to the FDA website <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm>.

Updated 05/13

Long-Term Care Facilities

Alaska Medicaid covers one initial evaluation and management (E/M) visit per physician, advanced nurse practitioner or physician assistant per patient stay in a certified intermediate care or skilled nursing facility.

Minimum legal requirements for subsequent physician visits are once every 30 days for the first 90 days, every 60 days thereafter.

Alaska Medicaid may cover additional visits only if supporting documentation attached to the claim substantiates the medical need for the additional visit. Other medically necessary emergency services are excluded from the 30-day limitation.

For additional information, refer to the [Long-Term Care Billing Manual](#).

Updated 06/12

Nutrition Counseling Services

Recipients at risk nutritionally may be referred by a physician, advanced nurse practitioner or physician assistant for nutrition assessment and counseling. Medicaid covers nutrition services provided by a registered dietitian or nutritionist for recipients under age 21 and adult recipients who are pregnant.

Nutrition coverage includes one initial assessment in a calendar year and up to 12 hours per calendar year for counseling and follow up care. If additional visits are needed, the referring provider must obtain service authorization (SA) using the Service Authorization Request Form ([AK-SA](#)) available at <http://medicaidalaska.com/providers/forms.shtml>. For instructions on completing the AK-SA, refer to [Section II: Professional Claims Management](#).

The referring provider must determine whether the recipient is at high risk nutritionally. High risk occurs when the recipient shows one or more of these symptoms:

- Shows flat growth
- Atypical height-to-weight ratio, head circumference, or sudden weight change
- Hemoglobin count of less than 10 grams or a hemostat of less than 30 percent
- Born with a weight of 2,500 grams or less
- Born at a gestation of 36 weeks or less
- Chronic disease
- Congenital anomaly or genetic disorder
- Pregnant or breast-feeding
- Nutritional condition that requires a special diet

Updated 05/13

Oral Evaluation

Physicians, advanced nurse practitioners and physician assistants may perform dental fluoride applications and oral evaluations, subject to coverage limitations. Providers must complete an Oral Health or Caries Risk Assessment training program and retain a certificate of completion. Upon request, the provider must present the certificate of completion from the training program to Alaska Medicaid.

Alaska Medicaid accepts oral health and caries risk assessment training programs from numerous sources, including the Smiles for Life National Oral Health Curriculum provided by the American Academy of Pediatrics (visit <http://smilesforlifeoralhealth.org> to sign up).

Alaska Medicaid covers a maximum of four topical fluoride varnish applications per calendar year. Providers may perform two oral evaluations per calendar year for patients under three years of age only. Providers should bill these services using a CMS-1500 or 837P transaction.

Updated 02/13

Outpatient Imaging Services

Alaska Medical Assistance covers imaging services performed in an outpatient setting when the procedure is medically necessary. The following outpatient imaging services require service authorization (SA):

- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET)
- Magnetic resonance angiography (MRA)
- Single-photon emission computed tomography (SPECT)

A physician, advanced nurse practitioner or physician assistant may request SA from Qualis Health through their web-based review system iExchange. Follow these guidelines when requesting SA:

- Spanned dates are not allowed
- The authorization will be valid for the facility (outpatient hospital or free-standing facility) performing the technical portion of the procedure.
- CAMA recipients cannot receive imaging services in an outpatient hospital setting but are eligible to receive services in a free-standing facility.

For additional information about requesting and obtaining SA, refer to [Section II: Professional Claims Management](#) or visit <http://qualishealth.org>.

Updated 04/13

Prescription Medications

Alaska Medical Assistance covers prescription medications when prescribed or dispensed by an enrolled physician, advanced nurse practitioner, or physician assistant.

For additional information, refer to the Pharmacy Billing Manual.

Preferred Drug List (PDL)

The [Preferred Drug List](#) is available at <http://dhss.alaska.gov/dhcs/Pages/pdl/default.aspx>.

Other Drugs

All prescriptions for "non-preferred" medications must contain documentation of medical necessity. Examples of medical necessity include:

- Patient Allergy: The patient is allergic to the inert ingredients of the preferred or generic medication
- Contraindications: The patient has a history of unacceptable/toxic side effects, contraindication to or an adverse drug-to-drug interaction with the preferred medication
- FDA Approved Multiple Indications: The non-preferred medication treats at least one more of the patient's diagnosed conditions than the preferred medication
- Ineffective Treatment: The preferred medication has proven ineffective in treating the specific patient for a diagnosed condition

Brand Name Multi-Source Medications

Alaska Medical Assistance will not pay for a brand-name medication if a therapeutically equivalent generic medication is available unless:

- The brand name medication is on the [Preferred Drug List](#); or
- The prescriber indicates on the prescription "brand-name medically necessary drug" or "allergic to the inert ingredients of the generic drug"; or
- The prescriber submits the prescription telephonically with instructions that the brand-name medication is medically necessary and documents it in the recipient's medical record.

Authorization for Prescribed Medications

Certain medications require service authorization (SA) before Alaska Medical Assistance covers these medications. The Division of Health Care Services (DHCS) maintains the [Prior Authorized Drug List](#) and [Interim Prior Authorized Drug List](#) on the website http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/authorization_hcs.aspx.

Unless otherwise indicated on the Prior Authorized Drug List or Interim Prior Authorized Drug List, the prescriber must request SA by calling the Magellan Medicaid Administration Clinical Call Center or faxing them a completed SA form. Providers may request medication SA forms from the Magellan Medicaid Administration Clinical Call Center or may access them online at <http://medicaidalaska.com/providers/rx/default.shtml> and on the DHCS website above.

Tamper Resistant Prescription Forms

Medications not prescribed by electronic transmission or by oral communication must be written on tamper-resistant paper or printed on plain paper with tamper-resistant features. Tamper-resistant paper or tamper-resistant printing must include at least one industry-recognized feature designed to prevent unauthorized copying of a completed prescription, at least one industry-recognized feature designed to prevent the erasure or modification of information written on the prescription, and at least one industry-recognized feature designed to prevent the use of counterfeit prescription forms. Any one feature may not be used more than once for proof of tamper resistance. Prescriptions must also contain the prescriber's National Provider Identifier (NPI).

For additional information, refer to the [Pharmacy Billing Manual](#).

Physician Administered Drugs (J-Codes)

Alaska Medical Assistance determines payment for physician administered drugs based upon the National Drug Code (NDC) billing unit and unit prices and reimburses these drugs at the lesser of the following:

- The Wholesale Acquisition Cost (WAC) + eight percent
- The billed amount

Dispensing Provider Reimbursement

Alaska Medical Assistance reimburses dispensing providers for the estimated acquisition cost of a drug. Additionally, dispensing providers may request Alaska Medical Assistance reimburse them (subject to all enrollment requirements, refer to [Provider Participation Requirements for Dispensing Physicians, Advanced Nurse Practitioners](#) and Physician Assistants) a dispensing fee of \$5.73 per medication strength per recipient per 28 days. Dispensing providers must meet the following two qualifications:

- The dispensing provider is more than 45 miles from a retail pharmacy
- The dispensing provider is not a covered entity under 42 U.S.C 256b or purchasing medications through the federal supply schedule

Updated 05/13

Reproductive Health

Abortion

The Hyde Amendment allows for federal funding of abortions when

"...pregnancy is the result of an act of rape or incest, or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."

Because Medicaid covered services are reimbursed through a combination of federal and state funds, an abortion may be reimbursed under Medicaid only if provisions of the Hyde Amendment are met.

When criteria for coverage under the Hyde Amendment are not met, under certain circumstances the state must pay for abortions pursuant to a 2001 order from the Supreme Court of Alaska. If the abortion was not elective and was necessitated because the pregnancy endangered the health of the woman, the Alaska Medicaid program may pay some or all of the costs.

Providers **must** submit a signed *Certificate to Request Funds for Abortion* form when abortion services are performed for Medicaid and DKC recipients. An original signature of the attending physician is required; a facsimile or photocopied signature or signature of the physician's authorized representative will not be accepted. The form **must be submitted to the Division of Health Care Services** at the address indicated on the form, and **not** to the fiscal agent as a claim attachment.

The Certificate to Request Funds for Abortion form is available at <http://medicaidalaska.com/providers/forms.shtml>.

Family Planning Services

Covered family planning services include:

- Dispensing birth control drugs and devices
- Office visits for counseling services
- Laboratory services
- Prescription drugs
- Sterilization
- Termination of pregnancy

The following enrolled providers, within the scope of certification and licensure, may render family planning services to eligible recipients:

- Physician
- Advanced nurse practitioner
- Physician assistant
- Family planning clinic operated by the state or local government, or a private entity
- Educational institution's student health service
- Federally qualified health center (FQHC) and rural health clinic (RHC)

All family planning providers who operate their own laboratory must have a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or registration; for additional information, refer to [Laboratory Services](#) in this section.

For additional information, refer to the [Family Planning Services Billing Manual](#).

Hysterectomy

Alaska Medicaid covers hysterectomies when performed for medical reasons. Alaska Medicaid will not pay for a hysterectomy performed solely to render an individual permanently incapable of reproducing. Alaska Medicaid requires providers to advise recipients orally and in writing that a hysterectomy will result in sterility; otherwise Alaska Medicaid does not cover the procedure.

The facility or admitting physician must obtain authorization from Qualis Health. [Section II: Professional Claims Management](#) of this manual provides additional information about requesting and obtaining SA from Qualis Health.

Before a hysterectomy is performed, the recipient must sign a [Hysterectomy Consent Form](#), available at <http://medicaidalaska.com/providers/forms.shtml>.

Only the Hysterectomy Consent Form will be accepted; no substitutions are allowed. The consent form must be complete and legible; forms containing correction tape or crossed out language will not be accepted.

Before the recipient signs and dates *Part III* of the form, the individual obtaining the recipient's consent must sign *Part II*, certifying that he or she informed the recipient orally and in writing.

The individual obtaining consent must effectively communicate all of the above information to any individual who is blind, deaf, or otherwise handicapped and must provide an interpreter for any individual who does not understand the language in the consent form or of the individual obtaining consent; however, Alaska Medicaid does not pay for interpreter services.

The recipient must sign her consent before receiving hysterectomy surgery, unless the physician who performs the procedure certifies in writing that:

- The individual was sterile before the hysterectomy, and states the cause of sterility
- The hysterectomy was performed under a life-threatening emergency in which prior acknowledgement was not possible (a description of the nature of the emergency must be included).

Updated 05/13

Obstetrical Care

Physician Guidelines

Alaska Medicaid covers routine obstetrical care when provided by a physician. Reimbursement for obstetrical services is made in accordance with RBRVS payment methodology. A physician may submit a global, all-inclusive claim for obstetrical services only if the recipient has third-party health insurance that pays a global rate.

CPT guidelines consider the use of oxytocin to initiate or augment labor part of a delivery and Alaska Medicaid does not reimburse for oxytocin separately.

Advanced Nurse Practitioner/Certified Nurse Midwife (CNM) Guidelines

Alaska Medicaid covers services for a normal vaginal delivery performed by an advanced nurse practitioner certified as a nurse midwife.

Sterilization

Alaska Medicaid covers sterilization for family planning purposes. Recipients must be mentally competent individuals, 21 years of age or older. Before sterilization is performed, the recipient must grant voluntary, informed consent by signing a [Sterilization Consent Form](#), available at <http://medicaidalaska.com/providers/forms.shtml>.

Only the Sterilization Consent Form will be accepted; no substitutions are allowed. The consent form must be complete and legible; forms containing correction tape or crossed out language will not be accepted.

After the recipient signs and dates the *Consent to Sterilization* portion of the form the individual obtaining the recipient's consent must sign the *Statement of Person Obtaining Consent* portion, certifying he or she orally advised the recipient concerning the following before the recipient signed the consent form:

- About the procedure
- Alternative methods of family planning and birth control
- Sterilization is considered irreversible
- About the discomforts and risks of the surgery as well as the benefits or advantages of sterilization
- That no federal benefits will be withdrawn if the individual decides not to be sterilized

The individual obtaining consent must effectively communicate all of the above information to any individual who is blind, deaf, or otherwise handicapped and must provide an interpreter for any individual who does not understand the language in the consent form or of the individual obtaining consent; however, Alaska Medicaid does not pay for interpreter services.

Consent may **not** be obtained from anyone who is

- In labor of childbirth
- Under the influence of alcohol or other drugs
- Seeking/Obtaining an abortion

- Deemed incompetent by a court of law

The waiting period between obtaining consent and performing sterilization must be at least 30 days and not more than 180 days. In cases of premature delivery or emergency abdominal surgery a waiver of the 30-day waiting period may be granted. In the case of premature delivery, the recipient must give informed consent at least 30 days before the expected delivery date. In the case of abdominal surgery, the physician must wait at least 72 hours after the recipient signs the form and must also describe the emergency.

The physician who performs the sterilization procedure must sign and date the consent form after performing the surgery. The physician's signature certifies that:

- He/She advised the individual about the requirements for informed consent (as set forth in the consent form)
- The individual is mentally competent
- At least 30 days have passed since the individual signed the consent form

After the physician signs the form, it should be attached to the claim submitted for the sterilization procedure.

Updated 06/12

Surgical Services

Preoperative and Postoperative Time Frames

Preoperative and postoperative medical visits are considered part of the total surgical package and are not separately reimbursable.

Co-Surgeons

When medical necessity requires co-surgeons to perform a surgical procedure, Alaska Medical Assistance reimburses at the lesser of billed charges or the rate calculated using RBRVS methodology x 125 percent. The reimbursement is divided equally between the surgeons.

Multiple Surgical Procedures

Alaska Medical Assistance reimburses multiple surgical procedures performed on the same patient during the same operative session (or on the same day) by the same surgeon as follows:

- The highest value procedure is reimbursed at the lesser of billed charges or 100 percent of the rate determined by RBRVS methodology.
- Each additional procedure is reimbursed at the lesser of billed charges or 50 percent of the rate determined by RBRVS methodology.

Bilateral Surgical Procedures

Guidelines require billing bilateral surgical procedures as a single line, using the appropriate CPT modifier for a bilateral procedure. Alaska Medical Assistance reimburses for these procedures at the lesser of billed charges or 150 percent of rate determined by RBRVS methodology.

Surgical Care and Management

Preoperative services provided by a physician other than the surgeon are identified on the claim form by using the CPT procedure code for the surgery plus the appropriate CPT modifier for preoperative surgical management. Postoperative services provided by a physician other than the surgeon are identified on the claim form by using the CPT procedure code for the surgery plus the corresponding postoperative CPT modifier. Each of these services is reimbursed at the lesser of billed charges or 10 percent of the rate determined by RBRVS methodology.

When a physician performs only the surgical procedure and does not provide preoperative and postoperative services, the surgical services are identified on the claim form by using the CPT procedure code for the surgery plus the CPT modifier for surgical care only. These surgical services are reimbursed at the lesser of billed charges or 80 percent of the rate determined by RBRVS methodology.

Surgical Assistants

Alaska Medicaid covers physicians, advanced nurse practitioners and physician assistants acting as surgical assistants for selected procedures. Surgical assistants are reimbursed at the lesser of billed charges or 25 percent of the rate established by the provider's RBRVS methodology.

Alaska Medicaid covers a second surgical assistant and pays for services at the same rate as the first surgical assistant; however, the surgeon must provide an explanation of the need for the second assistant. This explanation must accompany the claim. Alaska Medicaid does not separately reimburse licensed practical nurses, registered nurses, and interns acting as a surgical assistant.

Updated 06/12

Telemedicine

Alaska Medicaid will pay for a covered medical service furnished through telemedicine application if the service is

- Covered under traditional, non-telemedicine methods
- Provided by a treating, consulting, presenting, or referring provider
- Appropriate for provision via telemedicine

Covered Services

Covered telemedicine services are limited to:

- An initial visit
- One follow-up visit
- A consultation to confirm a diagnosis
- Diagnostic, therapeutic or interpretive services
- A psychiatric or substance abuse assessment
- Psychotherapy
- Pharmacological management services on an individual recipient basis

For instructions on billing for telemedicine services, refer to [Section II: Professional Claims Management](#).

Telemedicine Methods of Delivery

Alaska Medicaid will pay for telemedicine services delivered in the following manner:

- Interactive method: Provider and patient interact in "real time" using video/camera and/or dedicated audio conference equipment.
- Store-and-forward method: The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis.
- Self-monitoring method: The patient is monitored in his or her home via a telemedicine application, with the provider indirectly involved from another location.

Exclusions

Alaska Medicaid will not pay for

- The use of telemedicine equipment and systems
- Services delivered by telephone when not part of a dedicated audio conference system
- Services delivered by facsimile
- The following services provided by telemedicine application:
 - Direct entry midwife
 - Durable medical equipment (DME)
 - End-stage renal disease
 - Home and community-based waiver
 - Personal care assistant
 - Pharmacy
 - Private duty nursing
 - Transportation and accommodation
 - Vision (includes visual care, dispensing, or optician services)

Updated 05/13

Therapy Services

Eligible recipients may obtain outpatient occupational therapy, physical therapy, speech-language pathology and hearing services from an enrolled provider when provided within the scope of his or her license. Outpatient therapy and speech-language pathology services must be prescribed by a physician, advanced nurse practitioner, or physician assistant (except an initial evaluation); however, audiology services must be prescribed by an audiologist, otologist, otolaryngologist, or a physician acting within the scope of his or her license and training.

For additional information, refer to the [Therapy Services](#) or [Hearing Services Billing Manual](#).

Updated 02/13

Tobacco Cessation Counseling

A physician, advanced nurse practitioner or physician assistant may provide tobacco cessation counseling or order counseling to be provided by a pharmacist when a prescription for tobacco cessation medication is dispensed to the recipient. Recipients who wish to quit may receive drug therapy to aid their progress. Alaska Medicaid covers both nicotine replacement therapy and Chantix®.

For additional information, refer to the [Pharmacy Billing Manual](#).

Providers may also refer patients to the free Alaska Quit Line at 888.842.7848.

Updated 06/12

Vision Care Services

Alaska Medicaid covers a complete vision examination, including a check of refractive state, performed by a physician, advanced nurse practitioner and physician assistant.

Rochester Optical is the Alaska Medicaid contractor for lenses, glasses frames and contact lenses. All vision service providers are required to order from this contractor when prescribing eyewear for Alaska Medicaid recipients.

For additional information, refer to the [Vision Billing Manual](#).

Updated 06/12

Chronic and Acute Medical Assistance-Covered Services

Alaska Medical Assistance will reimburse physicians, advanced nurse practitioners and physician assistants for services rendered to a Chronic and Acute Medical Assistance (CAMA) recipient who has been diagnosed with:

- A terminal illness
- Cancer requiring chemotherapy
- Diabetes
- Diabetes insipidus
- Chronic hypertension
- A chronic mental illness
- A chronic seizure disorder

The only services reimbursable by CAMA are those provided to treat the CAMA recipient's CAMA covered medical condition.

CAMA covers medical services provided by a physician, advanced nurse practitioner or physician assistant in a practitioner's office or an outpatient clinic. Outpatient hospital services require service authorization (SA) and are limited to chemotherapy and radiology for the treatment of cancer. CAMA does not cover inpatient services.

CAMA also provides prescription benefits limited to three prescriptions per month and a 30-day supply of durable medical equipment (DME) for treating/monitoring the recipient's CAMA covered medical condition.

Updated 06/12

Non-covered Services

The services listed below are non-covered for physicians, advanced nurse practitioners and physician assistants. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. For additional non-covered services, refer to Section III: General Program Information.

- Services that are not medically necessary
- Services provided outside the scope of the provider's licensure
- Advance nurse practitioner serving as a primary surgeon
- Operating room assistance provided by a resident in training, intern, registered nurse or licensed practical nurse
- Infertility or impotence services
- Plastic or cosmetic services for enhancement purposes
- Gender reassignment surgical procedures or sequelae
- Case management services
- Educational services and supplies, interpreter services, medical testimony, travel by the provider, special reports and office supplies
- No-show or cancelled appointments
- Experimental or investigative services
- Swimming therapy, programs to improve overall fitness
- Vaccine products that are available for free
- Services billed using non-covered CPT or HCPCS codes
- Selected special services and report codes

Updated 05/13

Claim Submission

Refer to [Section II: Professional Claims Management](#) for claim submission instructions and to <http://medicaidalaska.com> for claim examples.

Pricing Methodology

Resource-Based Relative Value Scale

Alaska Medical Assistance reimburses physicians, advanced nurse practitioners and physician assistants using the resource-based relative value scale (RBRVS) methodology. Advanced nurse practitioners and physician assistants are reimbursed at 85 percent of the established rate for physicians.

For additional pricing information, refer to [Section II: Professional Claims Management](#).

Updated 05/13

Pricing for Services without Established Relative Value Units

Services for which the Centers for Medicare and Medicaid Services (CMS) has not established Relative Value Units (RVU) are manually priced by the department in accordance with 7 AAC 145.050(e).

For additional pricing information, refer to [Section II: Professional Claims Management](#).

Updated 05/13

Section II: Professional Claims Management



Prepared By
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About This Manual

The Department of Health and Social Services (DHSS) is the state agency designated to administer the Alaska Medical Assistance Program, which includes:

- Medicaid
- Denali KidCare (DKC)
- Chronic and Acute Medical Assistance (CAMA)

Unless otherwise specified, references to the Alaska Medical Assistance Program, or Alaska Medical Assistance, mean Medicaid, Denali KidCare, and CAMA. References to Alaska Medicaid, or Medicaid, mean only Alaska Medicaid and Denali KidCare.

Section II: Professional Claims Management, contains detailed, claim type-specific information about claims submission, processing, and payment, and is to be used by enrolled providers in conjunction with

- The appropriate provider-specific [Section I](#), and
- [Section III: General Program Information](#).

Updates to this manual will be necessary from time to time as federal and state medical assistance regulations are adopted. As updates are made, each affected segment of the manual will be annotated with the date of the change. Providers will be informed of these updates by remittance advice messages and announcements on the Alaska Medicaid website, <http://medicaidalaska.com>. Previously published manuals are available upon request.

Thank you for your participation in the Alaska Medical Assistance Program and for the services you provide.

Updated 06/12

Service Authorization

Certain services, procedures, and medications covered by Alaska Medical Assistance require service authorization (SA). Alaska Medical Assistance must review services prior to rendering to determine medical necessity. Providers should obtain SA first, except in cases of medical emergency. If the provider does not obtain SA when required, he or she may not be paid for those services. SA does not guarantee payment.

Currently, these agencies review and approve SA:

- Xerox
- Qualis Health
- Magellan Medicaid Administration (MMA)
- The Division of Senior and Disability Services (DSDS)

Each agency provides authorization for specific services; this manual discusses those services which professional providers may need authorization. For an explanation of the SA process for other entities, refer to the appropriate billing manual.

If providers need assistance determining which services require SA or which agency handles their SA request, please contact [Provider Inquiry](#).

Updated 05/13

Authorization from Xerox

Providers should submit requests for service authorization (SA) to Xerox for the services listed below. When submitting a request for SA, providers must use the appropriate SA method or form available at <http://medicaidalaska.com/providers/forms.shtml>. Specific SA submission requirements follow.

Services Authorized by Xerox

- Behavioral health services (to extend service limits)
- Mental health physician clinic
- Community behavioral health clinic
- Certain maternal/newborn admissions
- Durable medical equipment and medical supplies
- Hearing aids
- Home Infusion
- Emergency transportation/Medevac
- Non-emergent transportation and accommodation
- Selected prescribed medications as specified on the [Prior Authorized Drug List](#)
- Selected professional/outpatient services
 - CAMA-related radiation and chemotherapy performed at an outpatient hospital for the treatment of cancer
 - Chiropractic care
 - Home health
 - Hospice
 - Nutrition services
 - Private duty nursing
 - Respiratory therapy
 - Service that exceeds established annual or periodic service limitations
 - Vision services
- Surgeries not appearing on the [Qualis Select Diagnoses and Procedures Pre-Certification List](#)

Requesting Retroactive Authorization

Retroactive authorizations will be reviewed and considered when medical necessity will not allow time for service authorization prior to rendering the service. Retroactive requests for travel will be considered only when the travel is emergent and the Service Authorization Unit is closed.

Requests for retroactive authorization must be submitted on the Service Authorization Request Form ([AK-SA](#)) directly to the Service Authorization Unit. Dates of service on the claim form and the retroactive AK-SA form must be identical. Include the following information on the AK-SA in addition to the required fields:

- "Yes" in field three
- "Retroactive to MMDDCCYY" in field 13

Requesting an Unlisted Code Review

Unlisted codes do not require an AK-SA, but a written explanation (and itemization, if appropriate) with charges must accompany the claim. If a service or item must be billed using an unlisted code, the provider can use an AK-SA to request a review for coverage prior to rendering the service. No authorization number will be assigned for these reviews. If the review indicates approval, a copy of the form must accompany the claim.

Updated 05/13

Authorization for Behavioral Health Treatment

Providers must request service authorization (SA) for behavioral health treatment when the amount of services indicated exceeds the service limitations set out by Alaska Medicaid. There are two forms for requesting SA:

- [Community Behavioral Health Clinic Service Authorization Request](#)
- [Mental Health Physician Clinic Service Authorization Request](#)

Providers should use the appropriate form to request SA for outpatient behavioral health treatment, day treatment, and substance abuse treatment.

Each form includes instructions for completion; the forms and corresponding instructions are available at <http://medicaidalaska.com/providers/forms.shtml>. For additional information, refer to the [Behavioral Health Services Billing Manual](#) and [Mental Health Physician Clinic Billing Manual](#).

Updated 06/12

Authorization for Certain Maternal/Newborn Admissions

Xerox and Qualis share responsibility for authorizing certain maternal/newborn admissions. Refer to the following table to determine which entity should receive your authorization request:

Maternal/Newborn Stay Service Authorization (SA) Chart			
Mode of Delivery	Submit Claims as Payable without SA	Administrative SA from Xerox	Medical Necessity Review from Qualis
Vaginal delivery	Total stay from admit to discharge is two days or less	Delivery/Birth is the day after admission, but discharge is within two days of delivery/birth	Either delivery/birth is more than one day after admission OR discharge is more than two days following date of delivery/birth
Cesarean delivery	Total stay from admit to discharge is four days or less	Delivery/Birth is the day after admission, but discharge is within four days of delivery/birth	Either delivery/birth is more than one day after admission OR discharge is more than four days following date of delivery/birth

Updated 04/13

Authorization for Durable Medical Equipment, Specialized Medical Equipment, and Other Medical Supplies

The following items require service authorization (SA):

- Most durable medical equipment
- Specialized medical equipment
- Audiology equipment
- Home infusion therapy

To request SA, use a Certificate of Medical Necessity (CMN) and the Service Authorization Request Form (AK-SA) to meet all program documentation requirements. Other records may be accepted if they meet the documentation requirements found on the CMN.

Instructions for completing the CMN are found below. Both forms are available at <http://medicaidalaska.com/providers/forms.shtml>.

Durable Medical Equipment

Alaska Medicaid covers medically necessary and appropriate durable medical equipment (DME) when prescribed by a physician, advanced nurse practitioner, or physician assistant.

For DME items that require SA, a CMN must be completed. To request SA, use the AK-SA.

- The CMN may be used for most DME, supplies, prosthetics and orthotics.
- Quantities requested should be appropriate for a 30-day period. Orders in excess of a 30-day supply require written medical justification, otherwise the SA may be denied.
- The [Certificate of Medical Necessity – Incontinence Supplies](#) may be used for incontinence treatment only.

For additional information, refer to the [Durable Medical Equipment Billing Manual](#).

Specialized Medical Equipment

Home and Community-Based Waiver recipients may be eligible to receive specialized medical equipment (SME) when ordered by a physician. SME authorization requests are submitted as amendments to the recipient's plan of care.

For additional information, refer to the [Home and Community-Based Waiver Services Billing Manual](#).

Audiology Equipment

Request authorization for audiology equipment, including hearing aids, using the AK-SA. A CMN must accompany the request for authorization. For additional information, refer to the [Hearing Services Billing Manual](#).

Home Infusion Therapy

All home infusion therapy services require SA; providers must request authorization using the AK-SA and attach a CMN or patient notes, which must include the following:

- Written home health or hospice plan of care
- Number of requested nursing visits with procedure codes, number of requested home infusion therapy per diem services and HCPCS codes, drug dose, number of doses, directions, route of administration, diagnosis code(s), begin and end dates; and either

- A current Region D Durable Medical Equipment Regional Carrier (DMERC) Local Coverage Determination for Medicare covered external infusion pumps that is in effect for the requested dates of service, if applicable
- A current copy of the health plan's coverage of home infusion therapy, if applicable

For additional information, refer to the Durable Medical Equipment Billing Manual.

Completing the Certificate of Medical Necessity

The CMN is comprised of four sections. The attending physician, advanced nurse practitioner, or physician assistant acting within the scope of his or her license should fill out the following sections:

- Demographic information
- Section A: Clinical Information
- Section B: Clinical Assessment of Need for Prescribed Services or Item(s) and Plan and the ordering provider's attestation and signature

The provider supplying the DME/SME must fill out the following sections:

- Demographic information
- Section C: Requested Services or Items
- Section D: Supplier Attestation, Signature, and Date

The CMN is available at <http://medicaidalaska.com/providers/forms.shtml>.

Updated 06/12

Authorization for Emergency Transportation/Medevac

Alaska Medicaid requires providers to submit retroactive service authorization (SA) requests for emergency transportation, including air ambulance and medevacs. Authorization will not be made in advance.

NOTE: Ground ambulance services do not require service authorization.

Alaska Medicaid covers emergency medical transportation to the nearest medical facility capable of handling that medical emergency. Indian Health Service (IHS) beneficiaries may travel to the nearest IHS/Tribal facility.

To submit an air ambulance/medevac SA request; complete an [Air Ambulance Flight Summary](http://medicaidalaska.com/providers/forms.shtml) available at <http://medicaidalaska.com/providers/forms.shtml>. Attach the Air Ambulance Flight Summary to the claim form when billing for air ambulance or medevac services. Providers may submit a form of their own, but should ensure the form addresses all the information requested on the Air Ambulance Flight Summary.

Updated 06/12

Authorization for Non-Emergent Transportation and Accommodation

Providers must submit transportation/accommodation requests to Xerox. Providers record service authorization (SA) and bill for services using the Transportation Authorization and Invoice (AK-04). The AK-04 is a controlled form, each bearing a distinct identifying number. Providers must keep these controlled forms in a secure location. To request AK-04s, use the [Healthcare Forms Order Request](http://medicaidalaska.com/providers/forms.shtml) available at <http://medicaidalaska.com/providers/forms.shtml> or contact [Provider Inquiry](#).

Before travel occurs, a recipient's local provider should obtain authorization for

- Medical escorts
- Travel by air charter, airline, ambulance (air and ground), ferry, railroad, taxi or wheelchair van
- Hotel/motel with/without restaurant
- Pre-maternal home
- Travel for inpatient psychiatric patients or recipients entering substance abuse treatment

Phone Requests

The recipient's local provider should call the [Service Authorization Unit](#) to request a travel SA; have the following information ready for processing your request:

- Patient's Alaska Medical Assistance ID number
- Appointment dates
- Diagnosis
- Referring and receiving provider name
- Origin and destination
- Escort information, if applicable

The Service Authorization Unit will guide you through completing other necessary information on the form and provide instructions for separating the form. When Xerox indicates which services are authorized, complete one copy for each provider and one copy for each taxi ride.

For additional information, refer to the [Transportation and Accommodation Billing Manual](#).

Updated 06/12

Authorization for Prescribed Medications

Certain medications require service authorization (SA) before Alaska Medical Assistance covers these medications. The Division of Health Care Services (DHCS) maintains the [Prior Authorized Drug List](#) and [Interim Prior Authorized Drug List](#) on the http://dhss.alaska.gov/dhcs/Pages/medicaid_medicare/authorization_hcs.aspx.

Unless otherwise indicated on the Prior Authorized Drug List or Interim Prior Authorized Drug List, the prescriber must request SA by calling the [Magellan Medicaid Administration Clinical Call Center](#) or faxing them a completed SA form. Providers may request medication SA forms from the Magellan Medicaid Administration Clinical Call Center or may access them online at <http://medicaidalaska.com/providers/rx/default.shtml> and on the DHCS website above.

If the drug is administered in a provider's office and requires SA, report the appropriate HCPCS J-code and quantity to the Xerox [Service Authorization Unit](#) using the Service Authorization Request Form ([AK-SA](#)).

For additional information, refer to the [Pharmacy Billing Manual](#).

Updated 04/13

Authorization for Professional/Outpatient or Surgical Services

Refer to the appropriate fee schedule to determine if service authorization (SA) is required.

1. If SA is required, refer to the Qualis [Select Diagnoses and Procedures Pre-Certification List](#) and the [Outpatient Imaging Pre-Certification List](#) for diagnoses and procedures reviewed by Qualis. These lists are available at <http://www.qualishealth.org>.
2. If the service does not appear on either of the Qualis lists, submit your request for SA to Xerox using the Service Authorization Request Form ([AK-SA](#)).
3. Phone requests for professional/outpatient or surgical services SA are not accepted.

Services which Exceed Established Service Limitations

Certain services require SA after the services delivered have met or exceeded annual or periodic service limits. If a recipient requires additional services which exceed these limits, providers should submit an AK-SA and provide [medical justification](#) for additional services to be considered.

Infant Formulas and Medical Foods

When a recipient under age five is diagnosed with a medical condition that requires a formula other than a Women, Infants and Children (WIC) "contract" formula, SA is required and an Enteral Nutrition Prescription Request Form ([ENPR](#)) must be completed by a physician or other health care provider who is enrolled with Alaska Medical Assistance and licensed to write prescriptions. The ENPR is available at <http://dhss.alaska.gov/dpa/Pages/nutri/default.aspx>.

Updated 05/13

Authorization from Qualis Health

Qualis Health reviews service authorization (SA) requests for the following:

- Acute care inpatient stays and outpatient services for selected diagnoses and procedures identified on the [Qualis Select Diagnoses and Procedures Pre-Certification List](#)
- Acute care inpatient continued stays exceeding three days, including certain maternal/newborn admissions
- All inpatient psychiatric hospital/residential psychiatric treatment center stays
- Certain outpatient imaging services identified on the Qualis [Outpatient Imaging Pre-Certification List](#)

Providers are required to submit requests for review via the web on the Qualis Health web-based review system, iEXCHANGE.

For additional information, refer to the [Qualis Health Provider Manual](#) or visit <http://www.qualishealth.org>.

Updated 05/13

Authorization for Outpatient Imaging Services

The following outpatient imaging services require service authorization (SA):

- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET)
- Magnetic resonance angiography (MRA)
- Single-photon emission computed tomography (SPECT)

The [Qualis Outpatient Imaging Pre-Certification List](#) identifies CPT codes that require SA.

A physician, advanced nurse practitioner or physician assistant may request an outpatient imaging SA from [Qualis Health](#) through their web-based review system iExchange. When requesting SA, be advised:

- Spanned dates are not allowed.
- The authorization will be valid for the facility (outpatient hospital or free-standing facility) performing the technical portion of the procedure.
- CAMA recipients cannot receive imaging services in an outpatient hospital setting but are eligible to receive services in a free-standing facility.

Updated 05/13

Claim Submission

Xerox, the fiscal agent for Alaska Medical Assistance, processes claims submitted for Medicaid, Denali KidCare, and Chronic and Acute Medical Assistance (CAMA). Providers may submit claims electronically or on paper. Xerox receives and sorts all incoming claim forms daily. The Xerox mailroom archives claims and attachments and assigns a Claim Control Number (CCN) for identification. Each CCN is based upon the [Julian Calendar](#).

Billing Agents

A provider may use a billing agent or accounting firm to submit claims to Alaska Medical Assistance. However, payment by the provider for those services may not be based on the amount billed to or paid by Alaska Medical Assistance, such as a percentage basis.

Updated 06/12

Electronic Claims

Providers, or their representative, who have submitted the proper [Information Submission Agreement](#) (found at <http://medicaidalaska.com/providers/forms.shtml>) may submit claims electronically.

Professional providers must submit HIPAA-compliant electronic claims which meet The Accredited Standards Committee X12 Version 5010 837 Professional (837P) guidelines. For technical details regarding 5010 compliance, providers may purchase a Technical Report, Type 3 through Washington Publishing Company. Additionally, Xerox provides Alaska Medical Assistance-specific [companion guides](#) for submitting HIPAA-compliant electronic claims; found at http://medicaidalaska.com/companion_guides.shtml.

Alaska Medical Assistance provides an electronic claim submission software program called Payerpath. This software is available at no cost to the provider.

Attachments for electronic claims must be submitted separately by mail or fax. For additional information and instructions; refer to [Electronic Claims Attachment Transmittal](#) in this section for instructions.

To receive more information on electronic claim submission, write to or call the Electronic Data Interchange Department/Electronic Commerce Customer Support ([EDI/ECCS](#)) Department.

Advantages of Electronic Transactions

- Reduced claims processing time
- Reduced pended or denied claims
- Reduced data entry error

Updated 05/13

Paper Claims

Paper claim forms contain information necessary to process claims for services rendered to Alaska Medical Assistance recipients. Adhere to the following instructions for claims to be processed efficiently. Accuracy, completeness, and clarity are important.

- Do not fold or crease claims.
- Fill in handwritten claims neatly and accurately.
- Keep names, numbers, codes, etc., within the designated boxes and lines.
- Make corrections carefully. Do not strike or write over errors to correct. Correction fluid or tape may be used as long as the corrected information is readable.
- Include a return address on all claims and mailing envelopes.
- Send only required attachments.
- Use only blue or black ink to fill out the claim form. Light-colored or red ink is not perceptible when the claim form is scanned using optical readers.

Health Insurance Claim Form

Providers must bill paper claims for professional services to Alaska Medical Assistance on the Health Insurance Claim Form (CMS-1500). Providers may order CMS-1500 forms from Xerox. Use the [Healthcare Forms Order Request](#) available at <http://medicaidalaska.com/providers/forms.shtml> to order this and other forms. Please order a two month supply and allow four weeks for delivery.

National Provider Identifier Only Submission Encouraged for Paper Claims

Although not mandatory for paper claims, Alaska Medicaid strongly encourages national provider identifier (NPI)-only billing to reduce errors that can cause a claim to be denied or delayed. Providers submitting paper claims using their NPI no longer need to submit claims with a Medicaid Contract ID, however, the system will continue to use the Medicaid Contract ID if supplied for any paper claim submitted.

Updated 06/12

Timely Filing of Claims

All claims must be filed within 12 months of the date services were provided to the patient. The 12 month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier. In these cases, providers must bill Alaska Medical Assistance within 12 months of the service date and attach explanation of benefits documentation from the third-party carrier to the Alaska Medical Assistance claim.

The timely filing limit may be extended under the following conditions:

- **Court orders or administrative hearings:** The timely filing limit can be extended and payment made by court order. If a provider had reason to believe that the recipient was ineligible at the time service was rendered, and the recipient is subsequently determined eligible by a court or hearing authority, the claim may be paid if it is filed within the above timely filing guidelines after the date of the court or administrative hearing authority's decision that the recipient was eligible. A letter or document from the court or agency establishing the decision to make payment must accompany the claim.
- **Good cause:** The timely filing limit may be extended for "good cause." Good cause exists when an unexpected or uncontrollable event takes place which prevents a provider from submitting a timely claim (fire, storm, earthquake, etc.). Good cause does not include errors made by the provider or provider's billing staff. Good cause also does not include the recipient's failure to notify the provider of a court or administrative hearing authority's decision.

Proof of Timely Filing

Any time a claim is received after the timely filing period has expired, an attachment must accompany the claim to prove timely filing. Acceptable documentation must be dated within the timely filing period and must show that either the claim was previously received by Xerox within the timely filing period or the claim met one of the conditions for timely filing extension.

Examples of acceptable documentation include

- A copy of the remittance advice (RA) page showing claim denial
- A copy of a resubmission turnaround document (RTD)
- A copy of the in-process claims page of an RA
- Payerpath or other electronic claim submission transmission report
- Correspondence from Xerox, the Division of Health Care Services (DHCS), or the Division of Public Assistance (DPA)
- Court orders or administrative hearing documentation as outlined above

Filing Limits for Adjustments

Adjustment requests must be submitted within 60 days from the date of payment or within 12 months of the date of service if additional amounts are owed to the provider. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply.

Updated 06/12

Claims Cycle

Claims Processing

Claims process through the Medicaid Management Information System (MMIS); the MMIS checks claim information against master files using edits and audits to determine, for example, some of the following:

- Compatibility of procedures and diagnoses
- Provider eligibility at the time of service
- Recipient eligibility at the time of service
- Third party liability (TPL)
- Duplication of previously paid claims
- Service authorization (SA) on file, when required

After the claim processes, it will adjudicate (pay, pend or deny).

Updated 06/12

Adjudication

Pay

If the Medicaid Management Information System (MMIS) validates the information on the claim and information successfully passes all edits and audits, Alaska Medical Assistance will pay on the claim and record the payment in the provider's weekly remittance advice (RA).

Payment, less any recipient [cost share owed](#), represents full and total reimbursement for those covered services under Alaska Medical Assistance. Under federal regulations, providers may not "balance bill" recipients. This means

- Providers may not charge recipients for the difference between the amount billed and the amount Alaska Medical Assistance allows for a covered service.
- When a provider does not bill Alaska Medical Assistance correctly, the recipient is not responsible for the charges.
- When a provider does not bill Alaska Medical Assistance within [timely filing limits](#), the recipient is not responsible for the charges.

Pend

If the MMIS finds claim information that fails a validation check, the claim will pend and a claims examiner will review the information provided.

- If the claims examiner finds a data entry keying error on a submitted paper claim, he or she will correct these errors and release the pended claim for resubmission to the claims validation process.
- If the claims examiner cannot correct the claim, the MMIS will generate a resubmission turnaround document (RTD) which will print with the provider's weekly RA. Providers must provide the information indicated on the RTD within 90 days in order for the claim to adjudicate.

Deny

A claim may be denied for reasons such as:

- The billed service is not a covered benefit.
- The line item fails validation (the edit/audit process).
- A provider fails to return an RTD within 90 days.

Denied claim lines represent those services that are unacceptable for payment. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within timely filing limits.

Updated 06/12

Duplicate Billing

Duplicate claims may occur when providers submit two or more claims with some or all of the same information, including:

- Date of service
- Charges
- Recipient ID
- Provider Contract ID/National Provider Identifier
- Procedure codes

To avoid erroneous duplicate billing, providers should keep up-to-date records of all claims by reading their remittance advice and routinely checking on the status of claims.

Providers can avoid duplicate billing errors by adjusting any claim already submitted and paid instead of re-billing. This can occur when

- A provider needs to bill additional charges for a date of service.
- Primary insurance pays on a claim after Alaska Medical Assistance.

Updated 06/12

Coding

HCPCS Coding Convention

Alaska Medical Assistance, in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, uses the Healthcare Common Procedure Coding System (HCPCS) convention. HCPCS coding must be used for all professional/outpatient claims (originals and re-submittals), adjustments, and requests for service authorization submitted for processing.

HCPCS coding has two levels. Each HCPCS procedure or service has a five-digit alpha-numeric code, with provision for a unique two-position modifier for each level of coding.

Level I	American Medical Association current procedural terminology (CPT) codes as found in the annual revision of the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4).
Level II	The CMS codes for physician and non-physician procedures and services not found in the CPT.

To order a CPT book, visit the American Medical Association's website <http://ama-assn.org>.

Updated 04/13

Diagnosis Codes

The Centers for Medicare and Medicaid Services (CMS) requires that World Health Organization's International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes be entered on all claims that require a diagnosis.

Updated 06/12

Unlisted Codes

Unlisted procedure and service codes are to be used only when the provider is unable to locate a specific code listed in the current CPT, HCPCS, fee schedule, provider billing manual, or billing manual updates.

Unlisted services that cannot be billed under an identified procedure code are billed under an unlisted procedure code. When using an unlisted procedure code, a written justification or explanation with the following information must be attached behind the claim:

- A description of the procedure/service rendered.
- The reason no other procedure code was appropriate for the procedure/service rendered.

Any claim with an unlisted procedure code is pended for review. All other services billed on the same claim are also pended until the unlisted procedure code review has been completed. If Alaska Medical Assistance approves the item or service and agrees that it cannot be billed under an existing listed code, the code will be reimbursed at 50 percent of billed charges.

Updated 06/12

National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) requires that all claims submitted to Alaska Medicaid must comply with NCCI methodologies and are subject to NCCI edits. Two types of edits are mandated by NCCI: procedure-to-procedure edits and medically unlikely edits.

Procedure to Procedure Edits

Procedure-to-procedure edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together.

Medically Unlikely Edits

Medically Unlikely Edits (MUE) are units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.

Services denied for NCCI edits may not be billed to the recipient. The denied service is a provider liability. Providers may appeal individual claim denials to Xerox; for instructions, refer to [Appeals](#) in this section.

For additional information about NCCI, visit the Alaska Medicaid NCCI webpage at <http://medicaidalaska.com/providers/ncci.shtml> or the CMS NCCI webpage at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html>.

Updated 04/13

Third Party Liability

Providers who bill Alaska Medicaid are required to bill all third party resources (except the Indian Health Service) prior to billing Alaska Medicaid. However, if the services provided fall under the [Federal Third Party Liability Waiver](#), Alaska Medicaid will seek reimbursement from the third party.

Updated 06/12

Federal Third Party Liability Waiver

Alaska Medicaid has been granted a federal third party liability (TPL) waiver for certain providers that offer specific categories of service. At this time, providers who offer the services listed are not required to bill third party resources:

- Dental services
- Transportation and accommodation services (except air ambulance and ground ambulance services)
- Home and community based waiver provider services
- Personal care assistant services
- EPSDT screening services
- Prenatal care services
- Preventive pediatric services
- Eye wear (lenses/frames - This applies only to the contract supplier of eyewear)

Providers who render one or more of the services listed above are not required to bill a third party resource before billing Alaska Medicaid. Alaska Medicaid will reimburse a provider no more than the allowed amount and then seek reimbursement from the third party.

Providers may choose to bill the third party resource if the service provided is covered by that resource and the payment will exceed the expected Alaska Medicaid reimbursement amount.

Providers who offer services that are not listed above are required to

- Bill all third party resources before billing Alaska Medicaid (except the Indian Health Service).
- Include proof of all TPL resource payments when billing Alaska Medicaid.

Updated 06/12

Third Party Liability Avoidance

Alaska Medicaid has developed a process to assist providers with Medicaid claims for clients who have primary (third party) insurance coverage. The process may affect claims that the third party carrier has denied because

- The service is not covered by the benefit plan.
- The recipient's yearly or lifetime maximum benefits for a service have been exhausted.
- The servicing provider's credentials do not meet requirements for coverage by the insurance carrier.

The third party liability (TPL) avoidance process allows the Alaska Medical Assistance claims payment system to bypass TPL editing when certain conditions are met. It eliminates the need for providers to bill the primary insurance company for services that the insurance does not cover. The request for TPL avoidance review must include documentation from the carrier specifically stating the services that are not covered and a valid reason for the denial.

Depending on the reason for the TPL avoidance, Alaska Medicaid may require providers to request avoidance each year. For example, if yearly benefit maximums have been exceeded, a provider must reapply for TPL avoidance the following year after the yearly maximum for that calendar year had been met.

Conditions that would not qualify for TPL avoidance include services that were billed to the TPL carrier incorrectly or services for which required authorization was not received in advance. Other conditions may also apply. All requests for TPL avoidance will be reviewed and if the request is approved, the requirement to bill the third party insurance will be waived.

Guidelines for Requesting TPL Avoidance and Criteria for Review

TPL avoidance is limited to ongoing services and avoidance will not be approved for less than a six month span.

Example: If a recipient receives an influenza injection and the TPL carrier does not cover the service, this is a one-time event and is not considered ongoing. However, if a recipient is receiving medication management as a continuing service and the TPL carrier does not cover it, it is considered an ongoing service and is a candidate for a TPL avoidance review.

While waiting for a TPL avoidance decision, the provider should continue billing claims in order to document claim denial for TPL until the TPL avoidance request is approved. Upon TPL avoidance approval, Alaska Medicaid will consider overriding timely filing requirements if the provider can document claims were previously denied for TPL.

NOTE: Timely filing override will not be determined until after the TPL avoidance is approved.

Updated 06/12

Attaching Insurance Benefit Booklet Pages

Providers are required to bill all applicable third party resources and insurance carriers prior to billing Alaska Medical Assistance.

If the service is not covered according to the third party resource or insurance carrier benefit booklet, providers may attach a copy of the benefit booklet page(s) to the claim submitted to Alaska Medical Assistance. The benefit booklet page(s) must specify the patient's benefit plan name and indicate that the service being billed to Alaska Medical Assistance is not covered. It may be necessary to copy the benefit booklet's cover page which identifies the benefit plan name as well as any page(s) within the booklet that describes the coverage or non-coverage of the specific service category being billed to Alaska Medical Assistance.

Providers may also use benefit booklet pages when requesting third party liability (TPL) avoidance. For additional information, refer to [Third Party Liability Avoidance](#) in this section.

Updated 05/13

Non-covered Medicare HCPCS Codes

Codes published in the HCPCS coding manual that are indicated to be non-covered by Medicare are included in the Alaska Medicaid third party liability (TPL) avoidance file. This file is updated annually. When codes are added to the TPL avoidance file, the claims processing system will not search for related third-party information (e.g., Medicare in this example) when processing a claim with those codes. Therefore, when billing one of these codes, the code will be recognized as a non-covered Medicare code and billing Medicare is not required. Please note that even though billing Medicare is not required, Alaska Medical Assistance does not guarantee payment for the item or service provided.

Updated 06/12

Third Party Liability for Durable Medical Equipment

When a provider requests service authorization for durable medical equipment (DME), he or she must first receive authorization from any alternate payment resource. Additionally, the provider must present supporting documentation of the alternate resource's authorization at the time the provider submits a service authorization (SA) request to Alaska Medicaid.

If the provider suspects the recipient's alternate resources will not cover the DME due to coverage guidelines, the provider may still request SA from the [Service Authorization Unit](#). The SA request must document alternate resource non-coverage and clearly state that the provider is requesting reimbursement amounts above the remaining copay or deductible. Alaska Medicaid will approve beyond copay and deductibles only if the provider provides supporting documentation.

If the recipient's primary coverage is through Medicare and provider suspects that Medicare will not cover the DME due to coverage guidelines, the provider should submit the following documentation along with the request for SA:

1. A statement from the provider requesting SA for more than copay and deductibles.
2. A Medicare Certificate of Medical Need specifically lining out the recipient's medical need for the equipment.
3. A copy of the coverage criteria for Medicare.
4. An advanced beneficiary notice (ABN) signed by the recipient with the provider's explanation as to why the recipient's condition or circumstances do not meet Medicare coverage criteria.
5. A prescription (and if needed, a letter of medical need from a licensed practitioner following a clinical assessment).
6. A published retail price sheet for the item/service that is actually to be provided.

NOTE: A determination cannot be made without this information.

Xerox will return the request for SA to the provider indicating authorization for copay and deductibles only.

TPL avoidance will be automatically loaded as part of the annual update process for items/service statutorily non-covered by Medicare, as indicated in the current year HCPCS (refer to [Non-covered Medicare HCPCS Codes](#) in this section).

Updated 05/13

Payer of Last Resort

Alaska Medicaid is always the payer of last resort. Therefore, if a patient is eligible for Department of Veterans Affairs (VA), Medicare, and Medicaid benefits, providers must exhaust all Medicare and VA benefits before billing Alaska Medicaid. Providers may verify VA eligibility by identifying resource code "N2" on the Medicaid recipient's coupon.

Veterans identified with the resource code "N" have freedom of choice to utilize VA or Medicaid as desired. Alaska Medicaid does not require these recipients to obtain a Medicaid denial letter from the Alaska VA Healthcare System.

When providing care to a Veteran with a resource code of "N2", a provider must submit valid documentation of non-coverage from Medicare and the VA when billing. Valid documentation may include an explanation of benefits (EOB) showing non-coverage or a Medicaid denial letter from the Alaska VA Healthcare System.

An Alaska Medical Assistance recipient who is eligible for VA and Medicare can use either as his/her primary resource. However, the following conditions apply in regards to Alaska Medicaid paying anything for the claim:

- If VA is pursued as the recipient's primary payer (instead of Medicare), the claim is considered satisfied and neither Medicare nor Medicaid will pay anything more.
- If Medicare is pursued as the recipient's primary payer (instead of VA)

- VA will not pay for anything over the amount paid by Medicare.
- Alaska Medicaid may pay the Medicare copay and/or deductible if the Medicare Remittance Notice (MRN) and the VA denial are attached to the claim.
- Alaska Medicaid may reimburse according to the applicable Alaska Medicaid rates if the services billed are non-covered Medicare services and a Medicaid denial letter from the VA is attached to the SA request and/or claim.

Therefore, if a recipient is eligible for VA, Medicare, and Medicaid, Alaska Medicaid will not pay anything for the claim unless providers follow these steps:

1. Bill VA first and receive a formal denial (in writing) from VA or receive a Medicaid denial letter.
NOTE: If the Veteran has an applicable Medicaid denial letter from the VA, the provider does not have to bill VA first.
2. Bill Medicare correctly.
3. Bill Alaska Medicaid correctly and attach the denial from VA and the MRN.

If providers follow these steps bill the claim correctly, Alaska Medicaid may pay the Medicare copay and/or deductible.

Explanation

- VA is considered primary because they pay 100 percent of their allowed amount.
- Medicare is considered secondary because they pay 80 percent of their allowed amount with a 20 percent copay, which Alaska Medicaid can cover under the correct billing process.
 - However, Alaska Medicaid will not use state funds for a 20 percent Medicare copay if the claim could have been satisfied with 100 percent federal funds (VA is federally funded).

Please refer to the back of the CMS-1500 claim form (under *Refers to Government Programs Only*) for rules and information related to billing multiple federally funded programs.

Obtaining a VA Medicaid Denial Letter

To provide freedom of choice for Veterans with medical needs, the Veteran can request a Medicaid denial letter from the Alaska VA Healthcare System. This letter, which is for specific services, can be submitted to the Alaska Medicaid program as an explanation of Veteran's health benefits. Therefore, if the Veteran (identified by resource code "N2") chooses not to use VA as his/her primary payer, attach a copy of this letter to any related service authorization request and/or claims sent to Alaska Medicaid.

Important: All other Alaska Medical Assistance billing requirements still apply to claims submitted with a Medicaid denial letter, including

- Timely filing of claims
- Exhaustion of all other benefit resources (including Medicare) before billing Medicaid

The Veteran must request a Medicaid denial letter from the Alaska VA Healthcare System.

Alaska VA Healthcare System
Anchorage Regional Office
1201 N Muldoon Road
Anchorage, AK 99504
907.257.4780
888.353.7574 x 4780

The VA Integrated Care Department will fax or mail the Medicaid denial letter to the requesting entity, including the Veteran, any affected medical providers identified by the Veteran, or Alaska Medicaid.

Updated 06/12

Special Billing Requirements

J-Code/National Drug Code Submission Requirement for Practitioner-Administered Drugs

J-Codes are one component of the Level II HCPCS coding convention. All J-code drugs administered in an outpatient clinical setting and billed with a HCPCS value and unit must include the following information regardless of claim submission format in order to be considered for payment:

- National Drug Code (NDC)
- Units of measurement
- Numeric quantity administered (the actual metric decimal quantity)

This requirement extends to outpatient hospital billers as well as professional claims billers, and includes crossover claims.

The specific list of HCPCS codes requiring NDC can be found in the publication named [HCPSC codes requiring NDC as of April 1, 2008](http://www.hcpcs.org/publications/HCPSCodesRequiringNDCAsOfApril12008.pdf); this resource is available on the Alaska Medicaid website <http://medicaidalaska.com/providers/provupdates.shtml>.

Drugs administered in a clinical setting are payable by Alaska Medicaid only when NDCs are rebateable. A current listing of the manufacturers that have signed rebate agreements can be found on the CMS website <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.html>.

More detailed information about filling out the claim form using NDC codes can be found in the billing aid [J-Codes: Helpful Tips for Billing Physician-Administered Drugs](http://www.medicaidalaska.com/providers/rx/default.shtml) dated 2/21/2012 on the Alaska Medicaid website <http://www.medicaidalaska.com/providers/rx/default.shtml> under the Documents table. For additional information, refer to <http://www.nucc.org> as well under [Paper Claims](#) in this section.

Updated 06/12

Billing for Telemedicine Services

Submitting a claim for a telemedicine service is identical to the way a claim would be submitted for a face-to-face visit. Depending on the method of telemedicine used and the role of the provider in the consultation determines whether a modifier should be added to the procedure code. The role of the provider falls into three categories:

- **Referring Provider:** Evaluates a patient, determines the need for a consultation, and arranges services of a consulting provider for the purpose of diagnosis and treatment.
- **Presenting Provider:** Introduces a patient to the consulting provider during an interactive telemedicine session (may assist in the telemedicine consultation).
- **Consulting Provider:** Evaluates the patient and/or medical data/images using telemedicine mode of delivery upon recommendation of the referring provider.

A consulting provider may send data he/she has received during a store-and-forward telemedicine consultation to another consulting provider (with equal or greater scope of practice as determined by his/her occupational license or level of expertise within their field of specialty).

Updated 06/12

Same Day, Multiple Units Billing

Claims with multiple units of the same procedure code for the same recipient, on the same date of service, by the same provider must be billed on one claim line with the total number of units reported. The criteria for same provider (billing or rendering) is based on provider type. Claims submitted with multiple claim lines, whether on a single claim or multiple claim forms, are considered duplicates for claims processing purposes will be denied.

Updated 06/12

Single Line Billing for Anesthesia

Anesthesia base unit values and time must be submitted on a single claim line using the procedure codes found in the current edition of the *American Society of Anesthesiologists (ASA) Relative Value Guide*. Each of the ASA procedure codes has a base value unit that is included in reimbursement.

Alaska Medical Assistance reimburses for anesthesiology services at the lesser of billed charges or a calculation based on the ASA procedure base unit value and time. Remember these guidelines when billing anesthesia services:

- Anesthesia time begins when the anesthesiologist begins preparing the patient for surgery and ends when the anesthesiologist is no longer in personal attendance and the patient is safely placed under post-anesthesia supervision.
 - Submit the actual minutes spent providing anesthesia services as the units of service.
 - Do not add anesthesia base value units to the actual time you submit.
 - No physical status modifier or physical status procedure code is allowed.
 - Procedure code 01999 is not acceptable for reporting time.

Guidelines for Billing Anesthesia for CPT 01967 and 01996

ASA procedure code 01967 (Anesth/analg vag delivery) maximum allowable is 360 minutes per day.

ASA procedure code 01996 (Hosp manage cont drug admin) performed after insertion of an epidural or subarachnoid catheter is allowed once per day. It includes all related services performed on that day, such as the visit, removal or adjustment of the catheter, dose calculation and administration of the drug. This service does not require use of a modifier or reporting of time.

Updated 09/12

Servicing or Rendering Provider Claims

Certain rendering providers must be identified on a claim. If required to submit rendering information, use the following information to submit paper claims:

- The National Provider Identifier (NPI) for the rendering provider performing the service is entered in the un-shaded portion of field 24j. It must match the NPI of the enrollment record on file with Alaska Medical Assistance.
- The taxonomy may be needed, and is strongly recommended. When supplied, it is entered in the shaded portion of field 24j with the ZZ qualifier in the shaded portion of field 24i. The taxonomy code is entered in the shaded portion of field 24j must match the taxonomy code of the rendering provider's enrollment record.

For electronic claims, please refer to the [companion guides](#) for appropriate loop and field information.

Updated 06/12

Billing Group Requirements

The National Provider Identifier (NPI) of the billing group must be submitted (field 33a of the CMS-1500). This information is used to determine the Pay-to Provider.

The corresponding taxonomy code may also be submitted (field 33b of the CMS-1500). The ZZ qualifier immediately precedes the taxonomy.

Providers must submit the address with the full ZIP+4 postal code for the physical location of the group practice/business/agency (field 32 of the CMS-1500). This ZIP+4 postal code is not the payment address ZIP+4 postal code. Submit this information on all claims, electronic or paper.

Updated 06/12

Attachments to the Claim

All current forms, fax coversheets, and attachments are available on the Alaska Medicaid website at <http://medicaidalaska.com/providers/forms.shtml>.

Updated 04/13

Hysterectomy Consent Form

Before a hysterectomy is performed, the recipient must grant voluntary, informed consent by signing a [Hysterectomy Consent Form](http://medicaidalaska.com/providers/forms.shtml), available at <http://medicaidalaska.com/providers/forms.shtml>.

Only the Hysterectomy Consent Form will be accepted; no substitutions are allowed. The consent form must be complete and legible; forms containing correction tape or crossed out language will not be accepted.

Before the recipient signs and dates Part III of the form, the individual obtaining the recipient's consent must sign Part II, certifying that he or she informed the recipient orally and in writing.

The individual obtaining consent must effectively communicate all of the above information to any individual who is blind, deaf, or otherwise handicapped and must provide an interpreter for any individual who does not understand the language in the consent form or of the individual obtaining consent; however, Alaska Medicaid does not pay for interpreter services.

The recipient must sign her consent before receiving hysterectomy surgery, unless the physician who performs the procedure certifies in writing that

- The individual was sterile before the hysterectomy, and states the cause of sterility
- The hysterectomy was performed under a life-threatening emergency in which prior acknowledgement was not possible (a description of the nature of the emergency must be included).

Updated 06/12

Sterilization Consent Form

If a claim form has a procedure code that indicates a sterilization procedure was performed, the standard [Sterilization Consent Form](#) must be attached to the claim.

Only the Sterilization Consent Form will be accepted; no substitutions are allowed. The consent form must be complete and legible; forms containing correction tape or crossed out language will not be accepted.

The waiting period between obtaining consent and performing sterilization must be at least 30 days and not more than 180 days. In cases of premature delivery or emergency abdominal surgery a waiver of the 30-day waiting period may be granted. In the case of premature delivery, the recipient must give informed consent at least 30 days before the expected delivery date. In the case of abdominal surgery, the physician must wait at least 72 hours after the recipient signs the form and must also describe the emergency.

Updated 06/12

Medical Justification

When further justification of medical necessity is required, a statement should be attached to the claim when billing. An operative report can be used when applicable. Cases that require a statement of medical necessity/medical justification must include the following:

- When a recipient enrolled in the Care Management Program receives care from a rendering physician other than the primary care physician. Attach either
 - A letter or note from the primary care physician or
 - A copy of the recipient's emergency room record for the date of service
- Justification for more than one long-term care physician visit within 30 days
- Modifier for unusual services: attach written explanation
- Multiple modifiers
- Unlisted codes

Updated 06/12

Electronic Claims Attachment Transmittal

When submitting an electronic claim requiring transmittal of an attachment, enter the appropriate codes on the electronic claim (refer to the tables below) and complete the [Electronic Claims Attachment Transmittal](#) (found at <http://medicaidalaska.com/providers/forms.shtml>). Fax this form with any required attachment on the same day that the electronic claim is submitted. Include the recipient name, Alaska Medical Assistance Contract ID, and unique attachment control number (any alphanumeric code between two and 80 characters) on the attachment cover page. Use only the fax number shown on the transmittal form.

Identify documentation attachments for any of the following by entering the appropriate HIPAA compliant code in the attachment field(s) when completing the electronic claim:

Documentation Indicator	
AA	Available on Request at Provider Site
BM	By Mail
FX	By Fax

Type of Documentation	
B2	Prescription
B3	Physician Order

B4	Referral Form
EB	Explanation of Benefits
OZ	Support Data for Claim
PN	Physical Therapy Notes

These codes will identify that an attachment has been submitted and the claims will pend for review of the attachments. If the codes are not entered on the electronic claim when submitted, the claim will automatically generate a resubmission turnaround document.

Updated 06/12

Insurance Explanation of Benefits

If the Alaska Medical Assistance recipient has insurance coverage, attach a copy of the explanation of benefits (EOB) from the insurance company, showing the payment or denial.

If the third-party resource's benefit booklet indicates a service is not covered, attach a copy of the benefit booklet page(s) for the plan year of the date of service to the claim. These pages must specify the patient's benefit plan name and must indicate that the service being billed to Alaska Medicaid is not covered. When attaching such pages, providers do not have to bill that third-party resource or attach an EOB from that insurance company.

Updated 04/13

Claim Payment and Pricing Methodology

Pricing Methodology for In State Services

Alaska Medical Assistance reimburses in-state providers at the lesser of

- The provider's billed charges
- The rate identified for the specific type of provider
- The provider's lowest charge advertised, quoted, posted, billed, or discounted for any other person or patient at the same time, excluding
 - A sliding fee scale in place as a written policy for patients who earn no more than 250 percent of the federal policy level
 - Contracts for a service or services at a discounted rate (cannot exceed 20 percent of the provider's gross income)
 - Discounts given as a part of an employer benefit package
 - Contracts with a federal or state government agency (including Medicare)

NOTE: Pricing methodology is specific to each provider type; please refer to [Section I](#) of the appropriate billing manual.

Updated 06/12

Pricing Methodology for Out of State Services

Alaska Medicaid recipients may be eligible for coverage of medical benefits while outside the state of Alaska. This eligibility exists when the individual is temporarily absent and intends to return to Alaska. Payment for professional services provided to Alaska Medicaid recipients outside the state of Alaska is limited to the lesser of:

- The provider's billed charges
- 70 percent of the in-state Alaska Medicaid rate identified for the specific type of provider
- The rate established by the Medicaid agency in the jurisdiction where the service was provided

The provider must also maintain an active enrollment with Alaska Medical Assistance and the Medicaid program in his or her state; for additional information; refer to [Section III: General Program](#) information.

Updated 05/13

Cost Sharing

Except for the services noted below, Alaska Medical Assistance recipients eligible for services must pay the appropriate cost-share amounts.

The provider should collect the cost sharing amount from the recipient. Services may not be denied if the recipient is unable to pay the cost sharing amount when services are rendered. Alaska Medical Assistance will reduce payment to the provider by the cost sharing amount.

Eligible Medicaid recipients are responsible for the following cost-sharing amounts:

- \$50 per day up to a maximum of \$200 per discharge for inpatient hospital services
- Five percent of allowable charges for outpatient hospital services
- \$3 per day for physician services
- \$2 for each prescription for prescribed drugs that is filled or refilled

The following are not subject to recipient cost sharing requirements:

- Services to recipients under 18 years of age at the time of delivery of the service
- A service provided to a recipient in a long-term care facility (refer to [claim form instructions](#) for field 24H, requiring that specific codes be entered to exempt long term care patients)
- Services to a pregnant woman, including a service provided during the postpartum period (identified by eligibility code 11 on the recipient's eligibility coupon)
- Services for family planning and supplies

- Hospice services
- Services provided to an American Indian or an Alaska Native by
 - A tribal health program or
 - Referral from a tribal health program
- Services provided to an individual who is eligible for both Medicaid and Medicare, if Medicare is the primary payer for that service
- Emergency services
 - Emergency means inpatient hospital care provided to a recipient admitted into the hospital from the emergency room of that hospital and outpatient hospital services and physician services provided to a recipient in response to the sudden and unexpected onset of an illness or accidental injury, requiring immediate medical attention after the onset of the condition to safeguard the patient's life.
 - Immediate medical attention is considered medical care that cannot be delayed by 24 hours. (Refer to claim form instructions for field 24H, requiring that specific codes be entered to exempt patients receiving emergency services).
- Chronic and Acute Medical Assistance (CAMA) recipients, identified by eligibility code "21" on the recipient's eligibility card or coupon.
- Blindness and disability exam services, identified by the eligibility codes 15 and 25 on the recipient's eligibility coupon

Other Recipient Financial Responsibilities

Recipients are responsible for payment of all non-covered services; however, providers should not accept an Alaska Medical Assistance coupon for services not covered under Alaska Medical Assistance.

Updated 06/12

Recovery or Recoupment of an Overpayment

If Alaska Medical Assistance makes an overpayment to a provider, the overpayment will be recovered.

Alaska Medical Assistance will require a provider to refund any payment made for the following:

- Services billed without service authorization (SA) when SA is required
- Payment which exceeds the maximum allowable
- Non-covered services
- Services not rendered
- Service not authorized under the provider agreement
- Services paid by or eligible for payment from third party resource
- Amounts Alaska Medical Assistance identifies as an overpayment
- Overpayment due because of an error or omission of the Medicaid Management Information System (MMIS)
- Services that do not meet standards established for payment of services
- Services provided by a provider who is not enrolled
- Previously paid services (duplicate billing)
- Payment for service provided to an ineligible Medicaid recipient
- Payment for services provided to an eligible Medicaid recipient who is not eligible for the services rendered
- Overpayment due to the billing practices of the provider

When a provider must refund Alaska Medical Assistance, repayment may be made by the following methods:

- The provider may send a refund check payable to "State of Alaska" along with an Adjustment/Void Request Form ([AK-05](#)) to Xerox
- Alaska Medical assistance will reduce future payments, called recoupment
 - Recoupment will impact future payments to the provider until the amount of the overpayment has been offset.

The provider will be notified of recoupment by the provider's remittance advice when the action takes place within 120 days of the overpayment. If more than 120 days have passed since the overpayment, Alaska Medical Assistance will notify the provider in writing at least 60 days before recoupment begins. The remittance advice or notice to the provider will identify

- The reason for the recoupment
- The amount of the overpayment to be recouped
- The provider's right to obtain a review (refer to [Appeals](#) in this section)

If a provider stops billing Alaska Medical Assistance for services after receiving notice of recoupment action, Alaska Medical Assistance will make a demand in writing to the provider for repayment of the balance of the overpayment.

Recovery of overpayment does not apply to probate collections, or to providers who are bankrupt, out-of-business, or under sanction actions.

Updated 06/12

Method of Payment

Alaska Medical Assistance mails providers a state treasury warrant enclosed in their remittance advice weekly. Only providers with active, paid claims activity for the previous cycle will receive a check. The check may be cashed immediately.

All state warrants should be redeemed within 120 days of the issue date. Warrants outstanding over 60 days will queue a reminder letter to the designee provider of said warrant. Only one notice will be sent in regards to outstanding state warrants. Any re-issues will be administered through the State of Alaska Department of Revenue Unclaimed Property Section 180 days after the original issue date (AS 34.45.280 (e)).

When accepting payment from Alaska Medical Assistance, remember the following:

- Endorsing a check received from Alaska Medical Assistance certifies that the claim for which the check is payment is true and accurate unless written notice of an error is sent by the provider to Alaska Medical Assistance within 30 days after the date that the check is negotiated.
- Alaska Medical Assistance will not pay a claim that has been sold, transferred, or assigned to another entity including a collection agency, service bureau, or other entity that purchases or advances money for outstanding accounts receivable.

Payment Prohibited Outside the United States

Alaska Medical Assistance is prohibited by federal law from issuing Medicaid payment to any entity or financial institution outside the United States and its territories.

Updated 06/12

Warrant Status Change Request

In the event that a provider requires a stop payment and reissue of a state warrant, state policy must be followed. The warrant may be replaced ten calendar days after the date that the warrant was mailed to the provider. To request either a stop payment or replacement, a [Warrant Status Change Request](#) must be completed by the provider and faxed to Xerox. Xerox then forwards the form to the Division of Health Care Services (DHCS) for entry into the State of Alaska accounting system. Once the transaction has been verified and posted by DHCS, Xerox will reissue the warrant.

The required [Warrant Status Change Request](#), with instructions, can be found on the Alaska Medicaid website at <http://medicaidalaska.com/providers/forms.shtml>.

Updated 06/12

Edit Resolution

An edit is a three-digit explanation code illustrating the outcome of a manual or automated review. Edits appear on the remittance advice. Edit codes indicate

- Pended claims: Pended claims indicate a manual review of the claim is underway. Providers need not take any action.
- Returned claims (resubmission turnaround document [RTD]): The claim contains errors or is missing information. Providers should submit the RTD in order to move the claim forward. For additional information, refer to [Resubmission Turnaround Document](#) in this section.
- Denied claims: Denied claims have not met one or more criteria for reimbursement. Providers should review denial codes; sometimes denied claims can be resubmitted after correcting errors. For additional information, refer to [Denied Claims](#) in this section.

More than one edit may apply to a claim line, so edits are ordered by hierarchy. A provider may resubmit a claim or respond to the first edit listed on a claim line; however, any subsequently listed edits may still hold up the claim. Providers should read edits carefully, because their description includes important information which will help correct errors in order to successfully re-bill a denied claim.

Updated 04/13

Denied Claims

When a claim line is denied, submit a new claim with corrected information in order to be reconsidered for payment. To determine what corrections to make, refer to the explanation of benefits (EOB) code associated with the denied claim line.

- If a claim is denied for third party liability, the provider should bill all third-party resources first (with few exceptions) and re-bill Alaska Medical Assistance with proof of billing (EOB) or proof of non-coverage (Insurance booklet). Providers must bill all parties within 12 months timely filing.
- If a claim is denied for recipient eligibility, the provider should verify dates of eligibility and notify the recipient to seek retroactive eligibility to cover the date of service. If eligibility is updated, the provider should re-bill the claim thereafter.
- If a claim is denied for non-coverage, consider the following:
 - Is there a more appropriate procedure code to bill for the service?
 - Is the procedure code current for the date of service, type or provider, or recipient?
- If a claim is denied for missing service authorization (SA) information, providers should verify the SA number submitted is accurate. If the provider did not obtain SA, contact the authorizing agency for instructions.
- If a claim is denied for exceeding timely filing limits, the provider must file an appeal within 180 days. For additional information, refer to [Appeals](#) in this section.

If these errors can be addressed appropriately, providers should send in a new claim with corrected information.

Updated 06/12

Remittance Advice, Adjustments and Voids

Remittance Advice

The remittance advice (RA) is a claim status report. It is produced weekly for any Alaska Medical Assistance enrolled provider when there is claim activity to report, such as payment, denial, adjustment, pended claim, or claim requiring additional information. It tells the provider the status of each claim submitted for processing.

Following the cover page, an RA is organized into the following sections:

- Remittance advice messages
- Paid and denied claims
- Explanation of benefits (EOB) status codes (denial/error codes)
- Remittance summary
- Resubmission turnaround documents (RTD), if any
- ClaimCheck® edits, if any

NOTE: The Adjustment Claims, Voided Claims, and In-Process Claims sections are repeated as necessary to report all the types of claims a provider files; for example, primary service, Medicare crossover claims, etc.

It is important for providers to read the RA each week to stay informed of provider news and events; providers should also reconcile the RA each week in order to keep up with adjusted or denied claims and any RTDs needing attention. Providers can use their RA to

- Review submitted claims status
- Identify claims which require further action
- Learn about changes in Alaska Medical Assistance policy, reimbursement, and other guidelines

Sections of the RA are explained on the pages that follow.

Electronic Remittance Advice

If a provider requests, Xerox will transmit the RA electronically as a data file that many practice management software systems can recognize and manipulate. It can be used to post payments or to create or post to an aging report. Xerox will also continue to send the RA in paper form.

NOTE: Providers must submit HIPAA compliant 837 transactions in order to receive an 835 transaction response.

To receive the RA electronically each week, complete an [Electronic Remittance \(835\) Authorization Form](http://medicaidalaska.com/providers/forms.shtml), found at <http://medicaidalaska.com/providers/forms.shtml>.

Only one entity can receive the electronic RA (even if multiple entities are submitting for one provider), and that entity must have prior approval from Xerox to receive the RA.

Updated 06/12

Adjustment Claims

Adjustments occur when Alaska Medical Assistance must correct previously paid claims. Adjustments may occur when an error in billing or processing occurred. The provider must complete positive adjustments (adjustments that result in additional money paid for the claim) within 12 months of the date of service or within 60 days of payment. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply. Providers may request an adjustment electronically as an 837 claim replacement. The procedure for adjusting a claim on paper is discussed in [Adjustment/Void Request Form](#) in this section.

The use of the terms claim control number (CCN) and identification control number (ICN) are used interchangeably in the explanations that follow. The processed adjustment will appear in two parts on the remittance advice:

- Credit: Identified in the "Status" column, the credit lists the original CCN and reverses the original transaction. This is referred to on the adjustment claim page as "Adjust ICN." This portion adjusts the credits on the provider's 1099 by decreasing the amount paid.
- Debit: Identified in the "Status" column, the debit lists the new CCN and the corrected information and payment. It also lists the former CCN associated with the credit above. This is referred to on the adjustment claim page as "Former ICN." The date with the ICN is the date of the remittance advice on which original payment was made. If additional adjustments are necessary, use the debit CCN on an AK-05.

If the adjustment is incorrect on the remittance advice, submit another adjustment to correct it and enter the CCN of the debit portion of the adjustment in field 7A.

Updated 06/12

In-Process Claims

When a claim needs special handling in processing its status is said to be in-process.

If a claim is in-process due to an error that can be corrected only by the provider, the automated system prints a resubmission turnaround document (RTD). Then, the provider can fill in the needed information on the RTD or attach the needed documentation. This type of claim is shown in the Status column of the in-process claim page as "RTD."

If an in-process claim requires internal review by Xerox or the Division of Health Care Services, its processing is suspended or pended. For example, a claim may exceed timely filing or have attached documentation that requires manual pricing. This type of claim is identified in the Status column as pended. No action is required by the provider while a claim is pended; however, an RTD may be sent to the provider as a result of the internal review. For additional information about RTDs, review [Resubmission Turnaround Document](#) in this section.

The last remittance advice of each month reflects all in-process claims.

Updated 05/13

Financial Transactions

This section of the remittance advice (RA) may reflect any of the following financial transactions:

- Cost settlement with the provider
- Recoupment of interim payments
- Returned state-issued warrants or personal checks received from providers
- Withholding against payments to providers according to state instructions
- Payments to providers according to state instructions
- Payments to providers to rectify over-collections

Updated 06/12

Explanation of Benefit Description Page

This page lists all explanation of benefit (EOB) codes found on the remittance advice (RA) and a brief description of each code. The EOB codes and descriptions are furnished to help the provider understand the processed claims. This information is useful in correcting and re-billing denied claims. If further information is needed, providers should utilize the error code lookup webpage available at <http://medicaidalaska.com/providers/ErrorCodes.asp> or contact [Provider Inquiry](#).

Updated 06/12

Remittance Summary

The remittance summary shows the total weekly and year-to-date dollars paid to and collected from the provider. After the calendar year, Xerox sends each provider a 1099 tax information statement, showing total Alaska Medical Assistance reimbursement payments made during the year. Xerox also provides this information to the US Internal Revenue Service (IRS). A provider's 1099 will match the year-to-date total paid amount shown on the last remittance advice issued for the calendar year.

Updated 06/12

Resubmission Turnaround Document

A resubmission turnaround document (RTD) may accompany the remittance advice (RA), identifying errors or missing information on a claim. The RTD reports what was entered on the original claim form, what error occurred, and identifies the field in error. Return reason codes (also called edits) and messages are printed on the RTD after the claim information.

Do not attempt to use the RTD to make an adjustment or add an additional claim line. Refer to [Adjustment/Void Request Form](#) in this manual for information on making an adjustment to a claim.

Resubmission Turnaround Document Edits

RTD edits explain the outcome of a manual or automated claim review. RTD edits allow providers to correct certain errors on a claim without resubmitting the claim.

The provider should read these edits, find the fields on the RTD where the information is missing or incorrect, and enter the corrected information in the appropriate fields.

Returning the Resubmission Turnaround Document

After completing the requested information the RTD asks for, return the RTD to Alaska Medical Assistance either by [mail or fax](#) as indicated on the RTD.

In cases where Alaska Medical Assistance requires submission of additional information, any attachments must include the RTD form. These could include medical justification, a form of consent, or a third party resource's explanation of benefits (EOB). The RTD must be signed by the provider or an assigned representative, since it is a supplement to the original claim.

NOTE: Do not send the requested information without the RTD form. Return only the RTD, not the entire RA.

Timely Response

A provider is allowed 90 days to correct errors without having to resubmit a claim form. The RTD also lists the last date that the provider may send the corrected RTD to Xerox. If the corrected RTD is not received after 60 days, a second RTD will automatically generate. The claim will be denied (indicated by edit 076) if the provider does not send the necessary corrections within 30 days of the second notice. After the 90 day period, a corrected claim must be resubmitted.

NOTE: Edit 076 does not mean the 12 month timely filing limit has passed, only the 90 day RTD deadline.

Updated 06/12

Adjustments and Voids

Alaska Medical Assistance provides the Adjustment/Void Request Form ([AK-05](#)) for providers to submit a request to adjust or void claims. Providers may submit an AK-05 via mail or fax. Providers may also request an adjustment or void electronically through an 837 claim replacement request; for additional information, refer to the Technical Report, Type 3. The AK-05 is available at <http://medicaidalaska.com/providers/forms.shtml>.

NOTE: Providers may request an adjustment or void only for paid claims.

Updated 05/13

Adjustments

Providers should request an adjustment in order to correct a paid claim that was billed or processed incorrectly. For example, submit an adjustment when

- A procedure code billed needs correcting
- The charges billed need correcting
- The number of days needs correcting
- A third party resource pays/recoups reimbursement for the claim
- An update to service authorization (SA) occurs

Adjustments may increase or decrease the amount paid for the claim.

All adjustments must be submitted within 12 months of the date of service when payment is owed to the provider (positive adjustment). If no money is owed to Alaska Medical Assistance or the adjustment does not affect payment, there is no time limit.

Adjustments for Third Party Liability

When payment from a third party resource changes, Alaska Medical Assistance requires providers to submit an adjustment and attach an explanation of benefits (EOB). When a provider fails to attach an EOB with the adjustment request, Alaska Medical Assistance will take back all money previously paid on the claim, not just the amount requested in the adjustment.

Updated 06/12

Voids

Providers must request to void a paid claim submitted with incorrect information, including

- Wrong recipient ID number
- Wrong Medicaid Contract ID number
- Services were not rendered
- Providers were paid by Medicare subsequent to receiving payment from Medicaid
 - Providers MUST ALWAYS void these claims

All void requests are granted and there are no time limits associated with filing a void request.

Providers can avoid duplicate claim denials by allowing the voided claim to process before submitting any corrected claims. After the void appears on the remittance advice, it is safe to re-bill the claim.

A processed void request will result in a refund to Alaska Medical Assistance of the entire payment, reduction in the year-to-date dollar amount of claims paid to the provider appearing on the remittance advice and a provider's 1099 tax report, and deletion of the paid claim/claim line information from the recipient and provider history files. The Medicaid Management Information System (MMIS) keeps historical records of all voided claims, however.

Updated 06/12

Adjustment/Void Request Form

Guidelines

The Adjustment/Void Request Form (AK-05) may be used to do any of the following:

- Change (adjust) a paid claim line that was billed or processed incorrectly
- Void a paid claim line
- Repay an overpayment

Each AK-05 submitted should have an attached copy of the claim and a copy of the page of the remittance advice indicating its paid status.

NOTE: Do not use the AK-05 to correct a denied claim or claim line.

Overpayment/Refund

The AK-05 is used to refund an overpayment. Remember to always attach a copy of the claim and the remittance advice (RA) page showing the payment. There is no time limit associated with submitting an overpayment/refund. The provider can choose one of two refund methods:

- Submit the AK-05, complete field 4, and include a check for the dollar amount of the refund made payable to the State of Alaska.
- Submit the AK-05 without a refund check and allow the money to be automatically deducted from a subsequent Alaska Medical Assistance payment(s).

Policy When Processing a Refund due to Third Party Payment

- If the third party payment exceeds the amount reimbursed by Alaska Medical Assistance, refund the total Alaska Medical Assistance payment.
- If the third party payment is less than the amount reimbursed by Alaska Medical Assistance, refund Alaska Medical Assistance the amount equal to the third party payment.

In both cases, attach the third party explanation of benefits to the AK-05 and make the refund check payable to the "State of Alaska."

Updated 06/12

Appeals and Fair Hearings

Appeals

A provider may request review of a claim if payment of an initial claim was denied or reduced, or if payment was reduced due to a recoupment action (recovery of an overpayment) by Alaska Medical Assistance. Providers may also request an appeal for other services, including

- Non-certification of selected inpatient and outpatient procedures and diagnoses
- Residential and psychiatric treatment admissions and continued stay reviews
- Denied or reduced service authorization requests for different types of services, including
 - Substance abuse rehabilitation
 - Administrative wait and swing bed stays at acute care facilities
 - Long-term care admissions and continued stays
 - Home and community-based waiver services
 - Personal care assistant services
- Denied enrollment or disenrollment

In all cases, the provider must adhere to the timely filing requirements discussed in [Timely Filing of Claims](#) in this section.

NOTE: Before appealing a claim payment or denial of payment, the provider should try other methods to resolve the decision.

1. Paid Claim: Payment may be adjusted by submitting an Adjustment/Void Request Form ([AK-05](#)), correcting the information that was originally submitted, within the timely filing period for that date of service or within 60 days from the date of adjudication of the claim (refer to [Adjustment/Void Request Form](#) in this section). The payment amount will be recalculated based upon the corrected claim information.
2. Denied Claim: If a claim is denied because the information on it is incorrect, resubmit the claim with the correct information within the timely filing period for that date of service.

NOTE: Appeals must be in writing.

1. Send first level appeals to Xerox.
2. Send second level appeals to the appropriate Office or Division within the Department of Health and Social Services; for additional information, refer to [Second Level Appeal](#) in this section.
3. Send final level appeals attention Commissioner, Department of Health and Social Services.

Updated 04/13

Pre-Appeals Process

This process is available only for services that providers feel are exceptions to current Alaska Medical Assistance policies or editing which would normally be applied and result in denial or reduction of payment. To utilize this process, submit the claim with appropriate documentation that supports the exceptional circumstances to

Xerox State Healthcare, LLC
 Attention: Pre-Appeal Review
 PO Box 240808
 Anchorage, AK 99524-0808

To ensure that it is not confused with routine correspondence, the claim and supporting documentation are to be submitted by mail with a cover sheet clearly marked "Pre-Appeal Review" or the provider may use the [Provider Appeal Form](#) available on the Alaska Medicaid webpage <http://medicaidalaska.com/providers/forms.shtml>.

Providers will be notified of the outcome in a future remittance advice statement after the claim is processed.

Updated 06/12

First Level Appeal

A provider may request a first level appeal if payment of an original claim was denied or reduced, or if payment was reduced due to a recoupment action. The provider is encouraged to use the [Provider Appeal Form](#) located on the Alaska Medicaid webpage <http://medicaidalaska.com/providers/forms.shtml>.

Providers may file first level appeals with Xerox except for those services authorized by Qualis Health (refer to the [Select Diagnoses and Procedures Pre-Certification List](#) and to the [Outpatient Imaging Pre-Certification List](#)). For additional instructions on filing an appeal with Qualis, refer to the [Qualis Health Alaska Medicaid Provider Manual](#) available at <http://www.qualishealth.org>.

Providers must appeal for individual claim denials resulting from National Correct Coding Initiative (NCCI) edits, including

- Procedure-to-procedure edits
- Medically unlikely edits
- Units of service edits

For additional information about NCCI regulations, refer to [National Correct Coding Initiative \(NCCI\)](#) in this section or visit the Centers for Medicare and Medicaid Services (CMS) website at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/>.

Follow these guidelines in order to file a first level appeal:

1. First level appeals must be in writing and received within 180 days of the claim disposition date (the date of the remittance advice [RA]), or within the timely filing period for that date of service. Any appeal submitted past timely will not be considered.

NOTE: Providers may not file a first level appeal by facsimile, telephone or any other oral communication.

2. Include a copy of the claim denial or payment notice from the RA, a copy of the original claim that was denied or reduced, and any supporting documentation considered relevant (i.e., chart notes, claim check audit report, etc.) .
3. Providers should submit first level appeals with supporting documentation to the [Provider Services Unit](#), attention Appeals at Xerox.
4. Xerox will notify providers in writing of the first level appeal results.

If the reviewer upholds the initial decision, providers have the right to file a second level appeal.

Updated 05/13

Second Level Appeal

A provider may request a second level appeal when

- The provider is not satisfied with the results of the first level appeal
- The provider is not satisfied with a denied enrollment or disenrollment
- The provider is not satisfied with a service authorization decision

A second level appeal for National Correct Coding Initiative (NCCI) edits is permissible.

A second level appeal must be requested in writing to the appropriate Office or Division within the Department of Health and Social Services (DHSS). To select the appropriate Office and Division to send the second level appeal, refer to the table below.

Second Level Appeals Submission	
Provider Service Type	DHSS Office/Division
Community behavioral health clinic (treatment of mental health and/or substance use disorder) Inpatient psychiatric and residential psychiatric facility services Mental health physician clinic	Division of Behavioral Health http://dhss.alaska.gov/dbh/Pages/Contacts/default.aspx
Home and community-based waiver services Intermediate care facility Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD) Personal care assistant services Skilled nursing facility	Division of Senior and Disability Services http://dhss.alaska.gov/dsds/Pages/contact.aspx
Targeted case management for children under the Infant Learning Program	Office of Children Services, Infant Learning Program http://dhss.alaska.gov/ocs/Pages/default.aspx
Ambulatory surgery center Chiropractic services Dental care Dietician services Direct-entry midwife services Durable medical equipment and supplies, respiratory therapy services, and prosthetic devices Early periodic screening, diagnosis, and treatment (EPSDT) services End stage renal disease (dialysis) clinic Family planning Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) Home health care Hospice Hospital – inpatient and outpatient IHS clinic IHS hospital – inpatient and outpatient	Division of Health Care Services http://dhss.alaska.gov/dhcs/Pages/contacts_hcs.aspx

Imaging	
Laboratory	
Nutrition services	
Occupational therapy	
Pharmacy	
Physical therapy	
Physician clinic	
Physician, advanced nurse practitioner, and physician assistant services	
Podiatry services	
Private duty nursing	
Psychologist services	
School-based services	
Speech, hearing, and language	
Transportation (emergent and non-emergent) and accommodation services	
Vision care services	

To submit a second level appeal, follow these guidelines:

1. Second level appeals must be in writing and postmarked within 60 days of the date of the first level appeal decision by Xerox or within 60 days of the adverse enrollment or service authorization decision.
NOTE: Providers may not file a second level appeal by telephone or any other oral communication.
2. Include a copy of the Xerox first level appeal decision, or a copy of adverse enrollment or service authorization decision, a copy of the claim denial or payment notice, a copy of the submitted claim, and supporting documentation considered relevant.

Providers will be notified in writing of the final decision.

Updated 05/13

Final Level Appeal

Providers may appeal a previous decision to the Commissioner of the Alaska Department of Health and Social Services (DHSS) when they are not satisfied with the results of the second level appeal only when it relates to denial of a claim for **not meeting the timely filing requirement**.

Final level appeal steps are as follows:

1. An appeal to the DHSS Commissioner must be in writing and postmarked no later than 60 days after the date of the second-level appeal decision by the Division of Health Care Services or the hospitalization decision. Include a clear description of the issue or decision being appealed and the reason for the appeal.
2. Providers should submit this appeal to

Commissioner, Department of Health and Social Services
PO Box 110601
Juneau, AK 99811-0601

Updated 06/12

Fair Hearings

Alaska Medical Assistance recipients may request a fair hearing when

- Application for benefits under an Alaska Medical Assistance Program (Medicaid, Denali KidCare, or CAMA) is denied.
- Benefits are changed, reduced or terminated.
- Coverage for a specific medical service is denied.

In order to request a fair hearing, the recipient should call the [Recipient Helpline](#) or make a request in writing to

Xerox State Healthcare, LLC
Recipient Services Department
1835 S. Bragaw St., Ste. 200
Anchorage, AK 99508

Updated 06/12

Section III: General Program Information



Prepared By
Xerox State Healthcare, LLC



About This Manual

The Department of Health and Social Services (DHSS) is the state agency designated to administer the Alaska Medical Assistance Program, which includes:

- Medicaid
- Denali KidCare (DKC)
- Chronic and Acute Medical Assistance (CAMA)

Unless otherwise specified, references to the Alaska Medical Assistance Program, or Alaska Medical Assistance, mean Medicaid, Denali KidCare, and CAMA. References to Alaska Medicaid, or Medicaid, mean only Alaska Medicaid and Denali KidCare.

Section III: General Program Information contains fundamental information about the programs and is to be used by enrolled providers in conjunction with

- The appropriate provider-specific [Section I](#)
- Claim type-specific [Section II: Claims Management](#)

Updates to this manual will be necessary from time to time as federal and state medical assistance regulations are adopted. As updates are made, each affected segment of the manual will be annotated with the date of the change. Providers will be informed of these updates by remittance advice messages and announcements on the Alaska Medicaid website, <http://medicaidalaska.com>. Previously published manuals are available upon request.

Thank you for your participation in the Alaska Medical Assistance Program and for the services you provide.

Updated 06/12

Program Introduction

The Alaska Medical Assistance Program is authorized by the provisions of Title XIX (Medicaid) and Title XXI (Denali KidCare) of the Social Security Act. Together, Medicaid and DKC, and the state-funded Chronic and Acute Medical Assistance (CAMA) program, provide medical assistance to more than 140,000 low income individuals, approximately 20 percent of Alaska's residents.

Updated 06/12

Alaska Department of Health and Social Services

The Alaska Department of Health and Social Services (DHSS), "the Department", is the single state agency responsible under 42 C.F.R. 431 for administration of Alaska's Medicaid program. The following divisions of DHSS play key roles in the administration of Medicaid in Alaska.

Division of Health Care Services

Responsible for administration of the Alaska Medicaid program, the Division of Health Care Services (DHCS) oversees fiscal agent operations, including payment of six million medical claims annually to 12,000 enrolled health care and support providers who care for more than 140,000 of the most medically and financially fragile Alaskans. DHCS ensures functionality of the Medicaid Management Information System (MMIS), the state's largest single source of health care data, maintains and leads efforts in rate review and rate setting, policy and planning, Medicaid reform, quality assurance, certificate of need and health facility survey. DHCS also provides regulatory oversight and direct support to both Native, through the Tribal Health Program, and non-Native hospitals, physicians, pharmacies, therapists, clinics, and most other health care provider types.

Division of Behavioral Health

Overseeing mental health for Alaskans, the Division of Behavioral Health Services (DBH) provides programmatic management and oversight of substance abuse and mental health services throughout the state. Delivery of services includes both private and public providers.

Division of Senior and Disability Services

Managing Medicaid Waiver services, the Division of Senior and Disabilities Services (DSDS) oversees home and community based services as well as institutional-based care, Adult Protective Services, and senior nutrition support. DSDS also administers the Personal Care Assistance Program, several grant programs, and offers Medicare outreach and counseling through its Medicare Information Office.

Division of Public Assistance

The Division of Public Assistance (DPA) determines initial and ongoing eligibility for Medicaid and other federal and state assistance programs including SNAP, the Supplemental Nutrition Assistance Program (formerly known as Food Stamps), temporary financial assistance, WIC (Women, Infants, and Children), Child Care Assistance and the Low-Income Heating Assistance Program (LIHEAP).

Division of Public Health

Supervising numerous health-related programs and services, the Division of Public Health (DPH) leads efforts toward preventing epidemics and the spread of disease, protecting against environmental hazards, injury prevention, disaster response, health services quality assurance and accessibility, and promotion of healthy behaviors and lifestyles.

Updated 06/12

Medical Assistance Contractors

Xerox

The State of Alaska contracts with Xerox to serve as its fiscal agent. In addition to its primary function, operating Alaska's Medicaid Management Information System (MMIS), the fiscal agent is responsible for:

- Processing and payment of claims
- Provider enrollment
- Provider inquiry, problem resolution, and first level appeals
- Service authorization (SA) for transportation, dental, and other specified services
- Provider communication and outreach
- Provider training and billing manuals
- Recipient eligibility verification and assistance

Updated 09/13

Magellan Medicaid Administration

Magellan Medicaid Administrations provides pharmacy benefits administration for Alaska Medical Assistance. Magellan processes electronic Point-of-Sale (POS) system pharmacy claims and provides recipient eligibility for pharmacy services, allowable amounts for pharmacy services, and Prospective Drug Utilization Review (ProDUR) messages.

Through the National Medicaid Pooling Initiative administered by Magellan, Alaska Medical Assistance realizes millions in annual savings through multi-state pharmaceutical rebate agreements and the [Preferred Drug List](#) (PDL) managed by Magellan Medicaid Administration.

Magellan Medicaid Administration operates a Clinical Call Center (Service Authorization Help Desk) for the Managed Access Program, and a Technical Call Center for provider assistance.

Updated 06/12

Qualis Health

Serving as Alaska Medicaid's Quality Improvement Organization (QIO), Qualis Health provides

- Health utilization management/service authorization for
 - Select inpatient and outpatient diagnoses and procedures
 - All acute care inpatient stays exceeding three days
 - Psychiatric inpatient admissions
- Quality of care reviews
- Case management services
- Provider education
- TEFRA (Tax Equity and Fiscal Responsibility Act) application and renewal review

Updated 06/12

Rochester Optical

Rochester Optical is the Alaska Medicaid contractor for lenses, glasses frames, and contact lenses. All vision service providers are required to order from this contractor when prescribing eyewear for Alaska Medicaid recipients.

Updated 06/12

Provider Communication and Training

Provider Correspondence

The provider billing manuals are meant to be used in conjunction with other provider communication, including

- E-mail
- Provider newsletters
- Flyers
- Training seminars
- Provider message center announcements
- Remittance advice (RA) messages
- RSS (Really Simple Syndication) feeds
- Website
- Other written correspondence

For information, questions or suggestions about the provider billing manuals, other correspondence, or provider training, correspondence information is available on the Alaska Medicaid website at <http://medicaidalaska.com/providers/phnaddr.shtml>.

Updated 09/13

Provider Inquiry

The [Provider Inquiry Unit](#) assists providers with Medical Assistance-related questions. The following tips will help to ensure successful inquiries:

- Review the provider billing manual and bulletins before calling.
- Have all material related to the call available for reference, such as remittance advice, claim forms, recipient's Medical Assistance identification number, etc. In addition, when calling the [Service Authorization \(SA\) Unit](#), be sure to have handy the dates of travel, Transportation and Authorization Invoice, and SA number if calling for changes.
- Have the provider's Medical Assistance identification number available.
- Note the name of the person who answered the call. This saves duplication if the provider needs to clarify a previous discussion or ask the status of a previous inquiry.

Updated 06/12

Provider Training

Alaska Medical Assistance, in conjunction with Xerox, offers a wide variety of training to help new providers and their staff establish a solid foundation in Medicaid billing procedures. Established providers also benefit from these trainings, both to refresh their knowledge and to keep them informed of changes in Medicaid policies and procedures.

Provider training is free of charge. Training Schedules and computer-based training modules are available on the Alaska Medicaid [Learning Portal](#) at <http://learn.medicaidalaska.com>. To meet the needs of all providers, Xerox also offers live provider training in a variety of locations throughout the state and via web-based presentations; register for these classes through the [Learning Portal](#).

Updated 09/13

Provider Enrollment

Providers must be enrolled with the Alaska Medical Assistance Program in order to receive reimbursement for services rendered to eligible recipients. Additionally, a service rendered based on a referral, order, or prescription is reimbursable only if the referring, ordering, or prescribing provider is enrolled as an Alaska Medical Assistance Program provider.

To enroll as a new provider, submit an application using the [Provider Enrollment Portal](https://enroll.medicaidalaska.com) at <https://enroll.medicaidalaska.com>.

Updated 06/12

Provider Enrollment Process

Providers may enroll with Alaska Medical Assistance by submitting an application through the Alaska Medicaid Health Enterprise at <http://medicaidalaska.com>, a secure website that is accessible 24 hours a day, seven days a week. Health Enterprise includes links to numerous websites that can help provide information needed to complete enrollment.

Online training is available to guide providers through enrollment. To view this training, visit the Alaska Medicaid [Learning Portal](https://learn.medicaidalaska.com) at <https://learn.medicaidalaska.com>.

If extenuating circumstances prevent a provider from enrolling online, please contact the [Provider Enrollment Department](#).

Upon enrollment approval by the Alaska Department of Health and Social Services (DHSS), providers will receive a Medical Assistance Contract ID and a welcome packet.

Updated 09/13

Provider Agreement

As part of the enrollment process, providers must sign and submit a [Provider Agreement](#) certifying that the provider agrees to comply with applicable federal and state laws and regulations. The Provider Agreement remains in effect so long as the provider renders services to Alaska Medical Assistance recipients and applies to the provider and all of the provider's employees and contractors.

The provider agreement is available as part of the enrollment application process.

Updated 03/13

National Provider Identifier

All providers that are HIPAA-covered entities are required to obtain a National Provider Identifier (NPI) and must include the NPI as part of the Medicaid enrollment process. There are two categories of NPIs:

- Entity Type 1 NPIs are issued only to individuals (i.e., physicians, nurse practitioners, dentists, and therapists).
- Entity Type 2 NPIs are issued to groups (organizations such as hospitals, group practices, laboratories, and home health agencies).

To research which NPI type you have, please visit <https://nppes.cms.hhs.gov>.

Providers may obtain a NPI through one of the following options:

By web: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

By e-mail: customerservice@npinenumerator.com

By phone: 800.465.3203 (Toll-Free)
800.692.2326 (TTY)

By mail: NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059

Updated 06/12

Provider Business License Requirement

Providers such as in-state entities, including professional groups but excepting municipalities, city governments, and military are required by state statutes to obtain a business license in order to provide services. A copy of the current business license is required in order to maintain active enrollment with Alaska Medical Assistance.

Enrollment for existing providers whose business license has expired can be backdated up to 60 days in order to close a break in service if:

- The provider's enrollment was active when the license expired and
- The business license was renewed within 60 days of the expiration date

Providers wishing to backdate their initial enrollment may do so by as many as 12 months to accommodate timely filing requirements as long as their business license is current for that period. If the issue date for the license does not cover the entire 12 month period, the issue date of the license will be used as the enrollment begin date.

Claims billed for dates of service in which the provider does not possess a valid business license will not be paid by Alaska Medical Assistance until a valid license is obtained and enrollment is backdated to the date of service for all pending claims. Claims filed during a lapse in licensing may need to be appealed to receive reimbursement.

Updated 06/12

Locum Tenens

A provider who is practicing under a temporary or locum tenens permit, license, or authorization, and who is substituting for another provider, being evaluated for permanent employment, or temporarily employed by a facility while it attempts to fill a vacant position must enroll with Alaska Medical Assistance as required to be reimbursed for services rendered.

To be reimbursed for services rendered, a provider practicing as a locum tenens must:

- Obtain a license or permit through Alaska's Occupational Licensing.
- Enroll as a provider in Alaska Medicaid and obtain a Medicaid Contract ID.
- Enrolled locum tenens may receive reimbursement for covered medical services provided to eligible recipients.

Enrollment will be approved only for the period on the license or permit.

Alaska permits only medical and osteopathic physicians, advanced nurse practitioners, physician assistants, chiropractors, nurses, certified registered nurse anesthetists and nurse midwives to be a locum tenens. Plan ahead, as the process usually takes eight weeks to receive the permit. To apply for a permit, contact the Alaska Department of Commerce, Community, and Economic Development's Division of Corporations, Business and Professional Licensing (<http://commerce.alaska.gov/occ/>).

Updated 06/12

Out-of-State Provider Participation Requirements

Out-of-state providers must be enrolled in both the Alaska Medical Assistance Program and the Medicaid program in their state in order to receive reimbursement for services rendered to Alaska recipients.

Alaska Medical Assistance is prohibited by federal law from issuing Medicaid payment to any entity or financial institution outside the United States and its territories.

Updated 06/12

Changes in Enrollment

Providers must make any necessary changes to their enrollment information in writing only. Alaska Medical Assistance will not make any changes based on verbal requests. This ensures accuracy in completing changes as requested. The [Provider Enrollment Unit](#) must be notified within 30 days of any change in the following:

- Ownership
- Licensure, certification, or registration status
- Federal tax identification number
- Type of service or area of specialty
- Additions, deletions, or replacements in group membership
- Mailing address or phone number
- Medicare provider identification number

Providers may update their information through the Alaska Medicaid Health Enterprise at <http://medicaidalaska.com>.

Updated 09/13

Provider Participation Requirements and Responsibilities

Equal Treatment

Federal laws, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the 1975 Age Discrimination Act, prohibit discrimination against any person in the United States on the grounds of race, color, national origin, age, or handicap, which would deny that person participation in or benefits of any program or activity with federal financing. In addition, a provider must not discriminate against a person receiving Medical Assistance services who has a third party resource. Payments can only be made to providers who comply with federal laws. Billing for medical assistance services or supplies is considered evidence that the provider is complying with the Acts named above. Failure to comply may result in a determination by the Department of Health and Social Services (DHSS) that the provider is not qualified to participate in Alaska Medical Assistance.

Updated 06/12

Translation/Interpretation Services

Medicaid-enrolled providers are obligated under federal law (refer to [Equal Treatment](#) in this section) to provide access to health care services, including language interpreting services, when needed, for recipients who have Limited English Proficiency (LEP).

The U.S. Department of Health and Human Services has published a document that includes a four-factor analysis that guides providers through the process of determining the extent of their obligation to offer LEP services, and development of a plan to meet the needs of the LEP population. This document, [Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons](#), is available in Volume 68, Number 153 of the Federal Register, published Friday, August 8, 2003, and available at <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf>.

Updated 03/13

Documentation

Provider Records Requirements and Retention

A provider shall maintain records necessary to support the care and services for which payment is requested, and to retain those records for at least seven years from the date services were provided. 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 law, applicable Alaska Medicaid provider billing manuals, and any pertinent contracts) to a patient for which services have been billed to Medical Assistance, identifying 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 signed or initialed by the individual who provided each service.

Request for Records

At the request of a Department of Health and Social Services (DHSS) 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 that 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.

Updated 06/12

Audits

Payment Error Rate Measurement Program

In compliance with the Improper Payments Information Act of 2002, the Centers for Medicare and Medicaid Services (CMS) implemented a national Payment Error Rate Measurement (PERM) program to measure improper payments from Alaska Medical Assistance.

Alaska will be selected to participate in this program from time to time. In the event a provider enrolled in Alaska Medical Assistance is selected for claims review, the provider will be required to furnish all records requested within 75 days from the date the records are requested. Prompt response and provider cooperation is critical to this CMS project. In order to facilitate the success of this program Alaska Medical Assistance requests a person in each provider office be designated as the PERM contact – this information may be relayed to Alaska Medicaid by contacting the [Provider Inquiry Unit](#).

Failure to respond to PERM requests and/or insufficient documentation will be considered a payment error resulting in a payback by the provider and a monetary penalty for Alaska Medicaid. Specifics of this program may be accessed at the CMS website <http://www.cms.gov/PERM>.

When patient records are selected for review, documentation requested will be for claims paid by Medicaid for a defined time period. Additionally, federal law requires that providers submit records; sharing patient records with the PERM contractor is not a breach of patient privacy. In fact, providing these records is required by federal law.

Past PERM studies have shown that the reasons for most payment errors are no response or insufficient documentation. Even legitimate claims count as errors if CMS does not receive the requested medical record documentation on time.

Updated 06/12

Medicaid Integrity Program Audits

The Medicaid Integrity Program was created by the Deficit Reduction Act of 2005 and requires periodic audits of Medicaid claims for Alaskan providers. The Department of Health and Social Services (DHSS) will provide the auditor with Alaska payment methodology and policy, and review preliminary audits for accuracy prior to issuance. Providers will be required to provide documentation supporting claims submitted to Medicaid within 15 days of the date of request.

Updated 06/12

Fraud, Waste, and Abuse

Medicaid Provider Fraud Control Unit

A Medicaid Provider Fraud Control Unit (MFCU) was established in 1992 by the Alaska Legislature and operates within the State Attorney General's Office. This unit, under the Code of Federal Regulations (42 CFR 431.107), is entitled to access all provider records and information necessary to fully disclose the extent of services or items furnished to Medical Assistance recipients. Accordingly, the MFCU is an authorized representative of the Department of Health and Social Services (DHSS) for the purpose of investigating potential Medical Assistance fraud or patient abuse.

Pursuant to the provider agreement signed by the provider upon enrollment, and on file with DHSS, Alaska Medical Assistance providers must comply with the MFCU's requests for records or information about claims submitted to Alaska Medical Assistance or services provided to Alaska Medical Assistance recipients.

Updated 06/12

Surveillance and Utilization Review

Surveillance and Utilization Review (SUR) is a program that monitors and reviews services and claims to detect and prevent fraud, waste, abuse, and misuse of the Medicaid program by recipients and/or providers.

The goal of SUR is to provide a manageable approach to the process of aggregating and presenting medical care and service delivery data to meet two major concerns:

Surveillance	The process of monitoring covered services and items by Medicaid participants. Surveillance includes use of itemized data for overall program management and use of statistics to establish norms of care in order to detect improper or illegal utilization practices.
Utilization Review	The process of analyzing and evaluating the delivery and utilization of apparently aberrant medical care on a case basis to safeguard quality of care and to guard against fraudulent or abusive use of the Medicaid program by either persons and/or institutions providing services or persons receiving them.

The principal functions performed in SUR are as follows:

- Develop comprehensive statistical profiles for monitoring utilization patterns of health care delivery in the various categories of services authorized under the Alaska Medicaid program.
- Reveal possible instances of fraud and abuse by individual providers and recipients to deter and correct misutilization.
- Provide information indicating any potential deficiency or excess in the quantity and quality of services provided under the Alaska Medicaid program.

All claims submitted to Medicaid are subject to analysis and case review. SUR will identify and report to the Division of Health Care Services (DHCS) occurrences of program misuse, suspected fraud, billing irregularities, and overutilization of services, with recommendations for potential sanctioning.

Fraud is the misrepresentation of fact or omission of information with the intent to illegally obtain service, payment, or other gain. It can be committed by the recipient or the provider.

Abuse is the overutilization of covered services, providing or receiving unnecessary covered services, and providing or receiving duplicate services. It can be committed by either the recipient or the provider.

Updated 06/12

Recipient Fraud and Abuse

Recipient fraud can take many forms including making false statements to eligibility workers or failing to reveal resources or income to obtain medical assistance, use of Medical Assistance benefits by someone other than the recipient, falsifying a Medical Assistance card or coupon, prescription, or other document, and reselling/trading items provided by Alaska Medical Assistance.

Key factors in establishing recipient fraud:

- The fraudulent misrepresentation is intentionally represented as a statement of fact by the recipient.
- The fact misrepresented must be material.
 - An incorrect age, for example, would not be critical except where age is a crucial factor in determining eligibility.
- The misrepresentation must be untrue, and the person making the misrepresentation must know or believe it to be untrue or make it with a reckless disregard of its truth or falsity.
- The misrepresentation must be made for the purpose of obtaining a benefit or a payment to which the individual is not entitled.

Recipient abuse occurs when the recipient utilizes medical personnel and facilities to meet non-medical needs, obtains duplicate services, or is uncooperative in accepting treatment plans. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Factors associated with recipient abuse include:

- Visiting medical professionals for essentially social purposes, relief of loneliness, reassurance, or as a substitute for more meaningful social activities.
- Recipient with impaired mental health (diagnosed or undiagnosed) inappropriately seeking care from general practice providers which would more appropriately be provided by specialists or in mental health facilities.
- Recipient being inconvenienced or dissatisfied with appropriately administered medical care provided and seeking duplicate care in more congenial and convenient quarters.
- Negligence in caring for durable items (glasses, hearing aids, etc.).
- Manipulating the program to acquire drugs or supplies to support the recipient's inappropriate use or abuse, and for ineligible persons or to be sold or traded for personal gain.
- Gullibility in responding to promotional efforts or suggestions of practitioners to receive care or supplies for which they previously had no desire and are unlikely to use.

Updated 06/12

Provider Fraud and Abuse

Provider fraud is knowingly and willingly billing for services not received by the recipient, double billing for a single service, or improperly billing to receive reimbursement that the provider was not entitled to. Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

- Key factors in establishing provider fraud:
- The fraudulent misrepresentation is presented as a statement of fact by the provider.
- The fact misrepresented must be material.
 - An incorrect diagnosis code, for example, would not be critical except when the diagnosis code is a crucial factor in determining reimbursement for procedures performed.
- The misrepresentation must be untrue, and the person making the misrepresentation must know or believe it to be untrue or make it with reckless disregard of its truth or falsity.

Provider abuse occurs when the medical services provided are reimbursed in excess of those required, do not correspond with diagnosis, are insufficient to accomplish the purpose, or are otherwise of low quality. It also includes provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Factors associated with provider abuse include:

- Inordinate referral to practitioners or facilities with whom or with which the referring practitioner has a financial arrangement or interest (e.g., ownership interest in institutional facilities, pharmacies, laboratories, etc.).
- Use of institutional facilities for care suitable to office treatment or other forms of ambulatory care.
- Promotional and sales efforts to provide services for which recipients felt no need and which they would be unlikely to use (e.g., as sometimes happens with hearing aids and other prosthetic appliances.).
- An unstructured system for the delivery of medical care that results in duplicate or repetitive provision of services instead of transfer of medical records.
- Eccentric patterns of patient care (non-medically necessary services).
- Lack of sufficient medical resources (such as not having appropriate, less expensive alternative for medical care).

Updated 06/12

Fraud, Waste, and Abuse Reporting

Report suspected provider or recipient fraud and/or abuse to the Surveillance and Utilization Review fraud and abuse hotline at 800.256.0930, or 907.644.5975. Reports made in writing should be submitted to:

Xerox State Healthcare, LLC
 Surveillance and Utilization Review
 PO Box 240808
 Anchorage, AK 99524-0808

The [Fraud and Abuse Reporting Form](http://medicaidalaska.com/providers/forms.shtml) can be found at <http://medicaidalaska.com/providers/forms.shtml>.

The aforementioned method of reporting suspected fraud or abuse in no way restricts or relieves a citizen of the right and responsibility to report suspected criminal activity to the proper law enforcement authorities. Persons knowingly assisting recipients or providers in committing fraud are considered as aiding in the commission of that act and may be held responsible.

Updated 06/12

Sanctions

Sanctioning Providers

Grounds for Sanctions

Sanctions may be imposed by the Department of Health and Social Services (DHSS) for any one or more of the following reasons:

- Submitting or causing to be presented
 - For payment any false or fraudulent claim for services or supplies
 - False information for the purpose of obtaining greater compensation than that to which the provider is legally entitled
 - False information for the purpose of meeting service authorization requirements

- False or fraudulent application for provider status
- False information on a dispensing fee or drug cost survey initiated by DHSS in order to establish or revise drug reimbursement rates
- Failing to maintain, disclose, submit or make available to DHSS or its authorized agent
 - Records of services provided to Medicaid recipients and records of payments made for them
 - Business records or other information determined by DHSS to be necessary for the administration of the Medicaid program
- Failing to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers
- Failing to repay or make arrangements for repaying identified overpayment or otherwise erroneous payment.
- Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies from DHSS.
- Overusing the Medicaid program by inducing or otherwise causing a recipient to receive services or supplies not required or requested by the recipient.
- Rebating or accepting a fee or portion of a fee or charge for a Medicaid recipient referral.
- Charging recipients for services an amount above payment made by the DHSS.
- Breaching the terms of the [Provider Agreement](#), failing to comply with the terms of the provider certification on the Medicaid claim form or refusing to execute a new Provider Agreement when requested to so.
- Engaging in a course of conduct or performing an act considered improper or abusive of the Medicaid program or continuing that conduct following notification that it should cease.
- Violating any law (including AS 47.07 or any regulation adopted under it), regulation, or code of ethics governing the conduct of occupations, professions or regulated industries, or failing to meet licensure or other standards required by state or federal laws for participation.
- Being convicted of a criminal offense relating to performance of a provider agreement with the State of Alaska or relating to negligent practice resulting in death or injury to a patient.
- Being formally reprimanded, censured, suspended, terminated, or excluded by another entity including (but not limited to)
 - An association of the provider's peers
 - Another governmental medical program such as Medicare, worker's compensation, crippled children's program, and vocational rehabilitation services.
- Billing for an amount in excess of the normal charge to non-Medicaid recipients.
- Billing for a drug
 - Other than the drug dispensed
 - For a refill that was not authorized by the prescriber
 - Dispensed at a lesser quantity than that prescribed in order to receive multiple dispensing fees for one prescription (unless the drug provider is reducing the prescribed amount in order to dispense no more than a 30-day supply).
 - Falsely specifying that a prescriber required a specific brand name drug rather than a less expensive generic equivalent.

Types of Sanctions

These sanctions, although not limited to the following, may be invoked against providers based on the grounds for sanctions specified:

- Termination from participation in the Medicaid program.
- Suspension from participation in the Medicaid program.
- Suspension or withholding of payments to a provider.
- Referral to peer review such as a professional association.
- Transfer to a closed-end provider agreement not to exceed 12 months or the shortening of an already existing closed-end provider agreement.
- Attendance at provider education sessions.
- Prior authorization of services.
- Complete review of the provider's claims before payment.
- Referral to the state licensing board for investigation.
- Recovery of funds from the provider.

Imposition of Sanctions

The decision as to the sanction to be imposed will be at the discretion of the DHSS, with the following exceptions:

If a provider has been convicted of defrauding the Medicaid program, or has been previously suspended due to program abuse, or has been terminated from the Medicare program for abuse, DHSS will institute proceedings to terminate the provider from the Medicaid program.

The following factors will be considered in determining the sanctions imposed:

- Seriousness of the offense
- Extent of violations
- History of prior violations
- Prior imposition of sanctions
- Prior provision of provider education
- Provider's willingness to obey program rules
- Sufficiency of a lesser sanction to remedy the problem
- Actions taken or recommended by peer review groups or licensing boards

Scope of Sanction

A sanction may be applied to all known affiliates of a provider; however, each decision to include an affiliate must be made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where the conduct was accomplished within the course of his or her official duty or was effectuated by him or her with the knowledge or approval of the provider.

Suspension or termination from participation of any provider will preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association, to DHSS or its fiscal agents for any services or supplies provided after the suspension or termination.

A clinic, group, corporation, or other association that is a provider of services may not submit payment claims to Alaska Medical Assistance or its fiscal agents for any services or supplies provided by a person within that organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided before the suspension or termination.

When these provisions are violated by a provider of services which is a clinic, group, corporation, or other association, DHSS may suspend or terminate the organization or any individual person within it who is responsible for the violation, or both.

Notice of Sanction

When DHSS intends to impose sanctions on a provider, written notice to the provider must be sent by certified mail. If suspension, termination, or withholding of payment is proposed, the provider must be permitted an appeal. Absent a request for appeal, the proposed sanction will become effective 30 days from the date of the notice.

The notice shall set forth:

- The nature of the discrepancies or violations.
- The dollar value of the discrepancies or violations.
- The method of computing the dollar value.
- Notification of further actions to be taken or sanctions to be imposed by DHSS.
- Notification of any actions required of the provider and his or her right to a formal hearing.

The notice shall state whether or not DHSS intends to withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question, or that DHCS intends to suspend all payments to the provider.

When sanctions have been imposed on a provider, DHSS will notify, as appropriate, the provider's professional societies, the [Department of Commerce, Community, and Economic Development's Division of Corporations, Business and Professional Licensing](#) (<http://commerce.alaska.gov/occl/>), and any other interested federal or state agency of the findings made and the sanctions imposed.

If a provider's participation in the Medicaid program has been suspended or terminated, DHSS will notify the recipients for whom the provider has submitted claims for services that the provider has been suspended or terminated.

Updated 06/12

Appealing Sanctions

Within 30 days after receipt of the notice of sanction, the provider may request a formal hearing. The request for appeal must be in writing and must contain a statement accompanied by supporting documents setting forth the asserted violations, discrepancies, or dollar amounts that the provider contends to comply with regulations and the reasons for those contentions. The request for appeal must be sent to:

Division of Health Care Services
 Claims Appeal Section
 4501 Business Park Boulevard, Suite 24
 Anchorage, AK 99503

Upon receipt of the request for appeal, the withholding or suspension of payment may continue until a final determination is made regarding the appropriateness of the sanction. Unless a timely and proper request for appeal is received by the Division of Health Care Services (DHCS), the findings of the notice of sanction are considered a final and binding administrative determination. No formal review will be granted if the basis for termination is a failure to meet standards (including licensure or registration) required by federal or state law for participation in the Medicaid program.

Upon receipt of the request for appeal, a hearing must be scheduled to be held within 30 days of receipt of the request. Notice of the date, time, and place of the hearing must be sent to the provider and his or her attorney or representative. Any party may appear and be heard at any proceeding through an attorney at law or a designated representative. The hearing will be conducted by DHCS or designee. DHCS shall render a written decision that will constitute final administrative action.

Updated 06/12

Recipient Eligibility

Medical Assistance Eligibility Requirements

The Division of Public Assistance (DPA) determines initial and ongoing eligibility for Medicaid and Denali KidCare in accordance with federal and state regulations. DPA also determines eligibility for the state-funded CAMA program.

In addition to Medical Assistance, DPA determines eligibility for SNAP, the Supplemental Nutrition Assistance Program (formerly known as Food Stamps), temporary financial assistance, WIC (Women, Infants, and Children), Child Care Assistance and the Low-Income Heating Assistance Program (LIHEAP).

Individuals in need of medical or other assistance may contact DPA at <http://dhss.alaska.gov/dpa/Pages/default.aspx> or may consult the [Medicaid Recipient Handbook](#) available at <http://medicaidalaska.com>.

Updated 09/13

Medical Assistance Benefit Plans

Alaska Medicaid

Alaska offers more than thirty Medicaid benefit plans, known as categories of eligibility, for low-income children, pregnant women, families, and elderly or disabled individuals. Each category provides a distinct set of benefits and carries its own set of age, financial, and other eligibility requirements.

Individuals who are eligible for Medicaid receive monthly eligibility coupons. Most categories offer comprehensive health care coverage, while others provide coverage for specific services only:

- **Qualified Medicare Beneficiary (QMB)** provides payment of the Medicare Part B deductible and coinsurance, including that for some services otherwise available only to those under age 21, including chiropractic and podiatry.
- **Incapacity/Pregnancy Determination** provides payment only for an exam to determine incapacity or pregnancy for purposes of determining Medical Assistance eligibility.
- **Disability and Blindness Exam** provides payment only for an exam(s) necessary to determine Medical Assistance-qualifying disability or blindness.
- **Emergency Treatment for Unqualified Aliens** offers limited coverage for emergency medical conditions, including labor and delivery; that without treatment would place the individual's health in serious jeopardy or would cause serious impairment.

In addition to full medical coverage, Medicaid recipients who would otherwise need institutional care and who qualify for waived services may receive expanded services that allow them to continue living in their home or community.

For additional information about Alaska Medicaid, visit <http://dhss.alaska.gov/dpa/Pages/default.aspx>.

Updated 03/13

Denali KidCare

Denali KidCare is a Medicaid expansion program that provides comprehensive health care coverage to income-eligible children through the age of 18, and to pregnant women who meet income guidelines. Denali KidCare covers the same comprehensive services as Medicaid. Provider enrollment and participation requirements, service authorization requirements, claims billing and follow-up procedures are also the same as for Medicaid.

The only noticeable difference for providers between Medicaid and the Denali KidCare program is how recipients demonstrate proof of eligibility.

Children eligible for Denali KidCare receive an identification card as proof of eligibility. The card displays the recipient's name, ID number, date of birth, eligibility code, coverage period, and resource code/carrier ID.

- Children have continuous eligibility for twelve-month periods, regardless of changes in income or family composition.
- Disabled children and babies born to Medicaid enrolled women are eligible for one year.

Pregnant women eligible for Denali KidCare receive monthly eligibility coupons.

- Pregnant women are eligible through the second month following the end of the pregnancy.

Providers should use the same procedures to verify recipient's eligibility as with Medicaid. For additional information, refer to [Eligibility Verification System](#) in this section.

For additional information about Denali KidCare, visit <http://dhss.alaska.gov/dpa/Pages/default.aspx>.

Updated 03/13

Chronic and Acute Medical Assistance

Chronic and Acute Medical Assistance (CAMA) is an Alaska state-funded program that provides medical assistance for Alaska residents who do not qualify for Medicaid, have very little income, and have inadequate or no health insurance. The Division of Public Assistance (DPA) determines eligibility.

To be eligible for CAMA, a person must have a diagnosis of a terminal illness, cancer requiring chemotherapy, diabetes, diabetes insipidus, chronic hypertension, chronic mental illness, or chronic seizure disorder. A CAMA recipient with one of the diagnoses listed is considered to have a "CAMA covered medical condition."

A physician, advanced nurse practitioner, or physician assistant must certify that the patient is in need of ongoing treatment requiring prescription drugs, chemotherapy, or radiation for the treatment of their condition using a *Certification of Medical Status (MED 11)*. This form is available through the DPA.

Alaskans eligible for CAMA must apply before receiving medical services by contacting a DPA office or village fee agent. CAMA eligibility is not retroactive. Once accepted to receive CAMA services, the applicant receives a medical coupon showing the services covered.

For additional information about CAMA, visit <http://dhss.alaska.gov/dpa/Pages/default.aspx>.

Updated 03/13

Recipient Eligibility Verification

Providers are responsible for verifying that a patient is eligible for Medical Assistance and for the specific services. Verify eligibility using the following methods:

- Log in to the [Alaska Medicaid Health Enterprise](#) and select Member > Check Eligibility
- Submit and receive verification electronically. Instructions are available in the [Alaska Legacy 270/271 Companion Guide](#) available at http://medicaidalaska.com/hipaa_news.shtml.
- Call the [Automated Voice Response System](#) (AVRS) at 855.329.8986.
- Request to see and photocopy the recipient's Medical Assistance coupon or card that shows the current month of eligibility or the identifying authorization statement.
- Send a fax to the Provider Inquiry Unit using the [Recipient Eligibility Inquiry Form](#) available at <http://medicaidalaska.com/providers/forms.shtml>.
- Call the [Provider Inquiry Unit](#) at 907.644.6800 or 800.770.5650 (toll-free in Alaska).

Updated 09/13

Automated Voice Response System

Verification of eligibility through the Automated Voice Response System (AVRS) is available 24 hours a day, seven days a week by calling 855.329.8986. In the enrollment welcome packet each enrolled provider receives a unique AVRS identification number, PIN number, and instructions for using the AVRS.

Providers may also use the AVRS to submit inquiries for:

- Claim status
- Remittance advice information
- Service authorization status
- Physician fee schedule
- Service limits

Updated 09/13

Medical Assistance ID Cards and Coupons

The Division of Public Assistance (DPA) produces and distributes Medical Assistance identification cards and coupons (samples are shown below) that verify recipient eligibility for Medicaid, Denali KidCare or CAMA services for a specific month. Each card has five stickers that may be retained by providers as proof of recipient eligibility. Providers may also photocopy the recipient's coupon/card for proof of eligibility.

Temporary Medical Assistance coupons, also referred to as Medical Manual Coupons, may be issued when a delay in obtaining the identification card would be harmful or when the authorization is limited to a pregnancy or incapacity determination, disability examination, partial-month eligibility, or when the recipient is enrolled in the care management program. Temporary coupons may be computer generated, typed, or handwritten.

The medical identification card is not an authorization for payment of services that require service authorization.

Codes on Recipient's Card or Coupon

When referring to the medical assistance identification card or coupon, providers should be aware of the following items:

- Client (Recipient) I.D. Number: This is a 10-digit number that begins "0600XXXXXX"
- Month and Year of Eligibility
- Program Eligibility Codes
- Resource Codes (other insurance, also called Carrier IDs)
- Special Information or Authorization Statements

Alaska Medicaid Recipient Identification Card

Denali KidCare Recipient Identification Card

		DENALI KIDCARE RECIPIENT INFORMATION	
NAME		Denali KidCare Office (Enrollment Inquiries) Recipient Information Helpline (Coverage Inquiries)	269-6529 (Anchorage Area) 1-888-318-8800 (Outside Anchorage) 1-800-780-9972
ID #	DATE OF BIRTH	ELIG CODE	
COVERAGE EFFECTIVE DATES		HEALTH CARE PROVIDER INFORMATION <i>Providers must verify eligibility before providing services.</i>	
RESOURCE CODE		Eligibility Verification Coverage Inquiries	1-800-884-3223 (EVS) 1-907-444-6800 (Anchorage/Out of State) 1-800-773-5630 (Outside Anchorage)
Providers outside Alaska must verify eligibility before providing services. State of Alaska, Department of Health and Social Services Visit our website at www.hss.state.ak.us/dhcs/DenaliKidCare/		Submit claims to: Xerox State Healthcare, LLC P.O. Box 240769 Anchorage, Alaska 99524-0769	

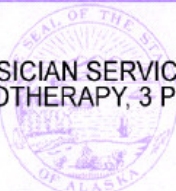
Alaska Medical Assistance Identification Card for Non-standard Authorization

RECIPIENT IDENTIFICATION CARD		STATE OF ALASKA		MEDICAL ASSISTANCE PROGRAM					
NAME OF ELIGIBLE PERSON(S)	CLIENT I.D. NO.	ELIG. MONTH	D.O.B.	SUB-TYPE	E.C.	RESOURCES			MEDICARE
Doe Jane F.	0600XXXXXX	1205	0165	GJ	21	Y	**	**	*****
*****	*****	****	****	**	**	**	**	**	*****
*****	*****	****	****	**	**	**	**	**	*****
*****	*****	****	****	**	**	**	**	**	*****

SAMPLE

AUTHORIZATION STATEMENT

AUTHORIZATION LIMITED TO PHYSICIAN SERVICES, PRIOR-AUTHORIZED OUTPATIENT HOSPITAL RADIATION AND CHEMOTHERAPY, 3 PRESCRIPTIONS PER MONTH, AND LIMITED MEDICAL SUPPLIES.



HEALTH CARE PROVIDER INSTRUCTIONS: THIS CARD IDENTIFIES THE PERSON LISTED ABOVE AS A CAMA RECIPIENT WHO IS ELIGIBLE TO RECEIVE MEDICAL ASSISTANCE FROM HEALTH CARE PROVIDERS ENROLLED TO USE THE ALASKA MEDICAL PAYMENT SYSTEM. PROVIDERS MUST VERIFY THAT THE BEARER OF THIS CARD IS THE NAMED PERSON AND WRITE THE CLIENT I.D. NUMBER ON OR ATTACH THE IDENTIFICATION CARD TO EACH CLAIM.

NOTE: Cooperation with third party resources includes supplying your provider with medical insurance coverage information such as detailed information. Providers must accept payment from all resources prior to billing CAMA.

Providers must check all medical manual coupons for any special information or authorization statements. The coupons specify what services are eligible for Medical Assistance reimbursement. Special information statements most commonly found on the medical manual coupon are:


- "Not Valid for Medicaid Services. Valid Only for Deductible and Coinsurance Payments for Medicare Services."
- "Authorization Limited to Disability Exam by a Licensed Physician or Psychiatrist, Waiver Determination by Care Coordination Agency, and Related Transportation Approved by Xerox."
- "Authorization Limited to Pregnancy Determination Only and Related Transportation as Approved by Xerox."
- "Authorization Limited to Incapacity Determination Only and Related Transportation as Approved by Xerox."
- "This Authorization is Valid Only for the State of Alaska to Pay the Above Person's Medicare Part A Premium. It is not valid for Payment of any Medical Services."
- "Restricted": Except in a medical emergency, only a provider designated by the Department of Health and Social Services (DHSS) may provide medical services to a recipient whose identification card or medical coupon has this wording. For additional information, refer to [Care Management Program](#) in this section.
- "Authorization is Limited to a Non-Disability Waiver Determination Rendered by a Care Coordination Agency and Related Transportation Approved by Xerox."

Updated 03/13

Medical Manual Coupon Issuance

MEMC		MEDICAL MANUAL COUPON ISSUANCE				112501 14:48	
RECIPIENT		D.O.B.		ELIG		RUTHTRAIN M	
I.D.	RECIPIENT NAME	MM DD YY	SEX	RACE	CODE	PGM/	RE-
0600000586	DOE	04 27 45	M	BL	25	ME	DE Y
JOHN DOE		*****					
123 MAIN STREET		*THIS AUTHORIZATION GOOD FOR*				VILL: K02	
FAIRBANKS AK 99709		* BENEFIT MONTH 1201 ONLY! *				DIST: 083	

SPECIAL INFORMATION (OPTIONAL)							
AUTHORIZATION SIGNATURE:				DOCUMENT#			
DIVISION OF PUBLIC ASSISTANCE				ISSUANCE INDICATOR:			



Updated 06/12

Medical Assistance Eligibility Codes

Code	Category
10	Public Health Service (IHS, AANHS, and TRICARE)
11	Pregnant Woman (Alaska Healthy Baby Program)
15	Incapacity/Pregnancy Determination
19	Waiver Determination
20	No Other Eligibility Codes Apply
21	Chronic and Acute Medical Assistance Coverage Only (CAMA)
24	300 percent Institutionalized
25	Disability and Blindness Exams
30	Adults with Physical and Developmental Disabilities (APDD), Waiver Only
31	APDD, Waiver Medical
34	APDD, Waiver Adult Public Assistance (APA)/Qualified Medicare Beneficiary (QMB)
40	Alaskans Living Independently (ALI), Waiver Only
41	ALI, Waiver Medical
44	ALI, Waiver APA/QMB
50	Under 21
51	Juvenile Court Ordered Custody of Health and Social Services
52	Transitional Medical Assistance
53	Illegal Alien/Unqualified Alien Emergency Coverage
54	Disabled/Supplemental Security Income (SSI) Child
60	Residential Psychiatric Treatment Center (RPTC) Waiver, 300 percent
61	RPTC Waiver
62	RPTC Waiver, Pregnancy Services
64	RPTC Waiver, APA/QMB
66	Qualified Disabled and Working Individuals – Medicaid Payment for Medicare Part A Only
67	QMB Only - Eligible Only for Medical Assistance Payment of Medicare Deductible and Coinsurance for Medicare-Covered Services
68	Special Low Income Medicare Beneficiary - Medicaid Payment for Medicare Part B Premium Only
69	APA/QMB - Dual Eligibility
70	Intellectual and Developmental Disabilities (IDD), Waiver Only
71	IDD, Waiver Medical

74	IDD, Waiver APA/QMB
78	SLMB (120-135 percent) – Medicaid Payment for Medicare Premium Only
80	Children with Medically Complex Conditions (CCMC), Waiver Only
81	CCMC, Waiver Medical

Updated 09/13

Chronic and Acute Medical Assistance (CAMA) Subtype

If the recipient's medical assistance eligibility code is 21 (CAMA), the recipient's coupon will show the subtype GJ:

"Authorization limited to physician services, service-authorized outpatient hospital radiation and chemotherapy, 3 prescriptions per month, and limited medical supplies."

Updated 06/12

Resource Codes

Many Alaska Medical Assistance recipients are also eligible for medical insurance programs, which will show on their Medical Assistance cards or coupons as "resource codes." Resource codes may also be referred to as carrier IDs. Resource codes alert the Alaska Medical Assistance provider to bill the other program before billing Alaska Medical Assistance in order to satisfy third-party liability requirements. If a recipient has more than one resource code, these codes will be listed on the recipient's eligibility card or coupon.

Federal Resource Codes

Some of the most common federal resource codes are as follows:

- G** Medicare Part A
- H** Medicare Part B
- J** Medicare Parts A and B
- M** CHAMPUS/TRICARE
- N** US Department of Veterans Affairs (VA)
- P** Alaska Area Native Health Service (AANHS) (not primary to Medical Assistance)

G, H, J

Some Alaska Medical Assistance recipients, particularly those over 65, are also eligible for Medicare. Their eligibility is indicated by resource code "G," "H" or "J." Alaska Medical Assistance and Medicare cover many of the same services. Alaska Medical Assistance providers must always bill Medicare before billing Alaska Medical Assistance for these recipients.

M

Military personnel and their families are covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS/TRICARE). Their eligibility is indicated on the Medical Assistance card or coupon by resource code "M." Alaska Medical Assistance providers rendering services to Medical Assistance recipients who are covered by CHAMPUS/TRICARE must enroll as a CHAMPUS/TRICARE provider and always bill the appropriate participating claims processor before billing Alaska Medical Assistance for these recipients.

Be sure to complete the fields on the appropriate insurance claim form (CMS-1500) that require CHAMPUS/TRICARE health insurance information on the insured. Also, providers must accept assignment in order to be paid by CHAMPUS/TRICARE and to receive the explanation of benefits (EOB) showing the coinsurance and deductible amounts. On the CMS-1500, check "Yes" in field 27 ("Accept Assignment?"). Medical Assistance will reimburse the CHAMPUS/TRICARE coinsurance and deductible amounts listed on the EOB, if they do not exceed the total Medical Assistance allowed amounts. For additional information about CHAMPUS/TRICARE billing, refer to the back of the CMS-1500 or UB-04 form.

Updated 03/13

N

Military personnel and Veterans may also receive health care benefits from the US Department of Veterans Affairs (VA). VA eligibility is indicated by resource code "N." When recipients have VA, Medicare, and Medical Assistance coverage, the providers must first bill VA, and then Medicare, before billing Medical Assistance. Since the VA payment is considered payment in full, and Medicare has a 20 percent coinsurance amount, VA is always considered the primary resource over Medicare.

Note: It is the Veteran's responsibility to

- Keep annual reviews current with the VA
- Provide the health care provider with the information about his or her VA coverage at the time of the appointment
- Follow all rules for using VA coverage before using Medicare or Medical Assistance

However, if the VA does not provide coverage for the medical service, the Alaska Medical Assistance recipient (Veteran) is responsible for providing the denial, and must:

- Obtain a formal denial in writing from the VA stating why the services for the Veteran's particular diagnosis and date of service are not available at the VA facility or at VA expense.
- Take a copy of the denial to the health care provider so the provider has an adequate and valid attachment for the provider's claim submission to Medical Assistance or crossover billing from Medicare.

P

Individuals who are part Alaska Native or American Indian are covered by the Alaska Area Native Health Service (AANHS), a federal medical program. Those who are eligible for both AANHS and Alaska Medical Assistance can choose between AANHS and Alaska Medical Assistance enrolled health care providers for all services covered under Alaska Medical Assistance. Their resource code is "P." Providers may bill Alaska Medical Assistance first and are not required to bill AANHS.

No Other Insurance Available Resource

Providers may bill Alaska Medical Assistance.

Y

Individuals with no other insurance available have a resource code of "Y."

Commercial Insurance Resource Code

Any two-character resource code, also referred to as carrier ID, refers to a specific commercial insurance company, and that company must be billed before submitting a claim Alaska Medical Assistance. For additional information, including further instructions, refer to Third Party Payment in this section. A current list of [commercial insurance resource codes](http://www.medicaidalaska.com/providers/carrierinfo.asp) is available at <http://www.medicaidalaska.com/providers/carrierinfo.asp>.

Updated 03/13

Care Management Program

The Care Management Program (CMP) was established to control harmful and costly inappropriate use of Medicaid-covered services. The CMP restricts a recipient to one primary care provider and one pharmacy, which encourages continuity of care and promote communication between the recipient's primary care provider and pharmacy.

Recipients who could benefit from the CMP are most often identified by the Department of Health and Social Services (DHSS) or by its fiscal agent, but are also referred to the program by medical providers or other concerned individuals. The [Care Management Referral Form](http://www.medicaidalaska.com/providers/forms.shtml) is available at <http://www.medicaidalaska.com/providers/forms.shtml>.

If after a utilization and medical records review DHSS determines the individual meets criteria for CMP, the recipient is notified of:

- The reason for, and the date of placement into the program.
- The names of the single medical provider and single pharmacy provider to be the exclusive primary care providers for the recipient for the duration of CMP placement.

The primary care provider for a CMP recipient functions as the principal supplier of medical care and acts as a 'gatekeeper', coordinating all other medically necessary services. The primary care provider determines when a referral to a specialist or other medical professional is necessary.

In order for a provider other than the primary care provider to be reimbursed by Alaska Medical Assistance, a written referral must be submitted with the claim and must include:

- Date of referral
- Condition to be treated
- Duration of the referral

In the event of a medical emergency, a CMP recipient may see any provider without restriction. A medical emergency exists when a recipient has a severe, life-threatening or potentially disabling condition that requires immediate intervention.

A CMP recipient's identification card or medical coupon is marked "RESTRICTED," and includes the name of the designated CMP provider(s). Care Management coupons are easily discernible by their bright pink color.

For questions or additional information, contact the [Surveillance and Utilization Review Department](http://www.medicaidalaska.com/providers/carrierinfo.asp).

Updated 06/12

Performing Services

Alaska Medical Assistance covers only medically necessary services provided to recipients by enrolled providers.

Updated 06/12

Covered Services for Alaska Medicaid and Denali KidCare

Services for Children and Adults

- Accommodations for non-emergency medical care
- Advanced nurse practitioner services
- Ambulance
- Ambulatory surgical care
- Anesthesia
- Dental care
- Durable medical equipment
- End Stage Renal Disease dialysis facility services
- Family planning
- Federally qualified health center
- Hearing services
- Home and community-based waiver services
- Home health care
- Hospice
- Hospital inpatient and outpatient
- Inpatient psychiatric services (recipients must be over 65 or under 21)
- Intermediate care facility (ICF) services
- Intermediate care facility for individuals with developmental disabilities (ICF/IDD) services
- Laboratory and X-ray
- Mental health clinic services
- Nurse midwife services
- Nutrition services for pregnant women and children under 21
- Occupational therapy
- Personal care
- Physical therapy
- Physician services
- Prescribed drugs
- Prosthetic devices and medical supplies
- Respiratory therapy
- Rural health clinic services
- Screening and brief intervention services
- Skilled nursing facility (SNF) services
- Speech-language therapy
- Substance abuse rehabilitative services
- Tobacco cessation services
- Transportation services for emergency and non-emergency medical care
- Vision care

Updated 06/12

Services for Recipients Under 21 Years of Age

Alaska Medicaid limits some services based on age. The following services are available only through the end of the month that a recipient turns age 21:

- Chiropractic
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screening
- Podiatry
- Private duty nursing
- School-based services

Updated 06/12

Case Management Services

Alaska Medicaid offers free, voluntary case management services through its contractor Qualis Health. Case management services are designed for recipients with complex conditions and costly health care needs, including:

- Chronic illnesses like diabetes, asthma, and congestive heart failure
- Acute catastrophic injuries
- Burns, wounds, and non-healing ulcers

- Organ transplants
- Cancer
- Terminal illnesses
- Neonatal complications

Qualis accepts case management requests from the following individuals:

- A recipient or his/her family member
- A physician, hospital, or other medical provider
- Alaska Medicaid
- A community or state agency

To refer a recipient for CM, contact Qualis Health or submit a [Case Management Referral Request](http://www.qualishealth.org) available at <http://www.qualishealth.org>.

Upon referral, a case manager will contact the recipient to discuss his/her specific healthcare needs and goals, create a plan of care, and coordinate with the necessary providers to meet the needs of the recipient. For additional information, refer to [Qualis Health Provider Manual](http://www.qualishealth.org) available at <http://www.qualishealth.org>.

Updated 03/13

Out-of-State Services

Alaska Medical Assistance covers services provided out of state to the same extent it would cover the service provided in Alaska if the service is provided to a recipient who is a resident of Alaska and Alaska Medical Assistance is able to verify one of the following circumstances:

- The recipient requires a medical service that is not available in this state or the provision of that service out of state is more cost-effective.
- The medical service is needed due to a medical emergency while a recipient is out of state and the recipient's health would be endangered if the recipient were required to travel to this state for the needed medical service. This eligibility exists when the individual is temporarily absent and intends to return to Alaska.
- Laboratory specimens are sent out of state because the laboratory service is not offered in this state; the laboratory service is more readily available out of state; or the laboratory work performed out of state is more cost-effective.

Alaska Medical Assistance may deny a request for a service provided out of state that requires prior if these are not met.

Payment for services provided to Alaska Medical Assistance recipients outside the state of Alaska is limited to the lesser of:

- The rate established by the Medicaid agency in the state where the services were provided.
- The rate or payment methodology established by Alaska Medical Assistance.

Updated 06/12

Arranging Patient Travel

Alaska Medicaid covers out of area and local transportation and out of area accommodation services when travel is required to receive medically necessary services.

Service authorization (SA) is required for all transportation and accommodation services.

Updated 09/13

Transportation Authorization and Invoice (AK-04)

The Transportation Authorization and Invoice (AK-04) is required for all travel. Providers may request supplies of the AK-04 by completing a [Healthcare Forms Order Request](#) or contacting [Provider Inquiry](#). The AK-04 is a controlled form, each bearing a distinct identifying number. Providers must keep these controlled forms in a secure location.

Updated 06/12

Authorized Escort

Alaska Medicaid will approve transportation and accommodation services for an authorized escort to accompany a recipient during non-emergent travel for medical treatment if the recipient is

- Age 17 or younger, or
- Age 18 or older, when the referring provider presents medical justification that an escort is medically necessary. The Department of Health and Social Services (DHSS) will make this determination.

An escort may be medically trained, but medical training is not required. Alaska Medicaid does not compensate escorts. Alaska Medicaid expects an approved escort to assist the recipient during the travel and to/from the medical appointment.

When an Alaska Medicaid recipient travels with an escort, it is expected that the recipient and escort will share a hotel room. Separate rooms are not routinely authorized for escorts. Escorts should be appropriate to share accommodations with the recipient. The Division of Health Care Services (DHCS) will review requests for separate rooms when there are unusual circumstances.

Service authorization is required for escort transportation and accommodation.

Meals and lodging are not routinely authorized for a medical escort when the Alaska Medicaid recipient is hospitalized, but may be authorized when

- It is cost effective to do so
 - For example, it may be less expensive to pay for meals and lodging than to pay for round trip airfare again at a later date.
- The recipient is age 17 or younger

Restrictions

- A medical escort is not authorized for the purpose of language interpretation. Under the provisions of the Americans with Disabilities Act (ADA), medical providers must assure adequate capabilities for communications with all patients. For additional information, review the flyer [Translation/Interpretation Services: Medicaid Provider Responsibilities](http://medicaidalaska.com/providers/provupdates.shtml) dated 03/02/2012 available at <http://medicaidalaska.com/providers/provupdates.shtml>
- A medical escort is not authorized when the recipient is transported by ground or air ambulance. Medical personnel to care for the patient are included in the flight charges.
- Alaska Medicaid does not pay for services incurred after the date of death. If a recipient dies while receiving medical treatment, Alaska Medicaid will cover the cost of an escort's return trip if the travel was originally approved. It is the responsibility of the escort to make arrangements with the airline through the Medicaid Travel Office to change the return date of travel. Transportation expenses of the deceased recipient are a mortuary expenditure that is not covered by Alaska Medicaid.

Exceptions

Some exceptions to the medical escort guidelines include:

- Minor individuals who are parents may escort their child(ren) without an additional escort.
NOTE: These same minors may travel without an escort for their own medical appointments.
- An adult female may escort a pregnant minor who is traveling to a pre-maternal home to await delivery. Alaska Medicaid will pay a reduced fee to the pre-maternal home to cover expenses incurred by the escort.
- Under limited circumstances, Alaska Medicaid may authorize a second escort. Documentation supporting the medical necessity of the second escort is required for medical review.

Outpatient Care

Patients and escorts are authorized for lodging and meals during the course of all outpatient treatments requiring an overnight stay. Meals and lodging are not authorized for travel that is completed in the same day.

Inpatient Care

Meals and lodging are not routinely authorized for a medical escort when the Alaska Medicaid recipient is hospitalized, but may be authorized when:

- It is cost effective to do so
 - For example, it may be less expensive to pay for meals and lodging than to pay for round trip airfare again at a later date.
- The patient is a child
- Coverage for meals and lodging during inpatient care is available when the provider submits information showing that the authorization is cost effective and reasonable for the welfare of the recipient.

Updated 09/13

Out of Area Travel

Out of area transportation coverage is available when

- Medically necessary services are not available in the recipient's community,
- The total cost of out of area medical and transportation/accommodation services is less than the cost of local services, or
- The recipient is an American Indian or Alaska Native who has requested services from the nearest Indian Health Services/Tribal facility.

Alaska Medicaid also covers necessary accommodation services for out of area travel. Accommodation services are limited to lodging and meals provided by enrolled hotels and restaurants.

Referring Provider Responsibilities

The local, *referring provider* must call the [Service Authorization Unit](#) to request out-of-area travel or fax to the Service Authorization Unit a completed Transportation Authorization and Invoice form (AK-04). SA requests for out of area travel may not be made by the recipient or escort.

The referring provider must have the following information available when requesting authorization for travel:

- Recipient's (and escort's, if applicable) Alaska Medicaid ID number
- Date(s) of scheduled services
- Diagnosis
- Referring provider name and
- Origin and destination
- Escort information and medical justification, if applicable

When the travel SA is approved, the referring provider must record the SA approval information on the AK-04(s). A separate AK-04 must be completed for each transportation/accommodation provider who will be billing for services. Providers must furnish all completed AK-04(s) to the recipient or escort so that he or she may make travel arrangements.

Alaska Medicaid expects the referring provider to counsel and assist the traveling recipient and escort concerning appropriate use of travel benefits.

Receiving Provider Responsibilities

The receiving provider is expected to schedule appointments so as to minimize the recipient's time spent away from home. Travel will be authorized for the day before scheduled services if airline travel does not permit arrival on the date of the recipient's appointment.

In instances where the recipient is traveling to receive care that requires service authorization (SA), the receiving provider should request SA for the medical services.

If the receiving provider determines that the recipient needs to stay longer for medical reasons or if weather or other circumstances delay the recipient's return-travel:

- The receiving provider must contact the [Service Authorization Unit](#) to authorize additional lodging and meals, and to modify return transportation arrangements. The SA number(s) and reason for rescheduling is required to make changes.
- The recipient must call the [State Travel Office](#) to make arrangements for approved travel adjustments.

Follow-up care or services related to complications resulting from medical interventions should be provided locally whenever possible.

Recipient Responsibilities

Following receipt of the approved AK-04(s) and after medical appointments are scheduled, the recipient or his or her representative must call the State Travel Office to make authorized transportation and accommodation reservations.

When traveling, the recipient and escort must keep each travel voucher with them during the trip and provide the appropriate original or carbon copy to each transportation/accommodation provider encountered. Travel vouchers cannot be replaced or cancelled if lost.

Recipients must leave and return as scheduled and keep all scheduled appointments. The recipient is responsible for any extra expenses incurred during the trip, including but not limited to:

- Travel expenses not immediately related to a scheduled, approved medical appointment
- Meals beyond those authorized, and meals at non-enrolled restaurants
- Alcoholic drinks
- Television
- Tips
- Room service
- Phone calls
- Laundry and dry cleaning
- Meals for guests

Updated 03/13

Local Travel

Alaska Medicaid may provide coverage for local transportation for a Medicaid recipient to travel by the least expensive and appropriate means to/from a medical appointment if the transportation request is made by the medical provider and if the following criteria are met:

- The recipient's Medicaid coverage must include transportation benefits. If uncertain, refer to the [Transportation and Accommodation Billing Manual](#) or contact Xerox [Provider Inquiry](#).
- The transportation must be for an appointment to receive a Medicaid covered service.
- The appointment must be medically necessary.
- The recipient must not have access to public transportation.
- The recipient must have no other mode of transportation available to him/her.
 - Does the recipient have a family member or a friend who can transport him/her to the appointment?
 - How does the recipient typically travel to local medical appointments?

To request local transportation:

1. The provider must call the [Service Authorization Unit](#); a staff member will verify the above information to establish that local transportation eligibility criteria are met.
2. If the recipient is approved for local transportation, the provider will receive a service authorization number to enter on a Transportation Authorization and Invoice (AK-04).
3. Complete the voucher and give the voucher to the recipient.

If the recipient has any questions regarding local transportation, please refer him/her to the [Recipient Services Helpline](#).

Updated 03/13

Early and Periodic Screening, Diagnosis, and Treatment Travel

Alaska Medical Assistance offers transportation assistance for eligible recipients who need to travel to early and periodic screening, diagnosis, and treatment (EPSDT) or EPSDT referral appointments.

The travel program covers visits for prenatal and post-partum follow-up for eligible recipients, as well as well child exams that meet the minimum recommendations found in the *Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care* as well as any follow-up care ordered by an appropriately licensed healthcare provider. Authorized trips to the pharmacy are also allowed included.

In some instances, a recipient can receive assistance for bus, taxi or private vehicle travel through a local public health center. Public health centers can authorize local travel for eligible recipients through Alaska Medicaid or recipients may call the EPSDT travel line at 907.269.4575 or 888.276.0606 (in-state toll free).

EPSDT Travel via Private Vehicle

If transportation for medical purposes is available to the recipient using a private vehicle, the recipient or the recipient's representative may contact the [local public health center](#) to seek authorization for mileage reimbursement. The public health center employee will need to verify the following:

- Recipient eligibility for Medicaid or Denali KidCare
- Recipient is under 21 years of age or pregnant
- Recipient is receiving an EPSDT service or EPSDT referred service
- Unavailability of other transportation resources

If the recipient meets all of the above qualifications for travel assistance, the public health center employee will give the traveler a form for mileage reimbursement stamped by a public health center employee. Travel can occur in the recipient's vehicle or a friend's vehicle.

After travel occurs, the traveler must send the mileage reimbursement form to Alaska Medicaid, who processes the mileage form for payment. The traveler should send the completed form to:

Alaska Medicaid/EPSTD
Alaska DHSS/Division of Health Care Services
4501 Business Park Blvd, Bldg. L, Ste. 24
Anchorage, Alaska 99503

NOTE: If more than one Alaska Medicaid eligible recipient in a family receives medical care during a single trip, the family should only submit one form for payment.

EPSTD Travel via Taxi or Bus

If a recipient requires transportation for a local EPSTD appointment, the local public health center or Alaska Medicaid may distribute taxi vouchers and bus tokens (by mail upon request). Only the most cost effective mode of travel will be authorized. Taxi and/or bus token assistance is only available to recipients who are under twenty-one years of age or pregnant.

The recipient or the recipient's representative can request bus tokens or a taxi voucher. Recipients enrolled in only Medicaid may receive approval for bus or taxi authorizations for the current month only; however, Denali KidCare recipients may request bus or taxi authorizations during the recipient's 12 months of continuous eligibility.

- For local travel needs in Anchorage, Eagle River, or the Mat Su Valley, call the Alaska Medicaid EPSTD travel line at 907.269.4575 or 888.276.0606 to request travel assistance. Requests must be made by 4:00 pm at least one business day prior to the appointment.
- For EPSTD appointments in other areas of the state, the recipient or recipient's representative must call the local public health center to obtain authorization for travel.

For taxi requests, the Alaska Medicaid office or public health center will process the request and forward an authorization to the appropriate taxi company. The taxi company will be provided a pick-up and appointment location. The recipient or recipient's representative must contact the taxi company to arrange travel times.

NOTE: If there are any changes regarding the appointment or recipient's information, the recipient or the recipient's representative must notify Alaska Medicaid or the public health center and in order to update travel information.

Taxis will not be reimbursed for wait time. At the end of the trip, the taxi company should submit an invoice for payment to Alaska Medicaid at:

Alaska Medicaid /EPSTD
Alaska DHSS/Division of Health Care Services
4501 Business Park Blvd, Bldg L, Ste. 24
Anchorage, Alaska 99503-7167

For all inquiries related to EPSTD travel, recipients may call the [Recipient Helpline](#) or the EPSTD travel line.

Updated 09/13

Long Term Care Travel

Alaska Medicaid covers travel to a long term care facility located outside the recipient's community of residence provided the recipient is eligible for travel services. The Division of Senior and Disability Services (DSDS) authorizes requests for long term care; when submitting a request for service authorization (SA), be sure to notify DSDS that travel to the facility is necessary.

If DSDS approves the long term care request, they will notify the provider of the SA, including whether travel to the long term care facility is approved. After the long term care provider receives SA, they should contact the [Service Authorization Unit](#) in order to arrange travel. When calling, the provider should be ready to provide the SA number as well as the full name (first, middle, last), date of birth, and gender of the traveling recipient.

Updated 09/13

Transplant Travel

When a Medicaid recipient is placed on a transplant waitlist, the rendering provider must call the [Service Authorization Unit](#) to request service authorization (SA) for travel. When a transplant becomes available, the SA will be activated to allow the transplant recipient to travel. If the recipient is notified of transplant availability outside business hours, the recipient will need to contact the after hours line at the Medicaid Travel Office.

In certain limited circumstances, Alaska Medicaid authorizes recipient travel for a transplant prior to transplant availability in order to provide adequate access to medical care; authorization is updated monthly.

Updated 09/13

Waiver Recipient Travel

Alaska Medicaid covers local transportation for recipients who are travelling to receive home and community based waiver services for which they are eligible. If transportation is needed, the recipient's care coordinator should indicate the need in the recipient's annual plan of care. The Division of Senior and Disability Services (DSDS) will review the plan of care and authorize appropriate transportation. For additional information, refer to the [Home and Community Based Waiver Services Billing Manual](#).

Updated 09/13

Chronic and Acute Medical Assistance Covered Services

The Chronic and Acute Medical Assistance (CAMA) program provides limited medical services to low-income Alaskans who are ineligible for Medicaid and have been diagnosed with:

- A terminal illness

- Cancer requiring chemotherapy
- Diabetes
- Diabetes insipidus
- Chronic hypertension
- A chronic mental illness
- A chronic seizure disorder

Alaska Medical Assistance will reimburse enrolled providers for the following services rendered to eligible CAMA recipients:

- Physician, advanced nurse practitioner, or physician assistant services for a CAMA-covered medical condition
- Three prescriptions filled or re-filled in a calendar month
 - Prescriptions cannot exceed a 30 day supply and must be prescribed for a CAMA-covered medical condition
- Limited medical supplies necessary for monitoring or treating a CAMA-covered medical condition
 - No durable medical equipment
- Service-authorized outpatient hospital radiation and chemotherapy services for the treatment of cancer
- Outpatient laboratory and x-ray services

CAMA Service Limitations

The only services reimbursable by CAMA are those provided to treat the CAMA recipient's CAMA-covered medical condition.

All CAMA-covered services, with limited exception, must be provided at an independent outpatient office setting and not at an outpatient hospital. CAMA does not cover inpatient services of any kind. Physician services provided in an inpatient hospital or nursing facility, and services furnished to an Indian Health Service (IHS) beneficiary by an IHS or IHS-funded facility are not covered.

The only services for which CAMA will pay when rendered in the outpatient hospital are

- Chemotherapy for the treatment of cancer
- Radiation for the treatment of cancer

Xerox must provide services authorization for these hospital-based services. Xerox only approves service authorizations when chemotherapy or radiation cannot be provided in an outpatient office setting.

Updated 06/12

Non-covered Medicaid Services

The Department of Health and Social Services (DHSS) will not pay for the following services, unless otherwise provided by regulation:

- A service that is not medically necessary and not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system
- A service that is provided outside the scope of the provider's licensure or not properly prescribed
- Advance nurse practitioner serving as a primary surgeon
- Alternative therapy or other service including acupuncture, homeopathic or naturopathic remedy, and Ayurvedic medicine
- Case management services*
- Chiropractic manipulation and podiatry services for recipients age 21 and older
- Brand-name drugs if a therapeutically equivalent generic drug is on the market
 - Excepting brand name drugs included on the Alaska Medicaid Preferred Drug List (PDL)
 - Excepting instances where the prescriber indicates "brand-name medically necessary drug" or "allergic to the inert ingredients of the generic drug"
- Drugs for which more than a 30-day supply is ordered per prescription
 - Excepting birth control drugs and drugs listed on the Alaska Medicaid PDL if dispensed in an unopened container
- Drugs used for the symptomatic relief of coughs and colds
- Drugs used to treat infertility, obesity, or baldness
- Drugs that are prohibited from receiving federal Medicaid matching funds (refer to 42 CFR 441.25)
- Educational services and supplies
- Experimental or investigative services
- Gender reassignment procedures or sequelae
- Hysterectomies performed for sterilization purposes only
- Impotence treatment or services
- Infertility services
- Interpreter services
- Maintenance therapy
- Medical testimony
- No-show or cancelled appointments
- Plastic or cosmetic services for enhancement purposes, hair or wrinkle removal
- Office supplies
- Oral vitamins, excepting
 - Analogs
 - B-complex vitamins for renal disease
 - Fluoride preparations
 - Folic acid
 - Prenatal vitamins
 - Vitamins A, D, and K
- Operating room assistance provided by an intern, registered nurse or licensed practical nurse
- Programs to improve overall fitness
- Selected special services and report codes
- Services billed using non-covered CPT or HCPCS codes
- Special reports
- Sterilization for recipients institutionalized in psychiatric facilities, for recipients who are under 21 years of age, or for recipients determined by a court to be incompetent
- Surgical Trays

- Swimming therapy
- Travel by the provider
- Vaccine products that are available for free

This list is comprehensive, but not exhaustive.

* Although Alaska Medicaid does not reimburse enrolled providers for case management services, these services are available through a contractual agreement with Qualis Health. For additional information, refer to [Case Management Services](#) in this section.

Updated 03/13