Overview

• Provider Enrollment Requirements
• Member Eligibility
• Service Categories and Qualifying Criteria
• Documentation
• Assessment and Treatment Plan
• Covered Services
• Service Authorizations
• Billing
• Additional Information
Provider Enrollment
Community Behavioral Health Services Provider Enrollment

Community behavioral health services (CBHS) provider enrollment requirements are detailed in 7 AAC 70.100, including:

- Certificate of department approval for one or more of the following service categories:
  - Behavioral health clinic services
  - Behavioral health rehabilitation services
  - Detoxification services – low, medium or high
  - Residential substance use treatment services
  - Day treatment services for children
CBHS Provider Requirements

• A CBHS provider must have a documented formal agreement with a physician for the purpose of providing general direction and directing clinical services

• May employ or contract with mental health professional clinicians, behavioral health clinical associates, substance use disorder counselors, and peer support specialists to provide services

• For all provider types and service categories:
  – Staff members must only perform services within the scope of their knowledge, experience, and education
  – Staff members must meet the qualifications for the level and type of service(s) they are providing
  – Providers should review and understand the State of Alaska’s Behavioral Health Regulations: 7 AA 29; 7AAC 43; 7 AAC 71; 7 AAC 100; 7 AAC 105; 7 AAC 110; 7 AAC 120; 7 AAC 130; 7 AAC 135; 7 AAC 140; 7 AAC 145; 7 AAC 155; 7 AAC 160
  http://www.legis.state.ak.us/basis/aac.asp#7
Provider Enrollment Process

• Enrollment begins online at www.medicaidalaska.com
• Select Provider>Enrollment, then click the appropriate link to begin the enrollment process
• Mail in required documentation and signature pages
• Enrollment training is available on the Learning Portal at www.learn.medicaidalaska.com
All forms with original signatures should be mailed to:

P.O. Box 240808
Anchorage, AK 99524-0808

Providers may also choose to deliver them to Conduent located at:

1835 S. Bragaw St.
Anchorage, AK 99508

http://manuals.medicaidalaska.com/docs/dnld/Form_Update_Provider_Information.pdf
Member Eligibility
Member Eligibility

Always verify member eligibility by using one of the following options:

• Request to see the member’s eligibility coupon or card that shows the current month of eligibility; photocopy for your records

• Call Automated Voice Response System (AVR):
  – 855.329.8986 (toll-free)

• Verify via Alaska Medicaid Health Enterprise website
  – http://medicaidalaska.com

• Fax complete Recipient Eligibility Inquiry Form - General
  – 907.644.8126

• Submit a HIPAA compliant 270/271 electronic Eligibility Inquiry transaction

• Call Provider Inquiry
  – 907.644.6800, option 1 or 800.770.5650, option 1, 1 (toll-free)
Member Eligibility

There are two aspects to member eligibility for CBHS services:

• AK Medicaid program eligibility
• Medical necessity
  – Does the patient meet the regulatory requirements as “eligible for behavioral health service”
Exclusions

AK Medicaid members in the following circumstances are not eligible for “clinic” behavioral health services:

• In the custody of federal, state, or local law enforcement, including juveniles in detention

• Between age 22 and 65 who are residents of an Institution for Mental Diseases
  – IMD – hospital, nursing facility, or other institution of more than 16 beds primarily engaged in providing diagnosis, treatment, or care to patient with mental diseases

• Residents of skilled nursing or intermediate care facility

• Inpatients of an acute care hospital or residential psychiatric treatment center
Service Categories and Qualifying Criteria
Clinic Services

- Professional Behavioral Health Assessment
  - Mental Health Intake Assessment H0031
  - Integrated Mental Health and Substance Use Intake Assessment H0031HH
  - Psychiatric Assessment 90791
- Psychological Testing and Evaluation
- Pharmacologic Management
- Psychotherapy services
- Short-Term Crisis Intervention
- Facilitation of Telemedicine Services
- SBIRT (Clinic and rehab) 99408
Rehabilitation Services

- Substance Use Assessment
- Client Status Review
- Behavioral Health Treatment Plan Review for Methadone Treatment Program
- Medical Evaluation for Detoxification Treatment Program
- Alcohol and Drug Detoxification Treatment
- Residential Substance Use Disorder Treatment
- Short-Term Crisis Stabilization services
- Case Management
Rehabilitation Services (cont.)

- Medication Administration
- Comprehensive Community Supports for Adults
- Therapeutic Behavioral Health Services for Children
- Peer Support
- Recipient Support
- Daily Behavioral Rehabilitation Services for Children
- Day Treatment Services for Children
- Facilitation of Telemedicine Services
• Initial services may be provided to any Medicaid-eligible member

• Initial services include:
  – Screening using the Alaska Screening Tool (AST)
  – Initial Client Status Review (CSR)
  – Screening, Brief Intervention and Referral to Treatment (SBIRT)
  – Professional Behavioral Health Assessments – assessments based on the provider’s qualifications

• All currently eligible AK Medicaid members meet qualifying criteria to receive AST, CSR, SBIRT, and assessment services

• Whether members meet qualifying criteria for further services is determined through the outcome of the agency’s screening and assessment efforts
Clinic Services Only

Recipients who are identified as meeting the following criteria are eligible for clinic services only:

• Child experiencing an emotional disturbance
  – Member under 21 years of age who is experiencing a non-persistent mental, emotional, or behavioral disorder that:
    • Is identified and diagnosed during a professional behavioral health assessment; and
    • Is not the result of intellectual, physical, or sensory deficits

• Adult experiencing an emotional disturbance
  – Member is 21 years of age or older who is experiencing a non-persistent mental, emotional or behavioral disorder that:
    • Is identified and diagnosed during a professional behavioral health assessment and
    • Is not the result of an intellectual, physical, or sensory deficits
Rehabilitation Services

A child or adult experiencing a Substance Use Disorder is eligible for Rehabilitation Services

- An individual who is experiencing a substance use disorder characterized by
  - A maladaptive pattern of substance use, or
  - Cognitive, behavioral, or physiological symptoms indicating that the individual will continue to use a substance despite significant substance-related problems associated with its use
Rehabilitation and Clinic Services

Child Experiencing a Severe Emotional Disturbance

- A recipient under the age of 21 who:
  - Has or at any time in the past year had a diagnosable mental, emotional, or behavioral disorder of sufficient duration to meet diagnostic criteria specified within the APA's Diagnostic and Statistical Manual of Mental Disorders that has resulted in a functional impairment (a disorder that substantially interferes with or prevents functioning of episodic, recurrent, or continuous duration and not as a result of temporary, expected responses to stressful events in the recipient's environment) which substantially interferes with or limits the child's role or functioning (achieving or maintaining the developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills) in family, school, or community activities
  - Exhibits specific mental, emotional, or behavioral disorders that:
    - Place the individual at imminent risk for out-of-home placement;
    - Place the individual at imminent risk for being placed in the custody of the DJJ
    - Have resulted in the individual being placed in the protective custody of OCS
Adult Experiencing a Severe Emotional Disturbance

• A recipient 21 years of age or older who:

• Has or at any time in the past year had a diagnosable mental, emotional, or behavioral
disorder of sufficient duration to meet diagnostic criteria specified within the APA’s
Diagnostic and Statistical Manual of Mental Disorders that has resulted in a functional
impairment (a disorder that substantially interferes with or prevents functioning of episodic,
recurrent, or continuous duration and not as a result of temporary, expected responses to
stressful events in the recipient’s environment) which substantially interferes with or limits
one or more life activities, including:
  – Basic daily living skills, such as personal safety, eating, and personal hygiene;
  – Instrumental living skills, such as managing money and negotiating transportation;
  – Functioning in social, family, or vocational/educational contexts
Rehabilitation and Clinic Services

A child or adult experiencing a behavioral health crisis

• A person experiencing an acute episode of mental, emotional, behavioral, or psychiatric disorder
Documentation
Purpose of Clinical Documentation

• To organize the complete treatment process
• To provide a record for program accountability
• To act as a communication aid between professionals
• To aid in identifying patterns in client behavior
• To serve as a memory aid for the counselor
• To support billing
• Treatment or evaluation services that are missing or not properly documented in the member’s clinical records or treatment plan are not reimbursable by Alaska Medical Assistance
• To follow State of Alaska regulations in 7 AAC 135 and 7 AAC 105
Tips for Clinical Documentation

• Use legible writing or typing
• Use format and file structure that are user-friendly
• Use quality assurance processes and checklists, including applicable notes
• Include both start and stop times as required for time-based codes or total amount of time spent (duration) for other services that are reimbursed based on the amount of time service is rendered
• Include signature and date
• Include either:
  – Credentials of rendering professional clinician staff
  – Title of rendering clinical associate staff
• Stay informed of changes in both federal and state legislation and regulations
• Document, document, document!
Recordkeeping

• Recordkeeping requirements are documented in the Individual Provider Agreement and Tax Certification and Group Provider Agreement and Tax Certification.

• Although most recordkeeping requirements are consistent for all providers, some requirements are provider-type specific.

• Providers must maintain complete and accurate clinical, financial, and other relevant records to support the care and services for which they bill Alaska Medical Assistance for a minimum of 7 years from the date of service.

• Providers are subject to audits, reviews and investigations.

Providers must ensure their staff, billing agents, and any other entities responsible for any aspect of records maintenance meet the same requirements.
Behavioral Health-Specific Record Keeping

Community behavioral health services providers (CBHS) “must maintain a clinical record for each recipient in accordance with the standards used for the Medicaid Program” [7 AAC 70.100(a)(6)] regardless of payment source.

- **7 AAC 135.130 Clinical Record**
  - A CBHS must maintain a clinical record that contains the following:
    - Screening using the Alaska Screening Tool (AST)
    - Client Status Review (CSR) - Initial & Updates every 90 to 135 days
    - Behavioral Health Assessment
    - Treatment Plan
    - Progress Notes (for each service / each day service provided)
  - To document active treatment, the provider must describe or list active pre-planned interventions provided to a recipient.
  - All changes to assessments and treatment plans must be noted in the recipient’s clinical record.
Assessment and Treatment Plan
Flow of Treatment

- Screening using AST
- Initial Client Status Review
- Behavioral Health Assessment
- Behavioral Health Treatment Plan
- Client Status Review: Every 90 – 135 days
- Treatment with documentation in Progress Notes
Alaska Screening Tool

• AST adopted by reference in 7 AAC 160.900

• A CBHS provider must complete the AST for each new or returning recipient of behavioral health services before a behavioral health assessment is conducted [7 AAC 135.100(a)]

• AST does not have to be completed for members only receiving:
  – SBIRT
  – Short-term crisis intervention/crisis stabilization or
  – Detoxification
Client Status Review

• The department will pay a CBHS provider for completing a client status review with the client present if it is used as relevant clinical information concurrent with:
  – An initial behavioral health assessment
  – CSR conducted every 90-135 days
  – Discharge from treatment [7 AAC 135.100(b)]
• Administer using the department CSR form
• Document by placing CSR form in clinical record
• Use to help determine the member’s level of functioning
• Use by directing clinician to:
  – Measure treatment outcomes
  – Make treatment decisions
  – Revise treatment plans
Professional Behavioral Health Assessments

If a behavioral health screening (AST), or a referral by a court or other agency, has identified an individual suspected of having a behavioral health disorder that could require behavioral health services, the department will pay a CBHS provider for one of the following behavioral health intake assessments [7 AAC 135.110]:

- Mental health intake assessment
- Substance use intake assessment
- Integrated mental health and substance use intake assessment
- Psychiatric assessment (used as intake assessment)
Professional Behavioral Health Assessments

Elements of all behavioral health assessments:

• Written report
• Documentation that the AST results were reviewed and considered
• Information on functional impairment
• Information for a concurrent initial client status review
• Treatment recommendations that form the basis of a treatment plan
• Identification of:
  – Need for recipient support services
  – Location and frequency of recipient support services
  – History of violence/need for vigilance
• Updates as new information becomes available
Mental Health Intake Assessment

- Conducted by a mental health professional clinician
- Conducted for the purpose of determining:
  - Member’s mental status
  - Member’s social and medical histories
  - Nature and severity of mental health disorder(s)
  - Complete DSM V and/or ICD-10 diagnosis codes
Substance Use Intake Assessment

• Conducted by a substance use disorder counselor, social worker, or other qualified staff member working within the scope of their authority, training, and job description

• Conducted to determine:
  – If the member has a substance use disorder
  – Nature and severity of disorder
  – Correct diagnosis
Integrated Mental Health and Substance Use Intake Assessment

• Must be conducted by a mental health professional clinician (able to diagnose both mental health and substance use disorders)
• Conducted for the purpose of determining:
  – All requirements for mental health intake assessment
  – All requirements for substance use intake assessment
Psychiatric Assessment

- A psychiatric assessment may serve as the professional behavioral health assessment if the member’s condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication [7 AAC 135.110(f)]

- A psychiatric assessment must be conducted by a physician, physician assistant, or advanced nurse practitioner who has prescriptive authority and who is working with the scope of their education, training, and experience

- Must include:
  - Review of medical and psychiatric history or problem
  - Relevant member history
  - Mental status examination
  - Complete multi-axial DSM diagnosis
  - Listing of identified psychiatric problems
Psychological Testing and Evaluation

• The department may pay a CBHS provider or independently practicing psychologist for psychological testing and evaluation to assist in the diagnosis and treatment of mental and emotional disorders [7 AAC 135.110(g)]

• Psychological testing and evaluation must be conducted by a mental health professional clinician working within scope of the education, training, and experience

• Psychological testing and evaluation include:
  – Assessment of functional capabilities
  – Administration of standardized psychological tests
  – Interpretation of findings
Behavioral Health Treatment Plan

• A behavioral health treatment plan means a written, individualized treatment plan
• Remains current based on Client Status Review conducted every 90-135 days
• Documented according to 7 AAC 135.120, 7 AAC 135.130 and 7 AAC 135.990 (7)
• Based on behavioral health assessment recommendations
• Developed with member or:
  – Member’s representative, if applicable, for members 18 and older
  – Treatment team if member is under 18
• Supervised by directing clinician
Behavioral Health Treatment Plan

Documentation requirements include:

• Member’s identifying information
• Date plan will be implemented
• Treatment goals related to assessment findings
• Services and interventions employed to address goals
• Frequency and duration of services and interventions
• Name, signature and credentials of directing clinician
• Signature of member or member’s representative
Behavioral Health Treatment Team

• Treatment team for member under age 18 **must** include:
  – Member
  – Member’s family members
  – Directing clinician
  – If member is in state custody, OCS staff member
  – If member is in DJJ custody, DJJ staff member
  – If child is experiencing a severe emotional disturbance, the case manager

• Treatment team for member under age 18 **may** include:
  – Representative(s) from foster care, residential child care, or institutional care
  – Representative(s) from members educational system
Behavioral Health Treatment Team

All treatment team members shall:

• Attend team meetings in person or by telephone
• Be involved in team decisions unless clinical record documents:
  – Other team members determine that participation by the team member is detrimental to the client’s well-being
  – Family members, school district employees, or government agency employees refuse or are unable to participate after the provider’s responsible efforts to encourage participation or
  – Weather, illness, or other circumstances beyond the member’s control prohibit participation
  – In instances where team members are not in attendance, providers should document the circumstances
• Concurrence of the directing clinician and the member or the member’s representative (at a minimum) is required to meet any provision requiring the team’s approval, concurrence or recommendation
Directing Clinician

• Definition in 7 AAC 135.990(13): Substance use disorder counselor or mental health professional clinician working within scope of their education, training and experience, who, with respect to the member’s treatment plan:
  – Develops or oversees development of the plan
  – Periodically reviews and revises plan
  – Signs plan each time plan is changed
  – Monitors and directs delivery of services identified in plan

• By signing treatment plan, the directing clinician attests that in their professional judgement, the services prescribed are:
  – Appropriate to the member’s needs
  – Delivered at adequate skill level
  – Achieving treatment goals
Progress Notes

Required for both 7 AAC 105.230 and 7 AAC 135.130
Progress note for each service/each day service is provided that includes:

• Full name of member receiving treatment
• Date each service was provided
• Diagnosis and medical need for each service
• Identification of each specific service provided (description of active treatment interventions)
• Extent each service is provided (duration of service expressed in service units or clock time)
• Start and stop times for time-based codes
• Annotated, dated case notes identifying each service delivered and including the treatment goals the service targeted and description of the member’s progress toward treatment goals
• Identification of each prescription, supply or plan of care prescribed
• Name, signature and credentials of individual who rendered service
Covered Services
Medically Necessary Services

• Services must be medically necessary and clinically appropriate
• Therapeutic interventions must align with the client’s developmental age
Short-Term Crisis Intervention

Provided by a mental health professional clinician who:

• Conducts initial assessment:
  – Nature of crisis
  – Member’s mental, emotional, and behavioral status
  – Member’s overall functioning related to crisis
• Develops short-term crisis intervention plan using department form that contains:
  – Treatment goals derived from assessment
  – Description of medically necessary and clinically appropriate services
  – Documentation by individual who delivered service
• Directs all services except pharmacologic management services
Clinician may order and deliver any medically necessary and clinically appropriate behavioral health clinic or rehabilitation service or intervention to:

- Reduce symptoms
- Prevent harm
- Prevent further relapse or deterioration
- Stabilize the member
Short-Term Crisis Stabilization

Provided by a substance use disorder counselor or behavioral health clinical associate who:

• Conducts initial assessment of member’s overall functioning in relation to crisis
• Develops short-term crisis stabilization plan
• Orders any medically necessary and clinically appropriate rehabilitation service to return member to level of functioning before crisis occurred
• Documents assessment, stabilization plan, and services on department form
Short-Term Crisis Stabilization

• Short-term crisis stabilization includes:
  – Individual or family counseling
  – Individual or family training and education related to crisis and preventing future crisis
  – Monitoring member for safety purposes
  – Any other rehab service

• Short-term crisis stabilization may be provided in any appropriate outpatient or community setting
  – Premises of CBHS
  – Crisis respite facility
  – Member’s residence, workplace or school

• Documented by the individual who provides the service
Pharmacologic Management

• In order for pharmacologic management services to be covered, services must be provided by an appropriately licensed provider

• A provider must monitor the member for purposes of:
  – Assessing the member’s need for pharmacotherapy
  – Prescribing appropriate medications to meet the member’s need; and
  – Monitoring the member’s response to medication, including:
    • Documenting medication compliance
    • Assessing and documenting side effects; and
    • Evaluating and documenting the effectiveness of the medication
Service Authorization
Service Authorization

• Steps from treatment plan to authorization
  – Authorizations start with the clinician
  – Assessment
  – Treatment plan
  – Prescription for treatment services and hours or other time units
  – Service Authorization request form with number of services and hours
• “Current” is defined as within the last 135 days, within the last treatment plan review, before the treatment plan expires
• Medical necessity must be documented on the service authorization request, and must be specific and personalized to the member
Administrative Information

- Service authorizations cannot cross from one fiscal year to another
- Service limits re-set each July 1st (state fiscal year)
- Service authorization dates cannot be extended
  - Additional services or units can be added on to existing service authorizations
  - Additions days of service require a new authorization
- Request the amount of services and units that will be needed for the next review cycle
- For the first authorization for a patient for a new fiscal year, remember not to request the amount of services that are allowed without authorization per the fee schedule
Calculating Total Units Needed

1. If a service is prescribed for 1.5 hours per day for 7 days per week, that would be 10.5 hours per week (1.5 x 7 = 10.5/week)

2. Multiply the weekly amount of the service by the number of weeks in the review cycle. 133 days is 19 weeks, so the hours for the review cycle would be 199.5. (10.5/week x 19 weeks = 199.5 hours in the review cycle)

3. Convert the hours into units by multiply the hours by 4 for 15 minute units or by 2 for 30 minute units, so if our example is 30 minute units, that would be 399 units. (199.5 hours x 2 units per hour = 399 units for the review cycle)

4. If this is the first review cycle for the fiscal year – subtract out the allowed amount for the service. Let’s say that 10 hours of the service are allowed for the state fiscal year without a service authorization. Remember to convert the hours to units for this operation! (399 units – 20 units (10 hours x 2 units/hour) = 379 units)
Use this form for requests up to 12 hours of services a day.
Use this form for requests over 12 hours of services a day.
## Community Behavioral Health Services Service Authorization (SA) Request

### Greater than Twelve Hours

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
<th>Modifier</th>
<th>Unit</th>
<th>Units Requested</th>
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<tbody>
<tr>
<td>Clinical Services: Psychotherapy</td>
<td>5001</td>
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<td>HR</td>
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<td>Psychotherapy for children, excl. with code 14400</td>
<td>14400</td>
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<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Group psychotherapy for children</td>
<td>5005</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Individual psychotherapy for children</td>
<td>5004</td>
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<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Family therapy w/patient</td>
<td>5007</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Family therapy w/o patient</td>
<td>5008</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Intensive care</td>
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<td>Intensive care for children, excl. with code 5007</td>
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<td>Hospital-based group psychotherapy for children</td>
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<td>Rehabilitation Services: Adult and Child</td>
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<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Alcohol and/ or drug use assessment</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Crisis intervention (suicide)</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Self-help peer (individual)</td>
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<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Case management</td>
<td>2001</td>
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<td>HR</td>
<td>15 min</td>
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### Rehabilitation Services, Child Only

<table>
<thead>
<tr>
<th>Service Description</th>
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<th>Unit</th>
<th>Units Requested</th>
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</thead>
<tbody>
<tr>
<td>Individual therapy for children</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Family therapy w/patient</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Family therapy w/o patient</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Intensive care</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
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<tr>
<td>Hospital-based group psychotherapy for children</td>
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<td>HR</td>
<td>15 min</td>
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<tr>
<td>Rehabilitation Services, Adult Only</td>
<td>2001</td>
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<td>HR</td>
<td>15 min</td>
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### Recipient Support Services (RSS), Adult and Child

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
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<td>HR</td>
<td>15 min</td>
</tr>
<tr>
<td>Payer-related ser.</td>
<td>2001</td>
<td>0</td>
<td>HR</td>
<td>15 min</td>
</tr>
</tbody>
</table>

As the assigned treating clinician for the above named recipient, hereby:

- Affirms the assessment of the recipient's sero-vulnerability, current level of functionality is documented in the recipient's clinical record and the treatment plan/plan services, units, and duration requested are medically necessary and consistent with the recipient's level of impairment.
- Affirms that, for this recipient who is a child, the clinical record documents the requested participation and the child's treatment team.
- Acknowledges the recipient is subject to management review of medical necessity and completeness of documentation according to the Department of Behavioral Health and Developmental Disabilities program rules and the Department of Health & Senior Services may require payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Managed Care program rules.
- Acknowledges that approval of this authorization request does not guarantee payment.

**Authorizations do not guarantee payment. Payment is subject to recipient's eligibility. Be sure the identification card is correct before rendering service.**

(Stamp) Statewide Medicaid/Managed Care Authorized Provider, Inc. (Stamp) Statewide Medicaid/Managed Care Authorized Provider, Inc. (Stamp) Statewide Medicaid/Managed Care Authorized Provider, Inc.
Service Authorization Tips

• Information documented on the service authorization must be:
  – Current
  – Personalized to the member
  – Complete
  – Correct
  – Detailed
• When requesting services over 12 hours a day, make sure to read the guidance document included with the form
• Make sure to check your unit calculations
• Requests may be either faxed or mailed in to Conduent
• Address and fax number for submission are on the forms
Service Authorization Request Reviews

• Service authorization request reviews are focused on:
  – Completeness of the SA request form
  – Description of current maladaptive behavior
  – Description of current functional status
  – Description of member’s need for requested services
  – Documented relationship between patient’s diagnosis and behaviors, functional status, and requested services

• Reviewer must assure that approved authorizations for services exceeding annual limits are driven by and clearly linked to the member’s current client status reviews and treatment plans
• Prevent overutilization of services when they are not medically necessary
• Assure that those who need the most intensive services are the ones receiving them
Accessing SA Information

To find your SA information on Health Enterprise:

• Log in
• Go to the Authorizations tab
• Go to View/Edit Authorization Request
• Click Search – if you do not enter any parameters, all of your SAs will appear
• To narrow your search, enter patient ID or other relevant information
• Select a client’s record by clicking on their name
• In the client’s record, scroll to the bottom of the page to see the SAs attached to the person
• Find SA listed that applies to you and click on it to see details, such as the units approved and dates
Travel Service Authorization

• Transportation may be covered when members must travel to receive covered, medically necessary services that are not available in their home community
  – To facility for approved treatment; from facility after discharge
  – During treatment, family may be approved to travel for on-site family therapy*
  – Therapeutic leaves of absence and trial home passes
  – Escort or escorts

• Out-of-state treatment is only covered for children receiving residential psychiatric treatment

• Travel service authorizations are arranged through Conduent

• For more information, consider attending our Arranging Patient Travel class, or see your billing manual

*Specific coverage rules, review criteria and limitations apply.
Billing
Claims Submission Methods

There are several billing options for Alaska Medical Assistance providers.

• Alaska Medicaid Health Enterprise
• 837P Transaction (electronic claim using billing software)
  – Companion Guide: http://medicaidalaska.com
• Payerpath (electronic claim)
• CMS-1500, Professional Health Insurance Claim Form (paper claim)
Additional Information
Overpayments & Repayment of Payment Errors

Providers should closely review each remittance advice (RA) to ensure it reflects accurate payment for all billed services, including correct member details and services provided.

• In accordance with 7 AAC 105.220(e), Alaska Medical Assistance providers have **30 days** from the time of payment to notify the department in writing of a payment error.

• Federal law (42 U.S.C. 1320(d)) requires repayment of overpayments to the department within **60 days** of identifying the overpayment.

• Mail the written overpayment notification and a copy of the RA page detailing the overpayment to the address below:

  Conduent State Healthcare, LLC  
P.O. Box 240807  
Anchorage, Alaska 99524-0807
Timely Filing

• All claims must be filed within 12 months of the date you provided services to the member
• The 12-month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier
Conduent Contacts

• Proactive Provider Support Specialist:
  • Kheonda Eppenger
  • 644-6854
  • kheonda.eppenger@conduent.com

• Service Authorization Manager:
  • Cheryl Smith
  • 644-8103
  • Cheryl-Smith@conduent.com
Web Resources

Websites:
• http://medicaid.alaska.com
• http://www.dhss.alaska.gov/dbh
• http://www.dhss.alaska.gov
• FAQs and Behavioral Health Regulations - http://dhss.alaska.gov/dbh/Pages/Resources/faq.aspx

Reference sheet for finding information resources via internet:
Additional Resources


• Information necessary for successful billing
• Includes provider-specific Medicaid billing manuals and fee schedules

You may also call:

• Provider Inquiry
  – Eligibility only – 907.644.6800, option 1,2 or 800.770.5650 (toll-free), option 1,1,2
  – Claim status and other inquiries – 907.644.6800, option 1,1 or 800.770.5650 (toll-free), option 1,1,1