Overview

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Provider Participation Requirements
All Providers (In and Outside of the State of Alaska)

- Enroll with AK Medicaid as an inpatient psychiatric hospital
- Licensed under AS 47.32 or the licensing requirements for the jurisdiction in which services are offered
- Properly accredited
- Meet all requirements of 7 AAC 140.350 – 140.365
Inpatient Psychiatric Hospital – Coverage and Enrollment (7 AAC 140.350 thru 140.365)

Coverage
- Available to members:
  - Under 21
  - Age 65 and older
- Service authorization must be in place for services to be reimbursed
- Following admission and plan of care development
- Facilities must provide therapeutically appropriate, medically necessary diagnostic and treatment services to the member

Provider Responsibilities
- Providers must record the results of each required screening, assessment and evaluation in written reports, which must be included in the member's medical record
- Providers must provide an accounting for any patient funds accepted for safekeeping
Residential Psychiatric Treatment Center – Coverage and Enrollment (7 AAC 140.400 thru 140.415)

Coverage
• Available to members 21 and under
• RPTCs must provide basic residential care as well as therapeutically appropriate, medically necessary diagnostic and treatment services

All Providers (In and Outside of the State of Alaska)
• Enroll with AK Medicaid as a residential psychiatric treatment center
• Licensed under 7 AAC 50.800-50.890 or the licensing requirements of the jurisdiction in which services are offered
• Accredited by:
  – The Joint Commission
  – Commission on Accreditation of Rehabilitation Facilities or
  – Council on Accreditation of Services for Families and Children
• Meet all requirements of 7 AAC 140.400 – 140.415
• RPTC facility director must sign and submit a letter of attestation of the facility’s compliance with federal regulations regarding restraint and seclusion.
Provider Responsibilities

- Provider must provide basic residential care and services that include:
  - Adequate dwelling space
    - must be in separate buildings or units
    - cannot exceed 60 residential beds per building if the residential unit is a separate and distinct area from other designated treatment units
    - Units must not exceed 30 beds for sleeping accommodations
  - Equipment, supplies, maintenance and insurance for resident use in program activities and case-specific services
- Providers must record the results of each required screening, assessment, evaluation and certification in written reports, which must be included in the member’s medical record
- Providers must provide an accounting for any patient funds accepted for safekeeping
Member Eligibility
## Member Eligibility Codes

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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](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, 2 or 800.770.5650, option 1, 1, 2 (toll-free)
Service Authorization
Service Authorization Requirements

• Service authorization is required for all inpatient psychiatric hospital and residential psychiatric treatment center services through Qualis Health
• The requesting provider submits service authorization requests through Qualis Health’s web portal
• For more information on Qualis Health procedures, processes, and criteria, see the Inpatient Psychiatric Review Provider Manual, available at http://www.qualishealth.org under Alaska Medicaid – Behavioral Health > Provider Resources
• AK Medicaid will authorize out-of-state services when medically necessary services are not available in state
• Service authorization is not a guarantee of payment, however do not forget to enter the service authorization number on your claim
Evaluation, Certificate of Need and Plan of Care
Inpatient Psychiatric Services

- Alaska Medicaid reimburses enrolled providers for medically necessary services for eligible members when delivered, ordered or prescribed by a provider acting within the scope of their license or certification.

- When admitting a member to inpatient psychiatric care, an interdisciplinary team must complete a diagnostic evaluation, certification of need for inpatient psychiatric services and a plan of care.
Interdisciplinary Team

- A clinician or clinicians:
  - A licensed psychiatrist, or
  - A licensed psychologist and a licensed physician, or
  - A licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychological associate, and
- A representative from an appropriate state division (i.e. OCS or DJJ), as applicable, and
- A clinical social worker, and
- A licensed registered nurse with specialized training or one year’s experience with treating mentally ill patients, and
- Other clinicians based on the member’s need
Diagnostic Evaluation

When admitting a member to an inpatient psychiatric hospital or RPTC, the interdisciplinary team must complete an initial evaluation of the member and complete a diagnostic evaluation.

- Inpatient psychiatric hospitals must complete a diagnostic evaluation no more than 60 days before admission or no more than 72 hours after admission.
- Residential psychiatric treatment centers must complete an internal diagnostic evaluation no more than 7 days after admission.
- Following completion of the evaluation, the interdisciplinary team must complete a certificate of need and establish a written plan of care.
The inpatient interdisciplinary team must complete the appropriate Certificate of Need

- The Certificate of Need must document:
  - Alternate, outpatient resources available locally cannot meet the member’s treatment needs
  - The member’s psychiatric condition requires inpatient care
  - Inpatient care is expected to improve the member’s condition or prevent regression

- A sample CON form is available in the Inpatient Psychiatric Review Provider Manual on http://www.qualishealth.org
Plan of Care

The member’s plan of care is based on information provided in the diagnostic evaluation and is formulated in consultation with the member and their family, guardian, or other individual into whose care or custody the member will be released following discharge. The plan must specify:

• Treatment objectives
• Prescribe an integrated program of appropriate therapies, activities, and experiences designed to develop the member’s independence
• Prescribe treatments to improve the member’s condition to function outside inpatient treatment
  – For members under 18, family therapy must be included unless contraindicated
• Discharge plan
• The plan must be comprehensive and in writing
• AK Medicaid will review the plan of care every 30 days in order to determine if continuation of care is required
• The initial plan of care is required at patient admission and must meet the requirement of any other plan of care
Inpatient Psychiatric Hospital Services
Inpatient Psychiatric Hospital Services

• Covered services include:
  • Intake assessment
  • Admitting history and physical examination, including:
    – Medical, developmental, social and medication history
    – Present illness(es)
    – Complete physical exam
    – Allergies (if applicable)
  • Individual, group, and/or family psychotherapy
  • Pharmacological management
  • Crisis intervention
  • Medication administration
Residential Psychiatric Treatment Services
Covered services include:

- Intake assessment
- Individual, group and family psychotherapy
- Individual, group and family skill development services
- Pharmacological management
- Medication administration
- Crisis intervention
Psychological Services and Testing

• Psychologists may administer services in an acute inpatient hospital, inpatient psychiatric hospital, or RPTC.
• Psychologist services must be indicated in the member’s written plan of care.
• If the interdisciplinary team determines that the member requires psychological testing and evaluation and the provider does not perform this service, then the member may be referred to an enrolled psychologist, mental health physician clinic, or community behavioral health services provider.
Restraint and Seclusion

RPTCs must comply with federal standards regarding restraint and seclusion as set forth in 42 CFR 483.350 – 483.376

• Facilities must attest compliance through submission of an attestation letter
  – Upon initial enrollment
  – Each time the RPTC names a new facilities director
  – No later than July 21 of each year

• The letter is available at http://medicaidalaska.com under Documentation>Documents & Forms>Enrollment forms
Therapeutic Transition Days

- Therapeutic transition days allow RPTCs and members more time to facilitate safe discharges
- Therapeutic transition days are authorized by Qualis Health
- Bill Therapeutic transition days using Revenue Code 0199
- Approved Therapeutic transition days are reimbursed up to $211.00 per day
Medicaid Covered Services
EPSDT

• Children under 21 should receive all medically necessary early and periodic screening, diagnosis and treatment care.

• After receiving authorization to admit an eligible child, inpatient psychiatric facilities must ensure the member receives appropriate EPSDT services within the appropriate timeframe:
  – Within 60 days immediately before admission, or
  – Within 5 days after date of admission

• Contact the member’s regular family doctor, referring physician, or the EPSDT office of DHCS to determine if the child’s last EPSDT screening is current
Family Therapy

• While inpatient, members under parental or state custody must receive family therapy as follows:
  – Inpatient psychiatric hospitals must hold family therapy 1 to 2 times/week with identified family members (Ex: divorced parents may participate separately)
  – RPTCs must hold family therapy once/week with identified family, if one exists
  – Facilities treating state custody youths must arrange weekly contact with state representatives in order to update treatment information and facilitate discharge planning, regardless of family involvement

• Document clinical reason for contraindicated family therapy in the member’s record
• Period of contraindication must also be documented in the plan of care
• Family therapy must resume as soon as clinically indicated
• If Tele-Med is available it is highly encouraged to be used for Family Therapy
• Provider must contact parents or guardians on a weekly basis to communicate treatment progress
Leave of Absence (LOA) – RPTCs only

• AK Medicaid covers therapeutic leaves of absence from an RPTC for up to 12 days/calendar year
  – Additional leave of absence days may be authorized through the Division of Behavioral Health using the Leave of Absence Request Form

• Facilities must bill therapeutic LOA days using revenue code 0183; bill unapproved LOA days as a non-covered day using revenue code 0189

• Do not bill for a LOA if:
  – If member leaves and returns for readmission later, then treat the readmit as a new admission and contact Qualis Health for a new service authorization
  – If member is admitted to another facility, then document the applicable date of discharge
Travel to, from, or during care

- Travel to an inpatient psychiatric hospital or RPTC may be requested only after Qualis Health has authorized the care.
- Travel to the provider may be authorized for the member receiving care as well as one parent, legal guardian or designee approved as an escort when traveling to or from the provider.
- A second escort may be authorized when medically necessary.
- Travel requests are processed by Conduent.
- For more information about authorizing medically necessary, non-emergent travel, consult section III of your provider billing manual.
- Therapeutic Trial Home Passes are submitted to Conduent for authorization.
Travel for On-Site Family Therapy (OSFT)

• AK Medicaid may authorize travel for one parent, guardian or designee for medically necessary on-site family therapy

• The member’s treatment plan or plan of care must include OSFT visits in order to confirm the plan meets the program requirements for medical necessity

• To meet OSFT program requirements, the facility must:
  – Plan OSFT no sooner than 90 days from the member’s admission or last OSFT visit period; if sooner, it must be approved by DBH
  – Plan at least one family psychotherapy session per OSFT visit period
  – Plan at least one other family intervention daily during the OSFT visit period
  – Plan the OSFT visit length of five days or less; if longer, it must be approved by DBH
Non-Covered Services
Non-Covered Services

The services listed here are non-covered for inpatient psychiatric hospitals and RPTCs. This list is representative and is not intended to be all-inclusive

• Services that are not medically necessary
• Service provided outside the scope of the provider’s licensure
• Educational services and supplies, interpreter services, medical testimony, travel by the provider, special reports and office supplies
• Experimental or investigative services
• Inpatient psychiatric hospital services for members between 22 and 64
• Inpatient services for members whose primary diagnosis is substance abuse related
Facilities forfeit all reimbursement for treatment and program participation if found performing any of these activities:

- Holding or rage therapy
- Verbal abuse and shaming
- Rebirthing
- Punitive approaches to behavioral management, including militaristic-style boot camp and “scared straight” programs
- Corporal punishment
- Therapeutic interventions not specifically directed toward the psychosocial risks and functional impairments of the child
Billing
Reimbursement for Inpatient and RPTC Services

AK Medicaid reimburses facilities as a per diem rate established by DHSS
• Facilities may receive reimbursement for only the number of approved days certified by Qualis Health
• AK Medicaid will pay for day of admission, but not for the day of discharge, transfer, or death
Claim Submission Options

• Electronic options:
  – Practice management software
  – Payerpath ®
  – Health Enterprise

• Paper option:
  – Institutional paper claim form
• You may need to submit additional documentation along with your claim forms
  – Fee schedules and billing manuals can help you determine if additional documentation is needed
  – Explanation of Benefits (EOB)
  – Proof of timely filing documentation
• If billing using a paper claim form, send attachments along with the claim form
• If billing electronically:
  – Record attachments in your claim, including a document ID#
  – On the same day you transmit your claim, fax your attachments to Conduent using the Attachment Fax cover sheet
  – Record the document ID# on the fax cover sheet and the attachments
Practice Management Software

- Refer to Implementation Guides and Companion Guides for electronic transactions information
  - http://medicaidalaska.com
  - http://www.wpc-edi.com
- Submissions must be HIPAA compliant - Contact Conduent Electronic Commerce Customer Support (ECCS) Coordinator
  - 800.770.5650 (option 1, 4) or 907.644.6800 (option 3)
- Electronic HIPAA compliant transactions (837I)
• Providers may bill electronically using Payerpath® or their own practice management software using the National Standard Format.

• Payerpath® claims are submitted via the internet
  - Free, internet-based, claims submission system
  - Limited immediate document editing to allow correction prior to submission
  - Claims are saved for rebilling additional services
  - Export files from practice management systems to Payerpath®, eliminating the need for double entry
Health Enterprise

Online claim entry at www.medicaidalaska.com
UB-04 Paper Claim Form

• Instructions are on the Conduent website under Documents>Documents & Forms>Provider Billing Manuals>UB-04 http://manuals.medicaidalaska.com/docs/dnld/Billing_USB04_Instructions.pdf

• Complete all required fields and other fields as applicable
• Fill in handwritten claims neatly and accurately
• Keep names, numbers, and codes within the designated boxes and lines
• Include a return address on all claims and envelopes
• Use appropriate, current coding (procedure, diagnosis)
• Include attachments as required:
  – Explanation of Benefits (EOB)
  – Proof of timely filing documentation
Claim Submission Procedures: Coding

• Through 9/30/2015 DOS use ICD-9 coding
• For DOS 10/1/2015 and after use ICD-10 coding
• Procedures/Items/Services:
  - Revenue codes
  - Healthcare Common Procedure Coding System (HCPCS)
  - National Drug Codes (NDC)
Billing Medicaid as Secondary

• AK Medicaid is payer of last resort, with a few exceptions
• If patient has other insurance, it must be billed first, except for Indian Health Services and services with a federal TPL waiver
• When billing Medicaid as a secondary payer:
  – Record the other insurance information and payment on the billing form
  – Include the EOB from the other payer(s) as an attachment with your claim
Medicare Crossover Claims

• Claims for members who have both Medicare and Medicaid that are being submitted electronically should automatically cross over from Medicare’s system to Medicaid’s
• If crossover claims do not appear on the Remittance Advice from Alaska Medical Assistance within one month of your receiving the EOMB from Medicare submit claim with all relevant attachments
• Bill the standard information required for non-crossover claims
• Attach the Explanation of Medicare Benefits (EOMB) and EOB from third-party payer, if applicable
Timely Filing

• All claims must be filed within twelve months of the date you provided services to the patient
• The twelve month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier
What is an Exception Code?

• An exception code is an explanation of how a claim was processed
  – Paid
  – Reduced
  – Denied
  – Suspended
• Four numeric digits
• Appears on Remittance Advice (RA)
Additional Information
Accessing Regulations and Statutes

http://www.alaska.gov/

• Click Find State Statutes and Regulations (“How Do I?” Tab under SERVICES)

• Under “Alaska Law Resources”
  – Select Alaska Statutes (AS)
  – Select Alaska Administrative Code (AAC)
    • Choose “Title 7 - Health and Social Services”
    • Choose “Part 8 – Medicaid Coverage and Payment”
    • Choose the appropriate chapter by service or topic
Alaska Medicaid Compliance & Ethics Training

• Compliance & Ethics: Alaska Medicaid 101 is a computer-based training which includes an interactive video presentation and a supplemental handbook

• This training serves to:
  – Familiarize providers with the responsibilities and requirements associated with being a Medicaid provider
  – Guide providers through the laws and regulations Medicaid providers must follow

• The training is available at http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm
  – Click on Enroll or Attend Training and log in*
  – Under Training Catalog, select Provider Compliance and Ethics Training
  – Click Enroll, then View

• Upon completion of the training, the attendee will see a certificate that can be personalized and printed for your records

• Please direct any questions to the Provider Training department at 907.644.6800 or 800.770.5650

*Requires account setup – this is a different login than Health Enterprise
Resources and Assistance

- The Conduent Website at http://medicaidalaska.com gives you access to:
  - The Provider Enrollment Portal
  - Health Enterprise
  - Billing manuals, fee schedules and forms
  - Newsletters and updates
  - Learning Management System

Kathy Doran 907.644.6802
Conduent Enhanced Provider Services – Behavioral Health