

# Alaska Medical Assistance Provider Billing Manuals



## Tribal Facility Services, Policies, and Procedures

Prepared By  
Conduent State Healthcare, LLC  
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# Table of Contents

<b>How to Get Help</b>	<b>1</b>
------------------------	----------

---

<b>About This Manual</b>	<b>2</b>
--------------------------	----------

---

<b>Common Provider Information</b>	<b>3</b>
------------------------------------	----------

---

Program Introduction .....	3
Why Tribes in Alaska Have Their Own Billing Manual .....	3
Alaska Department of Health and Social Services .....	4
Medical Assistance Contractors .....	5
Provider Communication and Training .....	6
Provider Inquiry .....	7
Provider Training .....	7
Program Participation Requirements and Responsibilities for Providers .....	7
The Provider Agreement .....	7
Documentation and Records Storage .....	8
Provider Enrollment .....	9
National Provider Identifier .....	9
Eligible Provider Types .....	10
Enrollment Requirements for Tribal Health Providers .....	12
Individual Enrollment of Providers in a Tribal Facility is Required .....	15
Provider Enrollment Portal .....	16
Reporting Changes in Enrollment to Alaska Medical Assistance .....	17
Member Eligibility .....	18
Confirming Member Eligibility .....	18
How to Confirm Member Eligibility .....	18
Eligibility Codes .....	20
Eligibility Subtype Codes .....	22
The Care Management Program .....	23
Performing Services .....	24
Alaska Medicaid and Denali KidCare Services .....	24
Reproductive Health .....	28
Out-of-State Services .....	31
Non-covered Services .....	31
Chronic and Acute Medical Assistance (CAMA) Services .....	31
Billing Guidelines .....	32
Choosing a Claim Method .....	32
How to Complete the CMS-1500 and Instructions .....	33
How to Complete the UB-04 Claim Form and Instructions .....	33
How to Complete the Dental Claim Form .....	33
Timely Filing of Claims .....	33
Determining Which Procedure Code or Revenue Code to Use .....	34
National Drug Code/J-Code Billing .....	35
When a Procedure Code Isn't Listed for a Service .....	39
Determining How Much to Bill for a Service .....	39
What to Attach to a Claim .....	40
How to Submit a Claim .....	40
Processing a Submitted Claim .....	42
Checking a Claim's Status .....	42

Adjusting or Voiding a Claim .....	43
Completing the Adjustment/Void Request Form .....	44
Receiving and Reconciling Remittance Advice.....	45
CMS-1500 Remittance Advice .....	46
UB-04 Remittance Advice .....	58
Responding to a Denied Claim .....	71
Appeals.....	72
Appeal Levels.....	72
Appeals for Timely Filing of Claims.....	73
How to File an Appeal.....	74
Claim Payment .....	79
The Encounter Rate .....	79
Medicaid Cost Sharing .....	80
<b>Tribal Clinics</b>	<b>82</b>
What is a Tribal Clinic?.....	82
Enrolling a Tribal Clinic.....	82
Enrolling a Dispensing Provider .....	82
Tribal Clinic Services .....	83
Billing for Tribal Clinic Services.....	86
Billing for Dispensing Services.....	88
<b>Health Professional Group</b>	<b>91</b>
Enrolling a Health Professional Group .....	91
<b>Behavioral Health Aides</b>	<b>92</b>
Enrolling a BHA .....	92
Enrollment Documentation .....	92
BHA Services .....	93
Billing for BHA Services .....	93
How BHAs are Paid.....	93
<b>Community Health Aides and Community Health Practitioners (CHA/Ps)</b>	<b>94</b>
Enrolling a CHA/P .....	94
Enrollment Documentation .....	94
CHA/P Services.....	95
Billing for CHA/P Services.....	95
How CHA/Ps are Paid .....	96
<b>Dental Health Aides (DHAs)</b>	<b>97</b>
Enrolling a DHA .....	97
DHA Services .....	97
Enhanced Dental Services for Adults .....	97



Billing for DHA Services .....	100
How DHAs are Paid .....	100

## **Tribal Outpatient Hospitals** **101**

---

What is a Tribal Outpatient Hospital? .....	101
Enrolling a Tribal Outpatient Hospital.....	101
Outpatient Hospital Services .....	101
Outpatient Hospital Services Requiring Service Authorization .....	104
Billing for Tribal Outpatient Hospital Services .....	104
How Tribal Outpatient Hospitals are Paid .....	106
Covered Revenue Codes for Tribal Outpatient Hospitals .....	107

## **Tribal Inpatient Hospitals** **108**

---

What is a Tribal Inpatient Hospital? .....	108
Enrolling a Tribal Inpatient Hospital.....	108
Inpatient Hospital Services .....	108
Inpatient Professional Services.....	108
Inpatient Hospital Services Requiring Service Authorization .....	112
Billing for Tribal Inpatient Hospital Services .....	114
How Tribal Inpatient Hospitals are Paid .....	116
Covered Revenue Codes for Tribal Inpatient Hospitals .....	117

## **Administrative Wait Beds** **118**

---

What is an Administrative Wait Bed? .....	118
Enrolling an Administrative Wait Bed.....	118
Administrative Wait Bed Services .....	119
Billing for Administrative Wait Bed Services .....	120
Long Term Care Authorization Form (LTC-01) Instructions .....	120
How Administrative Wait Beds are Paid.....	120
Administrative Wait Bed Revenue Codes and Descriptions .....	120

## **Swing Bed Providers** **123**

---

What is a Swing Bed? .....	123
Financial Considerations.....	123
Service/Staffing Requirements.....	123
Hospital Records Requirements .....	123
Federal Regulations for Swing Beds .....	124
Swing Beds Data Requirements .....	124
Enrolling a Swing Bed .....	124
Nursing Home Authorization and Reauthorization .....	125
Nursing Facility Responsibilities .....	125
Billing for Swing Bed Services.....	126
How Swing Beds are Paid.....	126
Swing Bed Revenue Codes and Descriptions .....	126

---

## **Long Term Care Facility** **129**

---

In-State LTC Facility Enrollment Requirements .....	129
LTC Admission Authorization .....	129
Level of Care Authorization .....	130
LTC Transfer Authorization .....	131
Transfer from Acute Care to LTC.....	131
Transfer from Non-Acute Care to LTC.....	131
Level of Care Transfer within Same Facility .....	131
Transfer from LTC to Other Facility .....	131
Discharge .....	132
Medicaid-Covered Services .....	132
Revenue Codes .....	132
Covered Days .....	132
Leaves of Absence.....	133
Claim Submission.....	133
All-Inclusive Pricing for LTC Services .....	133
Separately Payable Services .....	133
Recipient Cost of Care .....	134
Medicare Coverage Coordination .....	134
Change in Level of Care Claim Submission .....	135

---

## **Tribal Targeted Case Management Services** **136**

---

What is Tribal Targeted Case Management (TTCM)? .....	136
Case Manager Requirements .....	136
Enrolling a TTCM Services Provider .....	137
TTCM Services.....	137
Billing for TTCM Services .....	139
How TTCM Services are Paid.....	139

---

## **Service Authorization** **141**

---

Authorization from Conduent.....	141
Authorization for Behavioral Health Treatment .....	142
Authorization for Certain Maternal/Newborn Admissions .....	143
Authorization for Dental Services.....	143
Authorization for Durable Medical Equipment, Specialized Medical Equipment, and Other Medical Supplies .....	144
Authorization for Emergency Transportation/Medevac.....	146
Authorization for Home Health Services .....	146
Authorization for Non-Emergent Transportation and Accommodation .....	147
Authorization for Professional/Outpatient or Surgical Services .....	150
Authorization from the Division of Senior and Disability Services.....	151
Authorization from Magellan Medicaid Administration (MMA) .....	151
Authorization for Prescribed Medications .....	151
Authorization from Qualis Health.....	152
Authorization for Select Diagnoses and Procedures .....	152
Authorization for Acute Care Inpatient Continued Stays .....	152
Authorization for Inpatient Psychiatric Stays.....	153
Authorization for Outpatient Imaging Services.....	153

---

**Billing Third-Party Liability** 154

---

Attaching Insurance Benefit Booklet Pages .....	154
Non-covered Medicare HCPCS Codes .....	154
Payer of Last Resort.....	154

---

**Quick Reference** 157

---

How to Get Help .....	157
Services Not Covered by Alaska Medical Assistance .....	157
How to Get a Service Authorization .....	163
Determining the Correct Claim Form to Use .....	164
What to Attach to a Claim.....	164

---

**Administrative Information** 167

---

Regulations and Restrictions.....	167
Discriminatory Practices.....	167
Payment Error Rate Measurement (PERM) .....	167
Medicaid Provider Fraud Control Unit.....	168
Surveillance and Utilization Review Subsystem (SURS) .....	169
Definition .....	169
Administration .....	170
Fraud and Abuse Defined .....	170
Measuring Program Integrity.....	172
Penalty to Recipient: Restriction .....	175
Penalty to Provider: Sanctions.....	175

---

**Forms** 180

---

CMS-1500 Claim Form .....	181
UB-04 Claim Form .....	182
ADA Dental Form .....	183
Service Authorization Request Form .....	184
Certificate of Medical Necessity .....	185
Certificate to Request Funds for Abortion.....	187
Update Provider Information Request Form .....	188
Sterilization Consent Form.....	189
Hysterectomy Consent Form .....	190
Completing the Hysterectomy Consent Form .....	192
Electronic Claims Attachment Transmittal Form .....	193
Provider Appeals Form .....	194
Long Term Care Facility Authorization Forms .....	195
Healthcare forms Order Request .....	205
Adjustment/Void Request Form .....	206

<b>Glossary of Terms</b>	<b>207</b>
<b>Appendices</b>	<b>219</b>
<b>Appendix A</b>	<b>220</b>
Alaska Medicaid Abbreviations .....	220
<b>Appendix B</b>	<b>224</b>
Directory Assistance for the State of Alaska .....	224
<b>Appendix C</b>	<b>230</b>
Web Addresses .....	230
<b>Appendix D</b>	<b>234</b>
Julian Calendar.....	234
<b>Appendix E</b>	<b>236</b>
Care Management Program .....	236
Purpose .....	236
Background .....	236
Selection of Care Management Program Participants .....	236
Notification to Care Management Program Providers .....	236
Notification to Selected Recipients .....	237
Duration.....	237
Coupons for Care Management Program Recipients .....	237
Care Management Provider Exceptions .....	237
Coordination and Contact .....	238
<b>Appendix F</b>	<b>240</b>
Hospital Revenue Codes.....	240
<b>Appendix G</b>	<b>258</b>
BHA CPT and HCPCS Codes.....	258
<b>Appendix H</b>	<b>260</b>
CHA/P CPT, CDT, and HCPCS Codes.....	260
<b>Appendix I</b>	<b>267</b>
Prior Authorization Table for Prescription Drugs.....	267
Alaska Medicaid Prior-authorized Medications .....	267

**Appendix K**

**269**

---

Tribal Transportation Service Areas.....	269
ANTHC Prior Authorization .....	269
TCC Prior Authorization .....	269
YKHC Prior Authorization.....	269
Tribal Transportation Service Areas .....	270
Tribal Transportation Service Areas .....	275



# How to Get Help



Other phone numbers or addresses that you might need are included in [Appendix B](#).

If you have any questions or problems, you may contact the Tribal Organization Coordinator. This coordinator is a central point-of-contact for claims issues who will work with you to resolve problems and answer any questions you might have.

**Phone:** 907.644.6805 or 800.770.5650 (toll-free in Alaska)

**Fax:** 907.644.8130

**Address:** P.O. Box 240649, Anchorage, AK 99524-0649

When you call the coordinator, please make sure that you have all materials related to the call readily available.



For example, have ready your remittance advice, claim forms, recipient's Medical Assistance identification number, and the Medicaid Contract ID number of the provider you are calling about.

Updated 09/19/2019

# 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.

This manual includes information about Alaska Medical Assistance for the following types of providers and services:

- Tribal Clinics
- Behavioral Health Aides (BHAs)
- Community Health Aides/Community Health Practitioners (CHA/Ps)
- Health Professional Groups
- Dental Health Aides (DHAs)/Dental Health Therapists
- Tribal Outpatient Hospitals
- Tribal Inpatient Hospitals
- Swing Bed and Administrative Wait Bed Facilities
- Tribal Targeted Case Management Services for American Indians and Alaska Natives
- Telemedicine

This manual is organized into sections that contain:

- General provider information that applies to all provider types
- Information specific to each provider type
  - Service authorization
  - Third party billing
- Reference materials including contact information, applicable regulations, and forms

Updates to this manual will be necessary from time to time as federal and state medical assistance policies and regulations are adopted. As updates are made, each affected segment of the manual will be annotated with the date of the change. You will be informed of these updates by remittance advice messages, letters, and other means of communication.



# Common Provider Information

## 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 25 percent of Alaska's residents.

Updated 06/08/2018

## Why Tribes in Alaska Have Their Own Billing Manual

Healthcare funding for American Indian and Alaska Native (AI/AN) people began in 1910 when the Bureau of Indian Affairs was funded to provide healthcare services to this population. Healthcare responsibility was transferred to the U.S. Public Health Service in 1955 and became the Indian Health Service (IHS). The Indian Self Determination and Education Assistance Act (ISDEAA) passed in 1975 empowered tribes to take over the operations of federally funded programs.

Congress authorized Medicaid reimbursement to states for payment to IHS and tribal facilities operating health programs under self-determination agreements at 100 percent federal funds. Rates for inpatient and outpatient services are negotiated among federal agencies (IHS, CMS and The Office of Management and Budget (OMB)) and published in the federal register as payment amounts for each calendar year for Medicare and Medicaid.

In 1976, congress passed the Indian Health Care Improvement Act (IHCIA) to give initial authorization for IHS and Tribal Health programs to bill Medicare/Medicaid.

The Indian Health Care Improvement Act (IHCIA), amended Titles XVIII and XIX of the Social Security Act making it possible for Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) to pay the IHS for the Medicare and Medicaid services provided to AI/AN beneficiaries.

Medicaid is financed by both the federal and state governments. The Federal Medical Assistance Percentage (FMAP) is the proportion paid by the federal government and the remainder is the match paid by the state. In Alaska, the state match for most Medicaid programs is about 50 percent. However, for services provided to AI/AN Medicaid enrollees by Tribal health programs the state match is zero. In other words, the federal share, or FMAP, is 100 percent. The 100 percent FMAP exists because Indian health care is a recognized federal trust responsibility.

Specific exceptions to health policy standards enacted for the IHS and tribes under the authority of the IHCIA include:

- Exemption from state health facility licensing under Medicaid contained in federal regulations. Standards adopted under the IHS include certification by the Joint Commission of Healthcare Organizations (JCAHO) for healthcare facilities operated by the IHS and tribes.
- Exemption from state professional licensure of individual healthcare practitioners who are commissioned officers under the Public Health Service Act.
- The IHS and tribes funded through IHS are considered the payer of last resort, and eligibility for healthcare services through IHS funded programs is not considered "insurance."

- Limitation of patients seen at IHS and Tribal health facilities to program beneficiaries is not considered discrimination under the Civil Rights Act (IHS and tribes are permitted to see non-beneficiary patients as long as funding appropriated for the healthcare of American Indian and Alaska Native peoples is not diverted to them; tribes specify in their annual funding agreement with the IHS if they will see non-beneficiary patients).
- The IHS and tribes may not charge a beneficiary for most healthcare services they render. Medicaid covered services rendered to beneficiaries seen at an IHS facility are exempt from copays/coinsurance.

Updated 06/08/2018

## Alaska Department of Health and Social Services

The following divisions of DHSS play key roles in the administration of Medical Assistance in Alaska.

- The Division of Public Assistance (DPA) determines Alaska Medical Assistance eligibility.
- The Division of Senior and Disabilities Services (DSDS) administers the following Medicaid programs:
  - Personal Care Assistant
  - Long-Term Care
  - Home and Community-Based Waiver
- The Division of Behavioral Health Services (DBH) administers the following Medicaid programs:
  - Community Mental Health Clinic
  - Day Treatment
  - Inpatient Psychiatric Hospital
  - Mental Health Physician Clinic
  - Residential Psychiatric Treatment Centers
  - Substance Abuse
- The Division of Public Health (DPH) administers Women's, Children's and Family Health
- The Division of Health Care Services (DHCS) administers the remaining programs:
  - Advanced Nurse Practitioner-Nurse Midwife
  - Ambulatory Surgery
  - Chiropractic
  - Dental
  - Direct-Entry Midwife
  - EPSDT (Early and Periodic Screening, Diagnosis, and Treatment)
  - ESRD (End Stage Renal Disease)
  - Family Planning
  - FQHC (Federally Qualified Health Centers)
  - Hearing
  - Home Health
  - Hospice
  - Inpatient Psychiatric Hospital
  - Inpatient-Outpatient Hospital
  - Nutrition
  - Outpatient Therapies
  - Pharmacy

- Physicians
- Podiatry
- Private-Duty Nurse
- School-Based Services
- Transportation and Accommodation
- Tribal Health Program
- Vision
- X-Ray

Updated 06/08/2018

## Medical Assistance Contractors

### Conduent

The Alaska Department of Health and Social Services (DHSS) contracts with Conduent to serve as its Medicaid 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
- First level appeals
- Enrollment of new providers and maintenance of existing provider enrollment records
- Service authorization (SA) for transportation, dental, and other specified services
- Provider communication and outreach
- Provider training and billing manuals
- Recipient eligibility verification
- Provider inquiry/problem resolution

Refer to the [Contact Us](#) page in Health Enterprise for Conduent mailing addresses, phone numbers, and fax numbers.

Updated 06/08/2018

### Magellan Medicaid Administration

Magellan Medicaid Administration provides pharmacy benefits administration for Alaska Medical Assistance. Magellan processes electronic Point-of-Sale (POS) system pharmacy claims and provides member 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) at 800.331.4475 for the Managed Access Program, and a [Technical Call Center](#) for provider assistance.

Updated 06/08/2018

## Qualis Health

Serving as Alaska Medicaid's Quality Improvement Organization (QIO), Qualis Health provides health utilization management/service authorization for:

- Selected 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 level of care application and renewal

Updated 06/08/2018

## Rochester Optical

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

Updated 06/08/2018

## Provider Communication and Training

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

- Remittance advice (RA) messages (see additional information in [Receiving and Reconciling Remittance Advice](#))
- E-mail correspondence
- Monthly provider newsletters
- Provider flyers
- Provider training seminars
- RSS
- State letters
- Website updates
- Written correspondence

For information, questions or suggestions about the provider billing manuals, other correspondence, or provider training, contact Conduent or the Division of Health Care Services. Correspondence information is available on the Alaska Medicaid website at <http://medicaidalaska.com> (select Contact Us).

Updated 06/08/2018

## Provider Inquiry

Conduent trains its staff to respond to a wide array of provider inquiries, and strives to answer provider calls immediately. For successful telephone inquiries, please remember the following:

Guidelines to Efficient Telephone Inquiries	
1.	Review the provider billing manual and bulletins before calling.
2.	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 Unit, be sure to have handy the dates of travel, Transportation and Authorization Invoice, and Service Authorization number if calling for changes.
3.	Have the provider's Medical Assistance identification number available.
4.	Limit the length of the call. Provider Services personnel will help the provider until the problem is resolved or until it appears that a written inquiry is necessary to resolve the problem.
5.	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 06/08/2018

## Provider Training

Through its fiscal agent, Conduent, Alaska Medical Assistance offers a wide variety of training to help new providers and their staff establish a solid foundation in Medicaid billing procedures, and experienced provider's employees can benefit from these trainings as well, both to refresh their knowledge and to keep them abreast of recent changes in Medicaid policies and procedures.

All provider training is free of charge. Training schedules are located at <http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm>. Log in to see specific class details for each training location. Conduent offers provider training sessions in a variety of locations, including web-based presentations, to meet everyone's need.

Updated 04/10/2017

# Program Participation Requirements and Responsibilities for Providers

## The Provider Agreement

The provider agreement is a contract between the provider and the Alaska Department of Health and Social Services. When a provider signs the provider agreement and provides medical or medically-related

services to recipients and bills Alaska Medical Assistance for those services, the provider agrees that he or she will:

- Comply with applicable state and federal laws related to providing medical or medically related services to Alaska Medical Assistance recipients in this state, including laws related to recipient confidentiality, electronic transactions, and civil rights.  
**NOTE:** While Alaska Medical Assistance will make every effort to maintain current provider billing manuals, it is the provider's responsibility to comply with any laws enacted after a billing manual published date, and thereby not included in the manual.
- Cooperate in reports, reviews, surveys, or audits conducted by the Department of Health and Social Services (DHSS).
- Retain records necessary to disclose fully to Medical Assistance representatives the extent of services provided to recipients.
- Allow inspection of the provider's records, including desk and on-site review, by authorized representatives of state and federal Medicaid agencies.
- Allow Alaska Medical Assistance to take action to recover an overpayment.
- Follow policies and procedures in the current applicable provider billing manual.

Updated 06/04/2013

## Documentation and Records Storage

All providers must keep all records necessary to support the care and services for which they bill to Alaska Medical Assistance. Providers must retain those records for at least **seven years** from the date services were provided. Complete and accurate records must 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 Medical Assistance 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.

Updated 06/04/2013

## Request for Records

Providers must provide records when requested by the Department of Health and Social Services or its representative, an authorized federal representative, or another authorized representative, including an employee of the Department of Law. Providers must 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 06/04/2013

## Medicaid Electronic Health Records Incentive Program

As a result of the American Recovery and Reinvestment Act of 2009, incentive payments are available to eligible professionals who have adopted, implemented, or upgraded to a certified electronic health records

(EHR) system to be used in a meaningful manner. Eligible professionals include physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants.

Eligible providers must have a 30 percent Alaska Medical Assistance patient volume threshold to be eligible for the program, unless they are a pediatric physician who may have a 20 percent Alaska Medical Assistance patient volume. Providers must also meet meaningful use measures. Providers may receive incentive payments as high as \$63,750 over six years.

Program year 2016 was the last year a provider could begin participating in the program. Program year 2021 is the last year Medicaid incentive payments will be issued.

Providers can find more information and links to the Centers for Medicare and Medicaid Services (CMS) Registration and Attestation website and the Alaska State Level Registry (SLR) at:  
<http://ak.ara incentive.com>.

Updated 06/08/2018

# Provider Enrollment

## 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.

Type 1 NPIs are issued only to individuals, (i.e., physicians, nurse practitioners, dentists, and therapists). Type 2 NPIs are used by 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/>.

For more information regarding NPIs, please visit <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>.

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@npienumerator.com](mailto:customerservice@npienumerator.com)

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

By mail: NPI Enumerator  
P.O. Box 6059  
Fargo, ND 58108-6059

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## Eligible Provider Types

Most healthcare, transportation, accommodations, and medical equipment providers are eligible to enroll in the Alaska Medical Assistance Program. When enrollment criteria are met, the following providers are eligible. Some restrictions may apply. This listing is **not** all-inclusive but is excerpted from Chapters 105-160 and Chapter 48 of the *State of Alaska Administrative Code*, the *State of Alaska Medicaid Manual*, and the *Medicaid Eligibility Manual*.

### Behavioral Health

- Community mental health clinic
- Day treatment facility
- Mental health physician clinic
- Psychologist, Individual and Group
- Substance abuse treatment center

### General Medical

- Advanced nurse practitioner, Group
- \*Audiologist
- \*Certified Nurse Midwife
- Chiropractor, Individual and Group
- Dentist, Individual and Group
- Dental Health Aide (DHA)
- Dietitian, Individual and Group
- Direct-entry midwife
- Hearing aid dealer
- Nurse anesthetist
- Nutritionist, Individual and Group
- \*Occupational therapist, Individual
- \*Optometrist, Individual
- Optician, Vision Group
- Personal Care Assistants
- \*Physical therapist, Individual
- \*Physician, Individual and Group
- \*Physician assistant Group
- \*Podiatrist, Individual and Group
- Respiratory therapist
- \*Speech pathologist, Individual

### Health Professional Group

- Behavioral Health Aide (BHA)
- Community Health Aides & Practitioners (CHA/P)

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\* These provider types can be part of a tribal clinic.



### **Home and Community-Based Waiver Services Providers**

- Care coordination agency
- Environmental modification provider
- Home and community-based agency
- Residential supported living facility (adult foster care/adult residential care)

### **Hospitals**

- Administrative Wait Bed provider
- Ambulatory Surgical Care facility
- Inpatient acute care hospital
- Inpatient psychiatric acute care hospital
- Outpatient hospital
- Residential Psychiatric Treatment Center (RPTC)
- Swing Bed provider
- Tribal inpatient/outpatient hospital

### **Long Term Care Facilities**

- Intermediate Care Facility (ICF)
- Intermediate Care Facility/ Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD)
- Skilled Nursing Facility (SNF)

### **Other Facilities/Clinics**

- End Stage Renal Disease (ESRD) dialysis facility
- Federally Qualified Health Center (FQHC)
- Home health agency (includes RN, LPN, nurse aide, physical therapist, occupational therapist, and speech pathologist)
- Hospice
- Independent laboratory
- Indian Health Service (IHS)/tribal clinic
- Outpatient physical therapy/Speech pathology center (includes occupational therapist, physical therapist, and speech pathologist)
- Personal care agency
  - Agency-based
  - Consumer-directed
- Private duty nursing agency (includes RN and LPN)
- Rural Health Clinic (RHC)
- Tribal Clinic

### **Transportation/Accommodation Providers**

- Airline
- Ambulance, air and ground
- Ferry
- Hotel/Motel with or without restaurant

- Railroad
- Taxi
- Travel agency
- Wheelchair van
- Pre-maternal home

#### Other

- Durable medical equipment (DME) supplier (includes respiratory therapist and respiratory therapy technician)
- Early and Periodic Screening Diagnosis and Treatment (EPSDT). (Includes public health agency, public health nurse, RN, and LPN.)
- Pharmacy
- Portable X-ray provider
- Prosthetics and orthotics supplier
- School-based services
- Targeted Case Management for the Infant Learning Program
- Tribal Targeted Case Management

### Ineligible Providers

The services of the following professionals are **not** currently covered under the Alaska Medical Assistance Program:

- Christian Science practitioners
- Theological healers
- Naturopaths
- Registered Nurses
- Any other licensed or unlicensed practitioner not otherwise specified in Chapter 105-160 and Chapter 48 of the *State of Alaska Administrative Code*, the *State of Alaska Medicaid Manual*, and the *Medicaid Eligibility Manual*

Updated 06/08/2018

## Enrollment Requirements for Tribal Health Providers

For a Tribal provider to be paid for services by Alaska Medical Assistance, healthcare professionals providing medical services must meet the following license and certification requirements.



Licensed health professionals employed by a tribal health program do not have to provide an Alaska occupational license. However, these professionals must provide proof that they are licensed by another state or territory of the United States.

- **Physicians** (medical doctor or doctor of osteopathy)  
Current occupational license from the Alaska Division of Occupational Licensing
- **Physician Assistants**  
Current occupational license from the Alaska Division of Occupational Licensing

- **Advanced Nurse Practitioners**  
Current occupational license as a nurse practitioner from the Alaska Division of Occupational Licensing
- **Certified Nurse Midwives**  
Current occupational license as a nurse midwife from the Alaska Division of Occupational Licensing
- **Podiatrists**  
Current occupational license as a podiatrist from the Alaska Division of Occupational Licensing
- **Occupational Therapists**  
Current occupational license as an occupational therapist from the Alaska Division of Occupational Licensing
- **Physical Therapists**  
Current occupational license as a physical therapist from the Alaska Division of Occupational Licensing
- **Speech Pathologists**  
Current occupational license as a speech pathologist from the Alaska Division of Occupational Licensing
- **Audiologists**  
Current occupational license as an audiologist from the Alaska Division of Occupational Licensing
- **Optometrists**  
Current occupational license as an optometrist from the Alaska Division of Occupational Licensing
- **Community Health Aide**  
Current certification with the Community Health Aide Program Certification Board
- **Behavioral Health Aide**  
Current certification with the Community Health Aide Program Certification Board
- **Dental Health Aide**  
Current certification with the Community Health Aide Program Certification Board

## Required Enrollment Documents

Providers must submit the following documents to enroll in Alaska Medical Assistance:

- If a facility or clinic is requesting a new enrollment for a new facility/clinic or purchase of another facility/clinic, they are required to be listed on the IHS facility list. Notify your local IHS representative.
- New or changing facility/clinic enrollments are required to notify the DHSS Tribal staff within 90 days of requested enrollment effective dates.
- If the facility or provider will be performing laboratory services, a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or certificate of registration.
- Alaska Medical Assistance requires a hardcopy of your National Plan and Provider Enumeration System (NPPES) notification letter for submission with your provider enrollment application.
- Any other required documentation for the provider type being enrolled, such as licenses or certifications.



Tribal hospitals are not required to be licensed by the Alaska Department of Health and Social Services.

Tribal hospitals are exempt from state licensing requirements. Under agreement with the Indian Health Service, a tribal hospital maintains accreditation with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A tribal hospital is not required to obtain a food service permit from the Department of Environmental Conservation or a city, borough or municipality in the state. Tribal hospital food services are inspected by the Office of Environmental Health at the Alaska Area Office of the IHS.



There are 3 options for the enrollment of a Tribal outpatient hospital that results in different encounter rates depending on the services your facility chooses to bill separately.

- Outpatient hospital including physician and midlevel providers receive a full encounter rate
- Outpatient hospital excluding physicians only receive a reduced encounter rate but may bill physician services at fee for service
- Outpatient hospital excluding physicians and midlevel providers receive a further reduced encounter rate but may bill physician and midlevel services at fee for service

For more information regarding provider enrollment, refer to the Enrollment Computer-Based Training at <http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm>. When you have logged in, go to the Provider drop-down and click Enterprise. There are several computer-based trainings and quick reference guides available with information about enrolling.

## Out-of-State Provider Participation Requirements

Out-of-state providers must meet the licensing requirements of that state, and be enrolled in the Medicaid program in that state and in Alaska. Enrollment with Medical Assistance requires that proof of certification described above be on file with Conduent.

## Locum Tenens in Alaska

In Latin, locum tenens translates as “place holding” or, literally, “placeholder.” As a locum tenens in Alaska, you play an important role in covering gaps in medical delivery - particularly in rural areas. Your assignment might be to cover a vacationing physician assistant or to bolster a small clinic in the summer to help handle an influx of tourists and seasonal workers. Each locum tenens that may enroll with Alaska Medical Assistance must do so. For more details please refer to the Alaska Administrative Code regulating provider enrollment, 7 AAC 105.210 (c).

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

- Be enrolled in Alaska Medical Assistance.
- Obtain a license or permit through Alaska's Occupational Licensing (except those working in the Indian Health System).
- Submit claims using the NPI and supporting information issued for the tribal clinic where the service was provided.

Occupational licensing rules dictate that the duration of the locum tenens permit is **90** days. A one-time extension of **60** days may be obtained.

Alaska permits only medical and osteopathic physicians, chiropractors, physician assistants, nurse practitioners, certified nurse anesthetists, and nurse midwives to be locum tenens. Plan ahead, as the application processing time is typically eight weeks after receipt of the application by the Alaska State Medical Board.



**Note:** Not all locum tenens services are billable under the tribal clinic provider type. Refer to the Tribal Clinic list of approved services. If the locum tenens is not included on the list of Tribal clinic approved services, they may be billable through a Health Professional Group.

## Itinerate Providers

All services rendered by the permanent healthcare professionals at that location should be billed under the clinic NPI. Itinerate providers who are not permanently employed by or in contract with a tribal organization may not bill under the tribal clinic NPI and taxonomy. Below are the guidelines on how itinerate provider services may be billed:

- An itinerate provider who is not employed by or under contract with the tribal organization will bill Alaska Medical Assistance using the NPI connected to their medical group. The tribal clinic will not be paid for this service unless another covered clinic service is provided to the patient on the same day.
- The services of an itinerate provider from a different tribal hospital or clinic will be billed under the tribal hospital or clinic ID number where they are employed unless there is an agreement in place.
- The services of an itinerate provider from a tribal hospital will be billed according to the agreement between the tribal organization and the hospital. Details of the billing are dependent on the provisions of the agreement, but are subject to Alaska Medical Assistance billing rules.
- Provider types that are not billable under the tribal clinic are billed according to the enrollment and billing standards for the category of services provided.

Updated 06/08/2018

## Individual Enrollment of Providers in a Tribal Facility is Required

If an employed provider is eligible as an Alaska Medical Assistance provider, they will need to be affiliated to each location they provide services at. This may result in multiple affiliations to distinct clinic locations and/or health professional groups.

Providers must meet the license/certification requirements in order for the clinic to be reimbursed by Alaska Medical Assistance for medical services provided to recipients. Refer to [Required Enrollment Documents](#).

Providers will need to enroll in Alaska Medical Assistance individually and separately from the tribal facility. To enroll providers separately, providers must submit their application using the Provider Enrollment Web Portal at <https://medicaidalaska.com/portals/wps/portal/ProviderEnrollment> and attach proof that the provider has the required licenses or certificates to the completed application. Refer to [How to Enroll](#) below.

Ensure that enrolled providers are cross-referenced to the enrolled clinic they intend to bill for provision of services.

## How to Enroll

Follow these steps to enroll in Alaska Medical Assistance:

1. Make sure the facility or provider meets all the requirements.
2. Enroll by accessing the Conduent Provider Enrollment Web Portal at <https://medicaidalaska.com/portals/wps/portal/ProviderEnrollment>.
  - Call the Provider Enrollment Unit at 907.644.6800 or 800.770.5650 (toll-free in Alaska) for more information.
  - Access the Enrollment Computer Based Training at <http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm>.
3. After your enrollment has been approved, Conduent will send you a welcome packet.
4. Once you have your welcome packet and NPI, you can start billing Alaska Medical Assistance for services.

Your Requested Enrollment Begin Date is the date that you want the enrollment to be effective, which may be up to one year before the date that the enrollment application is received by Conduent.



### Example

If Conduent received your enrollment application on February 1, 2015 requesting that enrollment begin as of February 1, 2014 and your request is approved, you can bill Alaska Medical Assistance for services provided on or after February 1, 2014.

If you are requesting retroactive enrollment and have some claims for services that are close to the timely filing limits (12 months from the date of service), you can attach these claims to the enrollment application so that they will meet timely filing requirements.

Updated 06/08/2018

## Provider Enrollment Portal

The Provider Enrollment portal is an innovative online tool that makes it easier for new providers to enroll in the Alaska Medical Assistance Program. Providers can begin the process by visiting <https://medicaidalaska.com> then choosing Enrollment from the Provider drop-down. The secure website is accessible 24 hours a day, 7 days a week and includes links to Frequently Asked Questions and learning material that can help provide information needed to complete enrollment. If you have any provider enrollment questions, contact Provider Enrollment at 907.644.6800, option 2 or 800.770.5650 (toll-free), option 1, 3.

For more information regarding provider enrollment, refer to the Enrollment Computer-Based Training at <http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm>. When you have logged in, go to the Provider drop-down and click Enterprise. There are several computer-based trainings and quick reference guides available with information about enrolling.

Provider Enrollment is available only to new providers at this time. You are considered a new provider if you meet one of the following conditions:

- You have never been enrolled in the Alaska Medical Assistance Program.
- You are currently enrolled but are now enrolling as a different type of provider.
- You are currently enrolled but are using a different Tax ID.

When a provider enrollment application is approved, Conduent will send a Welcome to Medicaid letter that contains your new Alaska Medicaid Provider ID and any affiliated group information. A second letter is sent separately containing your AVRS PIN. If a provider requests Alaska Medicaid Health Enterprise access during their enrollment, their Enterprise username and a time sensitive one-time use password will be included in the second letter. Providers must log in and change the password before the password expires.

### Alaska Medicaid Provider ID:

A unique 7-digit identifying number which Alaska Medical Assistance uses to identify the provider's enrollment record. Providers receive a Provider ID when they enroll in Alaska Medical Assistance. The enrollment record contains pertinent information about the provider's participation with Alaska Medical Assistance, as well as unique provider information such as license number, SSN, NPI, taxonomy code, DEA number, CLIA #, etc. This record must reflect the provider's participation in good standing on the claim date of service, otherwise the claim will deny.



Use the Medicaid Provider ID in all correspondence with Conduent.

### NPI:

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identifier for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit identifier). "Intelligence-free" means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

Updated 04/10/2017

## Reporting Changes in Enrollment to Alaska Medical Assistance

Providers must inform Alaska Medical Assistance in writing, with an original signature, (faxing is not acceptable) of any change in their enrollment by completing the Update Provider Information Request located at <http://manuals.medicaidalaska.com/docs/enrollmentforms.htm>; this ensures accuracy in completing changes as requested.



Alaska Medical Assistance will not make any changes based on oral requests.

Conduent's Provider Enrollment 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
- Participation in Alaska's medical assistance programs
- Medicare provider identification number

Updated 06/08/2018

# Member Eligibility

## Confirming Member Eligibility

Alaska Medical Assistance will reimburse providers only for covered services provided to someone who is eligible for Medical Assistance on the date the services are provided. Therefore, before providing services, you should check the following information:

- Whether the patient is eligible for Alaska Medical Assistance
- Patient's age (and whether the service(s) being provided is(are) covered for someone of that age)
- Whether the patient is eligible under Medical Assistance for the service(s) being provided (Refer to [Eligibility Codes](#) later in this section for a list of which recipient eligibility codes are able to receive services at tribal locations.)
- Whether Medical Assistance covers the service(s) being provided

Updated 12/03/2015

## How to Confirm Member Eligibility

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 Enterprise 270/271 Companion Guide available at <http://manuals.medicaidalaska.com/docs/companionguides.htm>.
- Call the Automated Voice Response System (AVRS) at 855.329.8986.
- Request to see and photocopy the member'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 at 907.644.8126 using one of the Recipient Eligibility Inquiry Forms available at <http://manuals.medicaidalaska.com/docs/forms.htm>.
- Call the Provider Inquiry Unit at 907.644.6800, option 1, 2, or toll-free in Alaska at 800.770.5650, option 1, 1, 2.



1. Member Name
2. Member ID
3. Date of Birth
4. Eligibility Code
5. Eligibility Month/Year
6. Resource Code

**Sample**

NAME: 1  
ID #: 2  
DOB: 3  
ELIG CODE: 4  
COVERAGE EFFECTIVE DATES: 5  
RESOURCE CODE: 6

**DenaliCare**

This card is not a guarantee of coverage or eligibility. Providers must verify eligibility before providing services. State of Alaska, Department of Health and Social Services

**DENALI**

NAME: 1  
ID #: 2  
DATE OF BIRTH: 3  
ELIG CODE: 4  
COVERAGE EFFECTIVE DATES: 5  
RESOURCE CODE: 6

**SAMPLE**

**DenaliCare**

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/](http://www.hss.state.ak.us/dhcs/DenaliKidCare/)

Xerox  
P.O. Box 240808  
Anchorage, Alaska 99524-0808

**DIVISION OF PUBLIC ASSISTANCE  
DEPARTMENT OF  
HEALTH AND SOCIAL SERVICES**

**STATE OF ALASKA**

Office Contact: Phone: (907) 644-6842  
(800) 770-5650 Toll-Free

Case Number: 30000000  
Case Name: Jane E Doe  
Document #: 12345678  
Date: 04/09/2015

Jane E Doe  
123 Main Street  
Somewhere, Alaska 99009

**Care Management Program Coupon**

Dear Jane E Doe,

Who is eligible for medical assistance benefits?							
Dates	Who is eligible?	Date Of Birth	Gender	Client ID	TPL Code	Elig. Code	Type of Assistance
04/01/2015 to 04/30/2015	JANE E DOE	01/01/1990	Female	600012345	P	20	Denali Care Parent Caretaker

MEMC MEDICAL MANUAL COUPON ISSUANCE 112501 14:48 RAINTRAIN M

RECIPIENT I.D.	RECIPIENT NAME	D.O.B. MM DD YY	SEX	RACE	ELIG CODE	PGM/ RE-MEDSB	SOURCE(S)
2000123456	DOE JOHN	04 27 45	M	BL	25	ME DE Y	

JOHN DOE  
123 MAIN STREET  
FAIRBANKS AK 99709

\*\*\*\*\*  
\*THIS AUTHORIZATION GOOD FOR\*  
\* BENEFIT MONTH 1201 ONLY! \*  
\*\*\*\*\*

SPECIAL INFORMATION (OPTIONAL) AUTHORIZATION LIMITED TO DISABILITY EXAM BY A LICENSED PHYSICIAN OR PSYCHIATRIST, WAIVER DETERMINATION BY CARE COORDINATION AGENCY, AND RELATED TRANSPORTATION APPROVED BY XEROX.

AUTHORIZATION SIGNATURE: *Signature Required* DOCUMENT# FXXXXXX  
DIVISION OF PUBLIC ASSISTANCE ISSUANCE INDICATOR:

## Using the Automated Voice Response System

The Automated Voice Response System (AVRS) for member eligibility verification is available 24 hours a day, seven days a week by calling **855.329.8986**. In the enrollment welcome letter, 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

Training for the AVRS is available at <http://manuals.medicaidalaska.com/docs/akmedicaidtraining.htm>. The applicable training courses are titled *AVR Overview* and *Change Your AVR Pin*. Providers can print the *Enterprise Quick Reference - AVR*, located on the right side of the page, for quick reference.

Updated 06/08/2018

## Eligibility Codes

Code	Code Description	Tribal Clinic/CHA/Ps	DHAs	BHAs	Tribal Inpatient Hospital	Tribal Outpatient Hospital
11	Pregnant women (Alaska Healthy Baby program)	X	X	X	X	X
19	Waiver determination	X		X		
20	No other eligibility codes apply	X	X	X	X	X
21	Chronic and Acute Medical Assistance (CAMA) coverage only (refer to <a href="#">Chronic and Acute Medical Assistance (CAMA) Services</a> restrictions in the Tribal Clinics Section)	X (Non-IHS beneficiaries only)		X (Non-IHS beneficiaries only)		X (Non-IHS beneficiaries only)
24	LTC (300%) Institutionalized	X	X	X	X	X
25	Disability/Blindness/Waiver Determination	X				
30	Adults with Physical and Developmental Disabilities (APDD) Waiver – Special LTC	X	X	X	X	X
31	APDD Waiver	X	X	X	X	X
34	APDD Waiver – Adult public Assistance (APA)/Qualified Medicare Beneficiary (QMB) Eligible	X	X	X	X	X
40	Alaskans Living Independently (ALI) Waiver – Special LTC	X	X	X	X	X
41	ALI Waiver	X	X	X	X	X
44	ALI Waiver – APA/QMB	X	X	X	X	X

Code	Code Description	Tribal Clinic/ CHA/Ps	DHAs	BHAs	Tribal Inpatient Hospital	Tribal Outpatient Hospital
50	Child under 21 and not in state custody (including subsidized adoptions)	X	X	X	X	X
51	Child under 21 and in state custody (including Title IV-E Foster Care)	X	X	X	X	X
52	4-month Post-MAGI Medicaid eligibility (increased spousal support)	X	X	X	X	X
53	Ineligible Alien Emergency Coverage	X			X	X
54	Supplemental Security Income (SSI) Disabled Child	X	X	X	X	X
67	Medicare Premium Assistance – QMB Only Eligibility	X		X	X	X
68	Medicare Premium Assistance – Special Low Income Medicare Beneficiary Eligible Part B Payment Only	Medicare premiums only; not eligible for claim reimbursement.				
69	Medicare Premium Assistance – APA/QMB	X	X	X	X	X
70	Intellectual and developmental disabilities (IDD) Waiver	X	X	X	X	X
71	IDD Waiver	X	X	X	X	X
74	IDD Waiver – APA/QMB Eligible	X	X	X	X	X
78	Medicare Premium Assistance – SLMB Plus Eligible Part B Payment Only	Medicare premiums only; not eligible for claim reimbursement.				

Code	Code Description	Tribal Clinic/CHA/Ps	DHAs	BHAs	Tribal Inpatient Hospital	Tribal Outpatient Hospital
80	Children with Complex Medical Conditions (CCMC) Waiver	X	X	Z	X	X
81	CCMC Waiver	X	X	X	X	X
91	Individualized Supports Waiver (ISW) – Special LTC	X	X	X	X	X
92	ISW	X	X	X	X	X
93	ISW – Pregnant Woman	X	X	X	X	X
94	ISW – APA/QMB eligible	X	X	X	X	X

Updated 03/28/2019

## Eligibility Subtype Codes

Medicaid Subtype	Description
4M	Post-Medicaid due to excess spousal support
AF	Family Medicaid
AL	Emergency coverage for illegal alien
BA	Newborn - through month of 1st birthday (child born to a woman who was eligible for Medicaid in the month of delivery)
CP	CHIP, income above 177% FPL and equal to or less than 203% FPL, all ages, without insurance. Title 21 funding
EO	Eligible for MAGI Medicaid if not Institutionalized
FC	Title IV-E Foster Care child in State custody
FF	Former Foster Care Children under age 26
H1	Income above 159% FPL and equal to or less than 177% FPL, all ages, with insurance. Title 19 funding
H2	CHIP, income above 159% FPL and equal to or less than 177% FPL, all ages, without insurance. Title 21 funding
HC	Healthy Child income less than or equal to 159% FPL, age 0-5, with and without insurance. Title 19 funding
IP	Under 21 child in State custody & In-Patient Psychiatric
IV	Title IV-E Subsidized Adoption
JC	Juvenile Court Ordered Child in State custody

PB	Postpartum Coverage, income is equal to or less than 159% FPL
PC	Postpartum coverage, income is above 159% and equal to or less than 200% FPL. Title 19 funding.
PR	Pregnant Woman Coverage, income is equal to or less than 159% FPL.
PX	Pregnant Woman Coverage, income is above 159% and equal to or less than 200%. Title 19 funding
S1	Income is above 124% FPL and equal to or less than 159% FPL, ages 6-18, with Insurance. Title 19 funding
S2	CHIP, income is above 124% and equal to or less than 159%, ages 6-18 without insurance. Title 21 funding
SO	State-only (not IV-E) subsidized adoption (State custody)
SU	Six Up, income is equal to or less than 124% FPL, ages 6-18, with or without insurance. Title 19 funding
T1	Transitional Medicaid
TO	Under 21
VO	Child in voluntary state custody
<b>Expansion Medicaid Subtype</b>	<b>Description</b>
MX	Newly Eligible - Expansion
XP	Non-Newly Eligible
AL	Emergency Alien - Expansion
<b>Incarceration Medicaid Subtype</b>	<b>Description</b>
BI	Breast and Cervical Cancer
CI	DKC CHIP /Title 21 funding (Subtypes S2, H2, and CP)
EI	Emergency Alien
FI	Former Foster Care (in ARIES only)
KI	Pregnant Woman
NI	DKC non-CHIP/Title 19 funding (subtypes BA, HC, H1, SU)
TI	Under 21
MI	Newly Eligible - Expansion
XI	Non-Newly Eligible

Updated 06/08/2018

## The 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 using the [Care Management Referral Form](#).

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](#).

Updated 06/08/2018

# Performing Services

## Alaska Medicaid and Denali KidCare Services

The following services are covered for children and adults:

- |  |   |
|--|---|
| • Accommodations for non-emergency medical care      | • Family planning   |
| • Advanced nurse practitioner services               | • Federally qualified health center                                       |
| • Ambulance  | • Hearing services  |
| • Ambulatory surgical care                           | • Home and community-based waiver services                                |
| • Anesthesia   | • Home health care  |
| • Dental care  | • Hospice   |
| • Durable medical equipment                          | • Hospital inpatient and outpatient                                       |
| • End Stage Renal Disease dialysis facility services | • Inpatient psychiatric services (recipients must be over 65 or under 21) |
|  | • Intermediate care facility (ICF) services                               |

- Intermediate Care Facility for Individuals with Intellectual and 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

Some services are only covered for children, defined as recipients less than 21 years of age. These include the following:

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

## Pharmacy

If you have a pharmacy onsite, staffed by a licensed pharmacist, the pharmacy must enroll separately to submit claims under the pharmacy Provider NPI and be reimbursed for non-incidentals drugs and drugs dispensed to patients as take-home drugs.

Pharmacists employed by tribal health programs do not need to be licensed in Alaska as long as they are licensed in another state.

If a pharmacy is not onsite and take-home drugs are dispensed, you may choose to enroll under two different options. You may enroll the tribal clinic as a Dispensing Clinic provider type or enroll one or more individual healthcare professionals (who can dispense within the scope of his or her license) as a dispensing provider. A dispensing fee will not be paid to a dispensing provider unless the provider is located more than 45 miles from a commercial pharmacy that is not a covered entity. Refer to [Enrolling a Dispensing Provider](#).

Drugs included in the encounter rate are those provided at the time of the visit at a clinic, outpatient facility or physician's office that are incidental to the visit such as infusion therapy drugs, prescription implants or Synagis; these are not to be billed separately.

Drugs not included in the encounter rate are maintenance drugs and drugs that require more than one dose, oral, topical, rectal, or ophthalmic, up to a 30-day supply. These include pain medications, antibiotics, antivirals, oral chemotherapy, antipsychotics, antiepileptics, birth control and antihypertensives.

Refer to the [Pharmacy Provider Billing Manual](#) for additional information.

## Prescribing Drugs

To control the rise in pharmacy costs, the Alaska Department of Health and Social Services implemented a Preferred Drug List (PDL). Drugs on the list have been determined to be clinically effective and cost efficient for Alaska Medical Assistance by the Pharmacy and Therapeutics (P&T) Committee (a group of appointed physicians and pharmacists).

The PDL will be updated periodically as the P&T Committee adds additional drugs to the list. Current information is available at <http://dhss.alaska.gov/dhcs/Pages/pdl/default.aspx>. If a healthcare provider is prescribing a drug not on the PDL, he/she should document the medical necessity for the non-preferred drug on the prescription and in the patient's chart.

Healthcare providers who have access to federal sources of supply — such as Indian Health Service funded programs, Federally Qualified Health Centers, and 330-funded community health centers - are not required to use the PDL. The Alaska Department of Health and Social Services will continue to reimburse you for drugs obtained via a federal contract. However, DHSS requests that you use the drugs on the PDL whenever possible.

## Tamper-Resistant Prescription Forms

As of April 1, 2008, all Alaska Medical Assistance covered prescriptions that are not submitted electronically (e-prescribing or facsimile) or orally must be written on tamper-resistant prescription forms.

These tamper-resistant prescription forms must contain the NPI for the prescribing provider and employ at least (1) one industry-recognized feature designed to prevent unauthorized copying of a completed prescription, (2) one industry-recognized feature designed to prevent erasure or modification of information written on the prescription, and (3) one industry-recognized feature designed to prevent the use of counterfeit prescription forms.

Many measures are available to prevent each of these types of prescription fraud. Methods to address the unauthorized copying of a completed prescription can include:

- High-security watermarks on the reverse side of blank prescriptions
- Thermochromic ink that changes color or disappears when warmed
- Security patterns
- Void pantographs
- Microprinting
- Prismatic printing
- Lenticular patterns
- Encodation schemes

Methods to address the erasure or modification of information written on the prescription, including tamper-resistant background ink that shows erasures or attempts to change written information:

- Toner anchorage - "anchoring" toner to paper to deter its removal
- Chemical stains used to reveal chemical eradication attempts against ink or toner
- Laid lines used to reveal cut-paste attempts on an item
- Chemical reactive inks used to reveal washing attacks
- Overcoatings, laminates, and varnishes used to secure written content on the item
- Erasable ink backgrounds used to reveal attempts at ink and toner removal
- Borders and fill characters used to complicate attempts to add on extra information
- On-item encodation techniques, bar codes, and patterns used to validate item content



Methods that will help prevent counterfeit prescription forms include:

- Serially numbered blanks
- Duplicate or triplicate blanks
- Thermochromic ink that changes color or disappears when warmed
- Color-shifting ink that changes color when viewed from different angles
- Security features and descriptions listed on the prescription

While employing at least one feature from each of the three categories, any one feature may not be used more than once for proof of tamper-resistance.

If a written prescription does not comply with these requirements, the Department of Health and Social Services may take measures to recoup the cost of the prescription claim.

For more details and exceptions to the tamper-resistant prescription requirements, refer to the Alaska Administrative Code specific to drug reimbursement, 7 AAC 120.110. To find the regulation, go to:

<http://www.legis.state.ak.us/basis/folioproxy.asp?url=http://www.jnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac>

Navigate the Alaska Administrative Code by clicking on the links in the following order:

1. Title 7 Health and Social Services
2. 8. Medicaid Coverage and Payment (7 AAC 105 - 7 AAC 165)
3. 120. Medicaid Coverage; Prescription Drugs and Medical Supplies; Durable Medical Equipment; Transportation Services (& AAC 120.100 – 7 AAC 120.490)
4. 1. Prescription Drugs and Medical Supplies. (7 AAC 120.100 - 7 AAC 120.140)
5. 110. Covered drugs and home infusion therapy

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

The goal of the EPSDT program, also known as the Alaska Well Child Program, is to ensure that all Medicaid and Denali KidCare eligible children receive the health care they need, when they need it. The EPSDT program's focus is on promoting the physical, mental, social, emotional and behavioral health. Services are available to all Medicaid/Denali KidCare eligible children under the age of 21.

Providers may submit billing on the CMS-1500 or electronically using an 837P electronic professional claim form. Additional EPSDT policy, coverage, reimbursement, and claim filing instructions are found in the [EPSDT Billing Manual](#).

## **Newborn Bloodspot Screening**

The Department of Health and Social Services (DHSS) requires that all babies born in Alaska receive a newborn bloodspot screening. The provider attending the birth of the baby is required to collect the sample within 48 hours of birth. A parent or guardian's refusal to allow the screening must be reported to the Division of Public Health (DPH).

The newborn bloodspot test (84030) is performed at a single laboratory designated by DHSS. The department will not reimburse for costs incurred by use of a non-designated laboratory for the testing of the specimen. Providers are charged a single fee per newborn, which includes all required specimens and repeat specimen collections necessary due to poor quality or abnormal results. The fee includes all costs associated with the screening (e.g., the specimen card, shipping and handling, laboratory fees). For

additional information about the Newborn Bloodspot Screening Program requirements, refer to the [Division of Public Health](#).

### **Births in a Hospital Setting**

Alaska Medicaid covers newborn bloodspot screening performed in a hospital through the hospital's prospective per diem rate. The hospital must include the screening as a line item on their inpatient claim using procedure code S3620. No additional reimbursement is allowed to the healthcare provider collecting the sample or for additional samples collected outside of the inpatient hospital setting. If the sample is not collected by the hospital, another healthcare provider may collect the sample outside of the hospital setting and be reimbursed for the newborn bloodspot screening.

### **Births Outside of a Hospital Setting**

For babies delivered outside of a hospital setting, tribal clinics and free-standing birth centers are reimbursed for the incidental service of a newborn bloodspot screenings (S3620) only if core service is part of the encounter. No additional reimbursement is allowed for the collection of the sample.

For additional information on the newborn bloodspot screening requirements, visit DPH's [Newborn Bloodspot Screening Program](#) webpage.

Updated 01/30/2019

## **Reproductive Health**

### **Abortion**

Tribal facilities are federally funded. Because federal funds may not be used for therapeutic abortions, tribal facilities may not be reimbursed for any services related to a therapeutic abortion, including emergency room visits, office visits, etc.

Services for spontaneous abortions, or miscarriages, are covered and are reimbursed to the tribal facilities.

### **Family Planning Services**

Covered family planning services include:

- Dispensing birth control drugs and devices to men and women
- Performing vasectomies, sterilizations, and treatment for spontaneous abortions
- Office visits for counseling services (see the fee schedules for appropriate covered codes)
- Laboratory services
- Prescription drugs

The following enrolled providers may render family planning services to eligible recipients:

- Physicians
- Advanced nurse practitioners
- Physician assistants
- Family planning clinics operated by the Alaska Department of Health and Social Services, a local government, or a private entity
- Educational institution's student health services

- Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

All providers who render family planning services and who operate their own laboratory must have a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or registration.

## Hysterectomy

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

The provider must obtain authorization from Qualis Health. Refer to [Services Authorized for Qualis Health](#) for additional information about requesting and obtaining an SA from Qualis Health.

Before a hysterectomy is performed, the recipient must grant voluntary, informed consent by signing a *Hysterectomy Consent Form*, available at <http://manuals.medicaidalaska.com/docs/forms.htm>. 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*, in which he or she certifies 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 Medical Assistance 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).

## Obstetrical Care

### Physician Guidelines

Alaska Medical Assistance 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 Pitocin to initiate or augment labor part of a delivery and Alaska Medical Assistance does not reimburse for Pitocin separately.

### Advanced Nurse Practitioner/Certified Nurse Midwife (CNM) Guidelines

Alaska Medical Assistance covers services for a normal vaginal delivery performed by a nurse practitioner certified as a nurse midwife. The CNM may perform these services at a licensed free-standing birth center.

## Sterilization

Alaska Medical Assistance 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://manuals.medicaidalaska.com/docs/forms.htm>.

Only the *Sterilization Consent Form* will be accepted; no substitutions are allowed. The consent form must be **complete and legible** (dates and signatures in all fields must be documented for claim payment); 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 that before the recipient signed the consent form, he or she orally advised the recipient concerning the following:

- About the procedure
- Alternative methods of family planning and birth control
- That 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 Medical Assistance 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 a therapeutic 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 06/08/2018

## Out-of-State Services

Alaska Medical Assistance will cover a service provided out-of-state to the same extent it would cover the service provided in this state 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 situations:

- 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 service authorization if the above criteria are not met.**

Payment for services provided to Alaska Medical Assistance recipients outside the state of Alaska is limited to the lesser of: 1) the rate established by the Medicaid agency in the state where the services were provided; or, 2) the rate or payment methodology established by Alaska Medical Assistance.

Updated 06/04/2013

## Non-covered Services

Some services are not covered by Alaska Medical Assistance. Refer to [Services Not Covered by Alaska Medical Assistance](#) in the *Quick Reference* section for general guidelines.

Recipients are responsible for all non-covered services (*and cost sharing amounts if required by 7 AAC 105.610*). The provider should not accept a medical assistance coupon from the recipient if the service is not covered under the Alaska Medical Assistance Program.



**Note:** Provider billing manuals for the specific type of provider (for example, physicians, physical therapists, or advanced nurse practitioners) include additional information about coverage limitations.

Updated 06/04/2013

## Chronic and Acute Medical Assistance (CAMA) Services

The Chronic and Acute Medical Assistance (CAMA) program provides limited state-funded medical assistance to Alaska residents (who do not qualify for Alaska Medical Assistance) with one of the following conditions:

- Diagnosis of terminal illness
- Cancer requiring chemotherapy
- Diabetes
- Diabetes insipidus
- Chronic hypertension
- Chronic mental illness (as defined in 7 AAC 160.990)

- Chronic seizure disorder

The CAMA program will cover the following services, if they are related to one of the conditions listed above:

- Physician services (not provided to in an inpatient hospital or nursing facility)
- Three prescriptions filled or refilled in a calendar month (prescription cannot exceed a 30-day supply)
- Limited medical supplies necessary for monitoring or treating condition (no durable medical equipment)
- Authorized outpatient hospital radiation and chemotherapy services for cancer treatment



Tribal providers will not be reimbursed for a CAMA beneficiary who is an American Indian or Alaska Native. However, covered CAMA services for CAMA eligible recipients who are not tribal beneficiaries are reimbursable by Alaska Medical Assistance, if the facility has agreed to accept non-tribal beneficiary recipients.

Updated 06/04/2013

## Billing Guidelines

### Choosing a Claim Method



Required fields are the minimum required when billing on paper; additional fields may be required to comply with HIPAA EDI requirements.

The claim form that you use depends on which type of provider you are billing:

Provider Type	Transaction Type	Paper Claim Form
Tribal Clinic	837P	CMS-1500 (02/12 Version)
Inpatient Hospital	837I	UB-04
Outpatient Hospital	837I	UB-04
Physician services at an inpatient hospital (or at an outpatient hospital if your facility chose the ASC option; refer to the <a href="#">Tribal Outpatient Hospitals</a> section for additional information)	837P	CMS-1500 (02/12 Version)
Physician billing for CHA/P services	837P	CMS-1500 (02/12 Version)
Dentist billing for DHA services	837D	Dental claim form (J430 Version)
Ambulatory Surgical Center	837I	UB-04
Pharmacy	NCPDP	NCPDP Universal Claim Form (UCF)

You can submit claims electronically or via mail. Refer to [How to Submit a Claim](#) later in this section for more information.

Updated 10/15/2015

## How to Complete the CMS-1500 and Instructions

[http://manuals.medicaidalaska.com/docs/dnld/Billing\\_CMS1500\\_0212\\_Instructions.pdf](http://manuals.medicaidalaska.com/docs/dnld/Billing_CMS1500_0212_Instructions.pdf)

## How to Complete the UB-04 Claim Form and Instructions

[http://manuals.medicaidalaska.com/docs/dnld/Billing\\_UB-04\\_Instructions.pdf](http://manuals.medicaidalaska.com/docs/dnld/Billing_UB-04_Instructions.pdf)

## How to Complete the Dental Claim Form

[http://manuals.medicaidalaska.com/docs/dnld/Billing\\_ADA\\_2012\\_Instructions.pdf](http://manuals.medicaidalaska.com/docs/dnld/Billing_ADA_2012_Instructions.pdf)

## Timely Filing of Claims

All claims must be filed within 12 months of the date services were provided to the recipient. The 12-month timely filing limit applies to all claims, including those that are first filed with a third-party carrier. In these cases, providers must bill Alaska Medicaid within 12 months of the service date and attach the explanation of benefits from the third-party carrier to the claim. This does not apply to CHA/P claims since there is TPL avoidance in place. No other insurance payers reimburse for CHA/P services at this time.

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. 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.



Alaska Medical Assistance is the "payer of last resort," which means that you must bill all other insurance companies or organizations who may be responsible for the services prior to billing Alaska Medicaid. Refer to the [Billing Third-Party Liability](#) section for additional information. Even if other parties require primary billing, there is still a 12-month limit to submit a claim to Alaska Medicaid.

## 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 Conduent within the timely filing period or that 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 the in-process claims page of an RA
- Payerpath or other electronic claim submission transmission report



- Correspondence from Conduent, 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 the provider owes Alaska Medical Assistance additional money, the 60-day filing limitation does not apply.

Updated 03/09/2017

## Determining Which Procedure Code or Revenue Code to Use

Follow these guidelines to determine which procedure code or revenue code to bill:

Type of Provider	Code to Use
Tribal Clinic	The appropriate CPT or HCPCS procedure code covered by Alaska Medical Assistance that best describes the services provided by the healthcare professional. Refer to the applicable <i>Alaska Medical Assistance Fee Schedule</i> available on the Conduent Web site for each type of provider for a list of covered codes.
BHA	The appropriate CPT or HCPCS procedure code covered by Alaska Medical Assistance that best describes the services provided by the BHA. Refer to <a href="#">Appendix G</a> of this manual or the BHA CPT AND HCPCS list available on the Conduent web site for covered services for BHAs.
CHA/P	The appropriate CPT or HCPCS procedure code covered by Alaska Medical Assistance that best describes the services provided by the CHA/P. Refer to <a href="#">Appendix H</a> of this manual or the CHA/P CPT AND HCPCS list available on the Conduent web site for covered services for CHA/Ps.
DHA	The appropriate CDT procedure code covered by Alaska Medical Assistance that best describes the services provided by the DHAT. Refer to Appendix J: Dental Health Aide Codes, as well as the <i>Alaska Medical Assistance Dental Fee Schedule</i> available on the Conduent web site for a list of covered codes.
Physician Services at a Tribal Inpatient Hospital	The appropriate CPT or HCPCS procedure code covered by Alaska Medical Assistance that best describes the services provided by the healthcare professional. Refer to the applicable <i>Alaska Medical Assistance Fee Schedule</i> available on the Conduent web site for each type of provider for a list of covered codes.
Tribal Inpatient Hospital	The appropriate revenue and HCPCS procedure codes covered by Alaska Medical Assistance for inpatient hospitals. Refer to <a href="#">Appendix F: Hospital Revenue Codes</a> .
Tribal Outpatient Hospital	The appropriate revenue and HCPCS procedure codes covered by Alaska Medical Assistance for outpatient hospitals. Refer to <a href="#">Appendix F: Hospital Revenue Codes</a> .

Updated 06/08/2018



# National Drug Code/J-Code Billing

## Background

The Deficit Reduction Act of 2005 (DRA) included specific data submission requirements necessary to collect Medicaid drug rebates from drug manufacturers for physician-administered drugs. Additionally, Social Security Act Section 1927 requires state drug rebate participation. State Medicaid programs must gather and submit drug utilization information in order to secure drug rebates and receive Federal Financial Participation (FFP) for these drugs.

For more information on the Medicaid Drug Rebate program, visit <https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html>.

Alaska Medicaid outpatient drug regulations can be found at [7 AAC 120.110 Covered Outpatient Drugs and Home Infusion Therapy](#).

Alaska Medicaid drug payment regulations can be found at [7 AAC 145.400 – 7 AAC 145.410](#).

## Applicability

Drug rebates are applicable to:

- Claims for medications administered in physician's offices, clinics, and other outpatient settings, including Medicare part B and C crossover claims.
- National Drug Code (NDC) information used in conjunction with appropriate HCPCS/CPT codes for rendered services.
  - NDC codes should be used with "A", "C", "J", "P", "Q", and "S" codes.
  - Though not all-inclusive, providers may refer to the [NDC/HCPCS Crosswalk](#) to determine the appropriate HCPCS code for the NDC being used.

Drug rebates are not applicable to:

- IHS and tribally operated 638 facilities reimbursed at the federally published all-inclusive rate.
- ESRD bundled claims unless modifier "AY" is used to indicate an item or service rendered to an ESRD patient is not for treatment of ESRD.

## Guidelines for Reimbursement

To correctly identify the drugs and manufacturers to invoice and collect rebates, the Centers for Medicare and Medicaid Services (CMS) deemed that the use of NDC numbers is critical because there often several NDCs linked to a single HCPCS code.

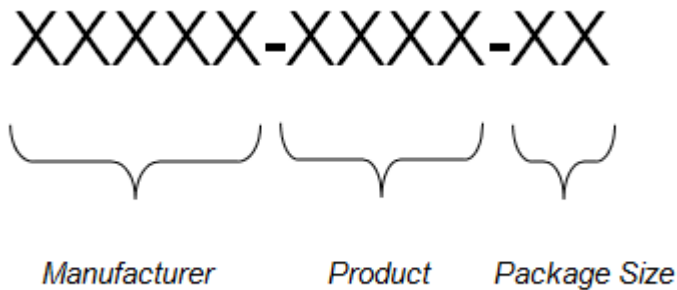
- Alaska Medicaid will pay claims submitted for these drugs only if the manufacturer participates in the Federal Drug Rebate program and federal matching funds are available.
  - Quarterly Drug Rebate listings are available on the CMS website <https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/data/index.html>.
- Bill the National Drug Code (NDC) for the actual drug that is administered.
- Record the NDC into the patient record.
- Do not use a miscellaneous code if a specific HCPCS-NDC match is available.

## Finding NDC information

The NDC is found on the prescription drug label of the drug container (e.g. vial, bottle or tube). The NDC is a universal number that identifies a drug or a related drug item.

## Deciphering the NDC Label

NDC consists of 11 digits in three sections:



Sometimes, the NDC on a product label does not include all 11 digits. When this occurs, it will be necessary to add leading zeroes to the appropriate section to create the 5-4-2 configuration. Record NDCs on your claims without hyphens or spaces.

## NDC Label Examples

	Example #1	Example #2	Example #3
Product label indicates:	54225-1798-29	452-72-89	45-6-9
Submit on claim as:	54225179829	00452007289	00045000609

## NDC Units

Acceptable units of measure for recording NDC quantities are as follows:

Code	Unit type	Description
UN	Unit	Powder for injection (needs to be reconstituted), pellet, kit, patch, tablet, device
ML	Milliliter	Liquid, solution, or suspension
F2	International Unit	Products described as IU/vial or micrograms
GR	Gram	Ointments, creams, inhalers, or bulk powder in a jar

## Billing Note

Milligram (mg) is **not** an acceptable unit qualifier when billing NDC quantities.

Drugs administered using a mg dosage must be converted for billing to UN if in a solid/powder form or ML if in a liquid/solution form. Only use GR if the drug meets the description for the grams unit type.

Refer to the CMS Drug Products in the [Medicaid Drug Rebate Program](#).

## Converting NDC Units to HCPCS Units

Providers are required to submit the NDC unit of measure and units administered as well as the HCPCS equivalent units on the claim form. The requirement is the same for Medicaid and Medicare crossover claims. Providers must identify the NDC, unit of measure, amount administered, the NDC strength, HCPCS code and HCPCS unit of measure.

### Billing Note

NDCs must be billed with the corresponding HCPCS based on description and quantity administered.

Claims may be denied if a misc. HCPCS code is billed when an appropriate NDC

### Example

The NDC unit of measure for 60793070010 is mL and 1 mL was administered. The NDC strength equals 600,000 iU per mL. The corresponding HCPCS code, J0561, is measured at 100,000 iU per billed unit.

In this example, 1mL of this NDC equals 6 units of J0561.

$$\frac{(NDC\ Strength) \times NDC\ Administered}{HCPCS\ Units\ of\ Measure} = HCPCS\ Billed\ Units$$
$$\frac{(600,000\ iU/mL) \times 1mL}{100,000\ iU} = 6\ Billed\ Units$$

The following information would be reported on the claim form for this NDC:

Description	Example Value
N4 qualifier	N4
11-digit NDC number from the drug label	60793070010
NDC unit of measure	mL
NDC units administered <b>Note:</b> Insert a decimal when reporting a fraction of a unit up to three decimal places.	1 or 1.000
Corresponding HCPCS codes	J0561
HCPCS units	6
Drug revenue code	0636

### Billing Note

Decimals must be used on all Medicaid and Medicare claims when billing a fraction of an NDC unit.

Partial units billed without a decimal may be denied.

## CMS-1500 Claim Form

Record the NDC information in the **shaded area** above the claim line in field 24.

24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS I MODIFIER		E. DIAGNOSIS PORTER		F. \$ CHARGES		G. DATE OF SERVICE		H. ICD-9-CM		I. RENDERING PROVIDER ID #	
MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY		
N460793070010ML1																									
10	01	17	10	01	17	11						J0561						12	00	6	1	N	NP1		

## UB-04 Claim Form

Record the NDC information in the **Description** field, form locator 43.

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
0636	N460793070010ML1.000	J0561	100117	6	12 00

## 837P Professional EDI format

### Loop 2410:

- Field CTP04 – Enter quantity
- Field CTP05 – Enter unit of measure

**Example: CTP\*\*\*\*2\*UN~**

- Field LIN02 – Enter qualifier 'N4'
- Field LIN03 – Enter NDC without hyphens

**Example: LIN\*\*N4\*1234567891~**

- Continue to enter HCPCS information in loop 2400 in field SV1.

## 837I Institutional – EDI format

### Loop 2400:

- Field SV201 – Enter the revenue code
- Field SV202-1 – Enter qualifier 'HC'
- Field SV202-2 – Enter the HCPCS code
- Field SV204 – Enter qualifier 'UN'
- Field SV205 – Enter the quantity

**Example: SV2\*250\*HC\*Jxxxx\*\*UN\*1~**

### Loop 2410:

- Field LIN02 – Enter qualifier 'N4'
- Field LIN03 – Enter NDC without hyphens

**Example: LIN\*\*N4\*12345678912~**

- Field CTP04 – Enter quantity
- Field CTP05 – Enter unit of measure

**Example: CTP\*\*\*\*2\*ML~**

Updated 01/29/2019

## When a Procedure Code Isn't Listed for a Service

Unlisted codes may be used only when you are unable to locate a suitable code listed in the current CPT-4, the Alaska Medical Assistance provider billing manual, or billing manual updates.



If you know in advance that a service or item will have to be billed using an unlisted procedure or service code, you can request that Conduent review the service or item for coverage before the services are provided. To request an "unlisted code review," complete the [Service Authorization Request form \(AK-SA\)](#) and submit it to Conduent.

After reviewing the unlisted code, Conduent will return the Service Authorization Request form and will mark whether it has been approved; however, you will not receive a Service Authorization Number. When submitting the claim for the unlisted procedure, you should include a copy of the Service Authorization Request form (with approval indicated) to the claim.

When using an unlisted procedure code, a written explanation with the following information must be attached behind your 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 "suspended" for review. All other services billed on the same claim are also suspended until the unlisted procedure code review has been completed. Before using an unlisted procedure code, carefully consider existing codes. Inappropriate use of unlisted codes will cause delay in processing submitted claims and you may be asked to re-bill the procedure using an existing procedure code.

Updated 06/08/2018

## Determining How Much to Bill for a Service

You must bill Alaska Medical Assistance at the lowest charge that is advertised, quoted, posted, or billed for the same procedure and number of units provided on the same day, regardless of the source or method of payment.

### Exceptions

- **If you accept Medicare assignment.** Even if you accept Medicare assignment and therefore bill Medicare at the Medicare fee schedule, you are not required to bill Alaska Medical Assistance at this rate.
- **If you have a sliding fee schedule.** If you have a written policy that establishes a sliding fee schedule based on the federal poverty level for Alaska, you do not have to bill Alaska Medical Assistance using the sliding fee schedule rate.
- **If you have a contract for a group.** If you have a contract to provide healthcare services at a discounted rate for a specific group of people, you do not have to bill Alaska Medical Assistance using this discounted rate. However, if the revenue from the contract exceeds 20 percent of your annual gross income, you **are** required to bill Alaska Medical Assistance at this lower rate. Contracts with a state or federal agency are exempt.
- **If you include discounted rates to your employees.** If you offer your employees a discounted rate on healthcare services as part of an employment benefit package, you do not have to bill Alaska Medical Assistance at this discounted rate.

Updated 06/04/2013

## What to Attach to a Claim

When determining what attachments are needed for claims with unique services, follow the guidelines below. You should also review specific attachment requirements for your provider type and for the code you are billing. Samples of these forms are included in the [Forms](#) Section.

If you are billing...	You must attach...
A sterilization	<i>Sterilization Consent Form</i>
A hysterectomy	<i>Hysterectomy Consent Form</i> Refer to <a href="#">Completing the Hysterectomy Consent Form</a> in the <a href="#">Forms</a> section for instructions.
An abortion	<i>Certificate to Request Federal (Medicaid) Funds for Abortion</i>
An unlisted procedure code	Written explanation (or <i>Service Authorization Request</i> form, if you requested an "unlisted code review")
A claim when the patient has other health insurance	Explanation of benefits (EOB) for the other insurance
A claim with modifier 62 (2 surgeons), modifier 66 (surgical team), modifier 22 (unusual services), multiple modifiers, or for a primary care recipient if he/she was seen by a healthcare provider other than their primary care provider	<i>Certificate of Medical Necessity</i> or statement of medical justification
A claim for an assistant surgeon, for a second assistant surgeon, or for multiple modifiers	Operative Report
For a private room	<i>Certificate of Medical Necessity/Private Room Approval</i>
A claim that needs proof of timely filing	Attach one of the following: <ul style="list-style-type: none"><li>• Copy of the remittance advice (RA) page showing claim denial</li><li>• Copy of the <i>In-process Claims</i> page of an RA</li><li>• Electronic claim submission transmission report</li><li>• Correspondence from Conduent, the Division of Healthcare Services, or the Department of Public Assistance</li><li>• Court orders or Administrative Hearing documentation</li></ul>

Updated 01/03/2017

## How to Submit a Claim

You may either mail a claim to Conduent or submit it electronically.

### Mailing Claims to Conduent

Follow these steps to mail claims to Conduent:

1. Complete the correct claim form and include any needed attachments. Refer to [Determining the Correct Claim Form to Use](#) and [What to Attach to a Claim](#) in this section.

2. Mail the claim and attachments to:  
Conduent State Healthcare, LLC  
P.O. Box 240649  
Anchorage, AK 99524-0649

When mailing claim forms to Conduent, follow these guidelines:

- Do not fold or crease, tear, or staple claims.
- Fill in the handwritten claims neatly and accurately, do not highlight or stamp information.
- Keep names, numbers, codes, etc., within the designated boxes and lines.
- Do not strike out, write over, or use correction fluid/tape to correct errors.
- Include a return address on all claims and mailing envelopes. Address labels may not extend past the edge of the claim form.
- Send only required attachments.
- Use only blue or black ink to fill out the claim form. Light colored or red ink is not visible when the claim form is scanned using optical readers.

## Submitting Claims Electronically

There are several ways in which you can submit claims electronically to Alaska Medical Assistance:

- Logging in to Alaska Medicaid Health Enterprise and selecting the **Claims** tab.
- Using Payerpath, a free, Internet-based claims submission system. You can either enter claims directly into Payerpath or upload claims from your practice management software. Payerpath is currently available for all providers except Pharmacy.
- Using National Standard Format (NSF) files exported from your practice management software. You can submit these files using a "bulletin board" or a "clearinghouse."

## Submitting Attachments Electronically

1. Identify the method and type of attachment documentation for the claim. Annotate the indicators in the appropriate electronic fields.
2. Create and assign a unique number of your choice to identify your electronic attachment and pair it to a specific claim.
3. Write that same identifying number, along with the recipient's name and Medicaid ID, on all pages of your support documents for that claim.
4. Print out an *Attachment Fax Cover Sheet* from the [Forms](#) site to use as a fax coversheet. Write your unique number on this coversheet.
5. Fax your coversheet and associated claim documentation the **same day** that you submit your electronic claim. Use only the fax numbers for EDI attachments: 907.644.8122 or 907.644.8123.

Identify claim attachments by entering the appropriate HIPAA compliant code in the attachment field(s) when completing the electronic claim. These are the most common codes:

Documentation Indicator (Attachment Method)	
AA	Available on Request at Provider site
BM	By Mail
FX	By Fax

Type of Documentation	
B2	Prescription
B3	Physician Order
B4	Referral Form
CK	Consent Form(s)
EB	Explanation of Benefits
M1	Medical Record Attachment
OZ	Support Data for Claim

Updated 03/09/2017

## Processing a Submitted Claim

After you submit a claim, Conduent will process it and provide you with feedback on a weekly basis (if you have any claim activity) in the form of a remittance advice (RA). The RA includes information on every claim being processed for a provider number. Claim activity includes payment, denials, adjustments, pends, and additional information needed. The RA also provides you with information, including changes in program coverage and rules, billing procedures, reminders and training schedules (refer to [Receiving and Reconciling Remittance Advice](#)).

When claims are processed by Alaska Medical Assistance, they are checked 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
- Duplication of previously paid claims
- Valid service authorization on file when required

If the claim fails the validation check, it will be denied or processing will be suspended until the claim can be reviewed internally or until additional information is received from you.

Updated 01/03/2017

## Checking a Claim's Status

If you want to check on the status of a submitted claim, you can do one of the following:

- Log in to your Health Enterprise account
  - Under the **Claims** tab, select **Claim Status Inquiry**
- If you are checking a large number of claims, fax a *Check Amount and Claim Status Inquiry Form* (available at <http://medicaidalaska.com> under Documentation > Documents & Forms > Forms) to Provider Inquiry at 907.644.8126.
  - Be sure that all included information is legible if handwritten
- Call Provider Inquiry 907.644.6800, option 1, 1, or 800.770.5650 (toll-free), option 1, 1, 1.

Updated 03/10/2016



## Adjusting or Voiding a Claim

### When to Adjust a Claim

Providers should request an adjustment in order to correct a 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 for Third Party Liability

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

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

### When to Void a Claim

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

- Wrong member ID number
- Wrong Medicaid Contract ID number
- Services not rendered

If a provider bills Medicaid prior to billing Medicare for dual-eligible members, the claim must be voided and rebilled to Medicare to ensure proper adjudication through both agencies.

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

Claims can be adjusted and voided

- By submitting an *Adjustment/Void Request Form* (AK-05) via mail or fax
- Electronically through an 837 claim replacement request (if billing using practice management software)
- Electronically through Health Enterprise if the original claim was submitted using the Provider Portal

If adjusting or voiding a claim using an AK-05 form:

1. Complete the form including the specific claim information and the reason for adjustment or void. Refer to [Completing the Adjustment/Void Request Form](#).
2. Attach a copy of the remittance advice page showing the claim's status as paid and a corrected original claim that includes all lines to be considered for payment, even if the original line(s) was paid. Suspended claims cannot be adjusted.
3. Send the completed form, corrected claim, and any attachments to:

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

All adjustments must be submitted within 12 months of the date of service when payment is owed to the provider (positive adjustment). There is no time limit to file an adjustment if the reason for adjustment does not affect payment or the adjustment would result in payment to Alaska Medical Assistance.



Providers may choose to attach a refund check made payable to the *State of Alaska* with their AK-05 form, or to take no action, allowing the State to deduct the amount from a subsequent billing cycle

Updated 01/03/2017

## Completing the Adjustment/Void Request Form

Follow these steps to complete the paper Adjustment/Void Request form available at <http://manuals.medicaidalaska.com/docs/forms.htm>.

1. **Claim Control Number** Leave this field blank. For Conduent use only.
2. **Provider Name and Address** (field 1): Enter the complete name and address of the provider.
3. **Billing Provider Number** (field 2): Enter the Medical Assistance provider identification number. If the claim was paid under an incorrect provider number, enter the incorrect provider identification number; that claim must be voided and a new claim submitted with the correct Medical Assistance provider identification number.
4. **Rendering Provider Number** (field 3): (if different from #2) Enter the rendering provider's Medical Assistance identification number if you bill with a group identification number (field 2). If the rendering provider identification number is different from the information in field 2, fill in field 3. Otherwise, leave it blank.
5. **Overpayment** (field 4): If an adjustment/void results in money owed to Medical Assistance, the provider may either refund the money or have it recovered from future payment of approved claims. If no check is enclosed, the money will be recovered from a future RA. If you attach a refund check to the AK-05, indicate the amount of the overpayment and your refund check number. Otherwise, leave field 4 blank. Make the check payable to the State of Alaska.
6. **Recipient Name** (field 5): Enter the recipient's name as it appears on the RA. If the payment was made for the wrong recipient, the paid claim must be voided and a new claim submitted.
7. **Recipient Number** (field 6): Enter the recipient's number as it appears on the RA. If the payment was made for the wrong recipient, the paid claim must be voided and a new claim submitted.
8. **Claim Control Number** (field 7a): Enter the first 11 digits of the Claim Control Number as it appears on the remittance advice (in the column titled Claim Control # or Claim Cntl Nbr). If adjusting an adjustment, use the CCN that appears with the debit portion of the adjustment.
9. **Line Number** (field 7b): Each line of the claim has its own number, and the claim line number appears in the far left column of the RA. If the wrong line number is recorded on the AK-05, the wrong line will be adjusted. Providers billing in the 837 Institutional format or on the UB-04 claim form will have only line "01."
10. **Reason for Adj/Void** (field 7c): Providers are to furnish sufficient information to properly process the AK-05 and attach documentation to support the request.

**Example 1:** Revenue code 300 was billed with a \$10.00 charge for the service. Adjust the claim to reflect a \$15.00 billed charge and check the box for "adjustment" on the AK05.

**Example 2:** Payment was received for a service that was not rendered by this provider. Submit an AK05 and check the "void" box. Claim is not required to process the void.

**Example 3:** Third-party insurance paid \$15.00. Send in an AK05 with the “adjustment” box checked along with the corrected claim reflecting TPL payment and attach the EOB.



For adjustments, attach a completed original claim form containing the correct claim information and a copy of the page of the RA that shows payment of the claim. You do not need to send the entire RA.

11. **Comments** (field 7d): Simple explanation. e.g., “Units increased to 50.” “Procedure code changed to \_\_\_\_.” “Billed using wrong Medicaid number.”
12. **Signature/Date** (field 8): The signature of the original provider or representative goes here. Enter the date the adjustment/void is signed.
13. **Part III Fiscal Agent Use Only:** Leave these fields blank.

The *Adjustment/Void Request Form (AK-05)* is a two-part form. Keep the “Retain for your Records” copy and submit the “Original Copy” to Conduent.

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

Updated 06/08/2018

## Receiving and Reconciling Remittance Advice

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



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, your primary service, Medicare crossover claims, etc.

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

- Message Page(s)
- Adjudicated Claims (Paid and Denied Claims)
- Adjustment Claims
- Voided Claims
- In-Process Claims
- Financial Transactions
- EOB Description
- Remittance Summary

Sample sections of the Professional (CMS-1500) and Institutional (UB-04) RAs are shown and explained on the following pages.

At your request, you can receive your RA in electronic form. Your electronic RA is transmitted as a data file that your software can recognize and manipulate. It can be used to post payments or to create or post to an aging report.

If you file electronically and would like to receive your RA electronically each week, complete an *Electronic Remittance (835) Authorization Form*, found at <http://manuals.medicaidalaska.com/docs/forms.html>.

Only one entity may receive the electronic RA, even if multiple entities are submitting claims for the provider. That entity must have prior approval from Conduent to receive the RA.

Reconciling your RA is extremely important and will greatly improve your Alaska Medical Assistance billing practices.

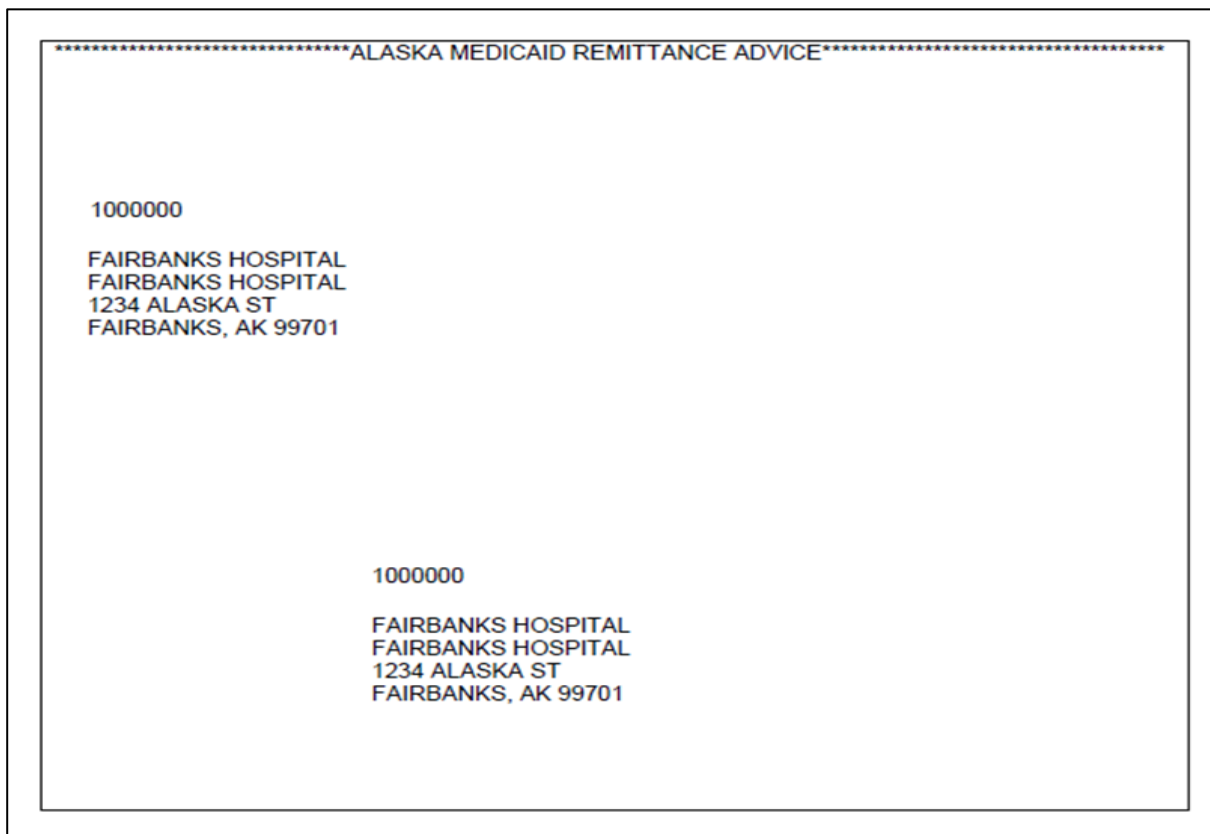
Updated 06/08/2018

## CMS-1500 Remittance Advice

After a provider submits a HIPAA-compliant claim, Conduent processes the claim and provides feedback in the form of a weekly report called a “remittance advice” (RA). In addition to important messages to the provider, the RA reports all claims activity, including payments, denials, adjustments, pends, and returns.

### Cover Page

Used for mailing to the provider, the cover page contains the provider’s Medical Assistance identification number, name, and address.

The image shows a sample of the 'Cover Page of the Remittance Advice' form. It is a rectangular document with a double-line border. At the top, a header line reads '\*\*\*\*\*ALASKA MEDICAID REMITTANCE ADVICE\*\*\*\*\*'. Below this, on the left side, is the provider's identification number '1000000'. To the right of the number is the provider's name and address: 'FAIRBANKS HOSPITAL', 'FAIRBANKS HOSPITAL', '1234 ALASKA ST', and 'FAIRBANKS, AK 99701'. This information is repeated on the right side of the page, with the identification number '1000000' centered above the address block.

**Cover Page of the Remittance Advice**

### Message Page

The first section of the RA, following the cover page, is used to relay messages from Conduent to the provider. The message page advises providers regarding:

- Changes in billing procedures or program coverage

- Billing procedure or program reminders
- Messages from the Department of Health and Social Services (DHSS) and Conduent
- Provider training schedules

Careful attention to this information will aid your claims processing.

*****ALASKA MEDICAID REMITTANCE*****		
FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS AK 99701 Payee ID:1000000 NPI: 1234567890	ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES MEDICAID MANAGEMENT INFORMATION SYSTEM REMITTANCE ADVICE	DATE: 02/18/15 REMITTANCE:9876543 PAGE: 2
<b>2015 Third and Fourth Quarter Provider Training Schedules Now Available</b>  Alaska Medicaid is pleased to announce that the third and fourth quarters of 2015 Provider Training classes are now open for registration. Training locations, dates and times of classes for 2015 may be viewed on the Learning Management System (LMS) at <a href="http://learn.medicaidalaska.com">http://learn.medicaidalaska.com</a> . For a complete list of courses and descriptions, log in to the LMS and select Provider Training from the Provider dropdown menu. For training dates and instructions for navigating the LMS, please see the provider flyers "2015 Third Quarter Provider Training Schedule Now Available" and "2015 Fourth Quarter Provider Training Schedule Now Available" in Health Enterprise (Documentation > Documents & Forms > Provider Updates).  <b>February Provider Newsletter Now Available</b>  Xerox, in conjunction with the Division of Health Care Services, publishes a monthly newsletter. The purpose of this newsletter is to offer providers useful information, monthly reminders, and tips to make billing easier. The Alaska Medicaid newsletter for the month of February is available now at <a href="https://medicaidalaska.com/portals/wps/portal/NewsLetters">https://medicaidalaska.com/portals/wps/portal/NewsLetters</a> and <a href="http://manuals.medicaidalaska.com/docs/updates.htm">http://manuals.medicaidalaska.com/docs/updates.htm</a> .		

### Message Page of the Remittance Advice

## Adjudicated Claims (Paid and Denied Claims Page)

This figure shows a sample RA page relating to adjudicated claims. To help you identify the information, note the circled number on the sample and refer to the corresponding explanation on the following pages.

Enterprise Operational Reports Report ID: OPR-PAY-L127		Alaska Department of Health and Social Services Remittance Advice Remittance No: 2987654 08/05/2015		3 PROVIDER NO:1000000 4 NPI :1234567890	
1 Pay to: PROFESSIONAL PROVIDER 2 FIREWEED PLACE ANCHORAGE, AK 99500-1234		7 Claim Type P - Professional ADJUDICATED CLAIMS			
8 MEMBER ID CLAIM CONTROL# SERVICE DATES 0100000001 1520900000001234 07/10/15 07/10/15 TPL \$0.00 EOB Codes:	9 MEMBER NAME PATIENT ACCT NBR CPT/ HCPCS MOD DESCRIPTION WASHINGTON, GEORGE 3232323232 99212 14 OFFICE/OUTPATIENT VISIT 1987654321 TOTAL CHARGE	15 1987654321 16 1.0 17 \$104.00 18 \$50.86 19 \$0.00 20 \$50.86 21 P	22 23 24 25 26 27 28	29 30 31 32 33 34 35	36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 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### Adjudicated Claim Page of the Remittance Advice

Circled Item	Adjudicated Claim Page Explanation
1.	<b>Pay to:</b> the name to which payment is made for services rendered.
2.	<b>Provider Payee Address:</b> the street, city, state, and ZIP code of the provider who is paid for the services.
3.	<b>Provider No.:</b> the Medical Assistance identification number of the billing provider.
4.	<b>NPI:</b> the National Provider Identifier of the billing provider.
5.	<b>Remittance No.:</b> a control number used by Conduent in the production of RAs.
6.	<b>Date:</b> the date the RA was created (the remittance cycle date).
7.	<b>Claim Type and Class:</b> identifies the type of claim filed by the provider and the status being totaled (e.g., "adjudicated," "in-process," etc.).
8.	<b>Medicaid ID:</b> the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).
9.	<b>Member Name:</b> the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file. If the claim is denied because the recipient number on the claim is invalid, no name will appear on the RA.
10.	<b>Claim Control Number:</b> the 17-digit number assigned to the claim by Conduent for processing, based on the Julian Date calendar.
11.	<b>Patient Acct Nbr:</b> the number assigned to a recipient or a claim by the provider for reference purposes. If the provider has indicated a medical record number on the claim form, it is printed on the RA to help the provider identify the patient who received the services.
12.	<b>Service Dates:</b> the date or dates the services were performed.
13.	<b>CPT/HCPCS MOD:</b> the assigned CPT code or HCPCS for the services or procedure rendered to the patient and any associated modifier.
14.	<b>Description:</b> the description of the services rendered. This is printed on the RA as it is described in the Procedure Code File; therefore, it may not be the same as written on the claim when it was submitted.
15.	<b>Render Prov:</b> the submitted NPI for the provider that rendered services.
16.	<b>Units:</b> the number of times/days that billed services were rendered.
17.	<b>Billed:</b> the amount billed to Medicaid for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
18.	<b>Allowed:</b> the dollar value for covered revenue codes, accounting for any accommodation cutback.

Circled Item	Adjudicated Claim Page Explanation
19.	<b>Oth-Ded:</b> the dollar value of other deductions impacting the line payment, such as co-payment.
20.	<b>Payment:</b> the total allowed amount multiplied by the pay mode, less copayment and third-party payment.
21.	<b>EOB:</b> EOB codes for each claim line. The descriptions for these codes are listed on a separate page at the end of the RA. For a denied claim line, the EOB indicates the reason for the denial.
22.	<p><b>Status:</b> the disposition of each specific claim, e.g., paid, deny.</p> <p><b>Paid (P).</b> Paid claim lines have passed final adjudication. They may be paid as submitted or at reduced amounts according to the program's reimbursement methodology.</p> <p><b>Deny (D).</b> Denied claim lines represent those services that are unacceptable for payment. Denial may occur if claims information cannot be validated by Conduent, if the billed service is not a program benefit, or if line items fail the edit/audit process. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within filing time limits.</p>
23.	<b>TPL:</b> the total amount paid by a third-party resource on the claim.
24.	<b>EOB:</b> the principal EOB code for the claim in its current status. The descriptions for these codes are listed on a separate page at the end of the RA. For a denied claim line, the EOB indicates the reason for the denial.
25.	<b>Total Billed:</b> the total amount billed on the claim.
26.	<b>Total Allowed:</b> the total allowed charges to which the payment percent (pay mode) is applied.
27.	<b>Total Payment:</b> the total allowed amount multiplied by the pay mode, less copayment and third-party payment.
28.	<b>Total Adjudicated Claims:</b> the number of claims totaled for each section of the RA.
29.	<b>Lines:</b> the number of claim lines totaled for each section of the RA.
30.	<b>Total TPL:</b> the total amount paid by a third-party resource for all claims in this section of the RA.
31.	<b>Total Units:</b> the number of units totaled for this section of the RA.
32.	<b>Total Billed:</b> the total amount billed for all claims in each section of the RA.
33.	<b>Total Allowed:</b> the total amount allowed for all claims in each section of the RA.
34.	<b>Total Oth-Ded:</b> the total dollar amount of deductions, not including TPL, from all claims in this section of the RA.
35.	<b>Total Payment:</b> the total amount paid for all claims in this section of the RA.



## Adjustment Claims Page

Previously paid claims may be adjusted if an error occurred in billing or processing. If payment is owed to the provider, an Adjustment/Void Request must be submitted within the 12-month timely filing period of the date services were rendered. If money is owed to Alaska Medical Assistance, there is no time limit for filing for an adjustment.

When an adjustment request results in a paid claim, the processed adjustment appears in two parts on the *Adjustment Claims Page* of your RA:

- **Credit.** Listed first in the transaction, the credit displays the original TCN details and reverses the original transaction. This portion adjusts the credits on the provider's 1099 by decreasing the paid amount.
- **Debit.** Listed second in the transaction, the debit displays the replacement TCN details, including the corrected information and payment. It also lists the former TCN associated with the credit above. The date with the *Adjust TCN* is the date of the remittance advice on which original payment was made. If additional adjustments are necessary, use the debit TCN.

This figure shows a sample adjustment claim page from an RA. The sample page identifies adjustment requests as they are processed. Note the circled numbers on the sample page and refer to the corresponding explanations after the sample page.

Enterprise Operational Reports Report ID: OPR-PAY-L127		Alaska Department of Health and Social Services Remittance Advice Remittance No: 2840000 05/11/2016				PROVIDER NO:1000002 NPI :1098765432		
Pay to: MCCORMICK CHIROPRACTIC 200 PEPPER LN STE 8 ANCHORAGE, AK 99508-1234		Claim Type P - Professional ADJUSTMENT CLAIMS						
MEMBER ID CLAIM CONTROL# SERVICE DATES	MEMBER NAME PATIENT ACCT NBR CPT/ HCPCS MOD DESCRIPTION	REND PROV	UNITS	BILLED	ALLOWED	OTH-DED	PAYMENT EOB	STATUS
1 060055552 15322111100001112 03/20/14 03/20/14 TPL \$0.00	CROCKER, BETTY 12345678 98940 CHIROPRACT MANJ 1-2 REG	1000002506	-1.0	-\$60.00	\$0.00	\$0.00	\$0.00	D
2 Adjust TCN: 14297810000000000			3 Dated: 04/14/14					
4 060055552 15322111100001113 03/20/14 03/20/14 TPL \$0.00	CROCKER, BETTY 12345678 98940 CHIROPRACT MANJ 1-2 REG	1000002506	1.0	\$60.00	\$45.40	\$0.00	\$45.40	P
5 Adjust TCN: 14297810000000000			6 Dated: 04/14/14					
7 Total Adjusted Claims: 16	8 Lines: 18	9 TPL \$0.00	10 0.0	11 \$0.00	12 \$356.03	13 \$0.00	14 \$356.03	

### Adjustment Claim Page of the Remittance Advice

Circled Item	Adjustment Claims Page Explanation
<b>Credit</b>	
1.	<b>Medicaid ID, Member Name, Claim Control Number, Patient Acct Nbr, Service Dates, CPT/HCPCS/Mod, Description, Rend Prov, Units, Billed, Allowed, Oth-Ded, EOB, Status, Total Charges Billed, Total Charges Allowed, TPL, Total Payment:</b> the information in this section will reflect the originally submitted claim. All numeric details will be reflected as a negative number. Status in this section reflects how each claim line adjudicated on the original claim.
2.	<b>Adjustment TCN:</b> the TCN of the original claim being adjusted.
3.	<b>Dated:</b> the payment date of the original claim now referenced as the credit.
<b>Debit</b>	



Circled Item	Adjustment Claims Page Explanation
4.	<b>Medicaid ID, Member Name, Claim Control Number, Patient Acct Nbr, Service Dates, CPT/HCPCS/Mod, Description, Rend Prov, Units, Billed, Allowed, Oth-Ded, EOB, Status, Total Charges Billed, Total Charges Allowed, TPL, Total Payment:</b> the information in this section will reflect the adjusted claim. All numeric details will be reflected as a positive numbers. Status in this section reflects how each claim line adjudicated on the adjusted claim.
5.	<b>Adjustment TCN:</b> the TCN of the original claim being adjusted. This is duplicated to help providers keep track of all credits and associated debits for each adjusted claim.
6.	<b>Dated:</b> the payment date of the original claim now referenced as the credit.
<b>Section Totals</b>	
7.	<b>Total Adjusted Claims:</b> the number of claims totaled for each section of the RA.
8.	<b>Lines:</b> the number of claim lines totaled for each section of the RA.
9.	<b>Total TPL:</b> the difference in the total amount paid by a third-party resource for all claims in this section of the RA.
10.	<b>Total Units:</b> the difference in the total billed units for all claims in this section of the RA.
11.	<b>Total Billed:</b> the difference in the total amount billed for all claims in this section of the RA.
12.	<b>Total Allowed:</b> the difference in the total amount allowed for all claims in each section of the RA.
13.	<b>Total Oth-Ded:</b> the difference in the total amount deducted, excluding TPL, for all claims in this section of the RA.
14.	<b>Total Payment:</b> the difference in the total amount paid for all claims in this section of the RA.

## Voided Claims Page

A previously paid claim line can be voided and would result in a deduction from the provider's 1099 total. An Adjustment/Void Request is submitted by the provider. Instructions for submitting a void are discussed under *Adjustments and Voids*.

This figure shows the claim lines voided on the remittance cycle. Note the circled numbers on the sample page and refer to the corresponding explanations. All values in the voided section will be zero or negative representative of voiding the transaction from the payment history.

Enterprise Operational Reports Report ID: OPR-PAY-L127			Alaska Department of Health and Social Services Remittance Advice Remittance No: 2840000 05/11/2016				PROVIDER NO:1000002 NPI :1098765432		
Pay to: MCCORMICK CHIROPRACTIC 200 PEPPER LN STE 8 ANCHORAGE, AK 99508-1234			Claim Type P - Professional VOID CLAIMS						
MEMBER ID	MEMBER NAME								
CLAIM CONTROL#	PATIENT ACCT NBR								
SERVICE DATES	CPT/HCPCS MOD DESCRIPTION		REND PROV	UNITS	BILLED	ALLOWED	OTH-DED	PAYMENT EOB	STATUS
TPL \$0.00			TOTAL CHARGE	-1.0	-\$40.00	-\$9.84	\$0.00	-\$9.84	
Voided TCN: 1435300000000070 Dated: 12/22/14 EOB Codes									
1	060555551 WASHINGTON, MARTHA								
	16116890123456781 1234567								
	10/29/14 10/29/14 96110 33 DEVELOPMENTAL SCREEN W/		1987654321	-1.0	-\$40.00	-\$11.57	\$0.00	-\$11.57	P
TPL \$0.00			TOTAL CHARGE	-1.0	-\$40.00	-\$11.57	\$0.00	-\$11.57	
2 Voided TCN: 14354000042342300 3 Dated: 12/29/14 EOB Codes									
	0609876543 WORTHINGTON, TIMMY								
	16116890111223341 1200021								
	06/05/14 06/05/14 96110 33 DEVELOPMENTAL SCREEN W/		1987654321	-2.0	-\$80.00	-\$25.47	\$0.00	-\$25.47	P
TPL \$0.00			TOTAL CHARGE	-2.0	-\$80.00	-\$25.47	\$0.00	-\$25.47	
Voided TCN: 14352300040263400 Dated: 12/22/14 EOB Codes									
4 Total Voided Claims: 44 5 Lines: 48 6 TPL \$0.00 7 -67.0 8 -\$2,820.00 9 -\$674.53 10 \$0.00 11 -\$674.53									

### Voided Claim Page of the Remittance Advice

Circled Item	Voided Claims Page Explanation
1.	<b>Medicaid ID, Member Name, Claim Control Number, Patient Acct Nbr, Service Dates, CPT/HCPCS/Mod, Description, Rend Prov, Units, Billed, Allowed, Oth-Ded, EOB, Status, Total Charges Billed, Total Charges Allowed, TPL, Total Payment:</b> the information in this section will reflect the originally submitted claim. All numeric details will be reflected as a negative number. Status in this section reflects how each claim line adjudicated on the original claim.
2.	<b>Voided TCN:</b> the TCN of the original claim being voided.
3.	<b>Dated:</b> the payment date of the original claim referenced in the void.
<b>Section Totals</b>	
4.	<b>Total Voided Claims:</b> the number of claims totaled for this section of the RA.
5.	<b>Lines:</b> the number of claim lines totaled for this section of the RA.
6.	<b>TPL:</b> the total amount paid by a third-party resource for all claims in this section of the RA.
7.	<b>Total Units:</b> the total units for all claims in this section of the RA.
8.	<b>Total Billed:</b> the total amount billed for all claims in this section of the RA.
9.	<b>Total Allowed:</b> the total amount allowed for all claims in this section of the RA.
10.	<b>Total Oth-Ded:</b> the difference in the total amount deducted, excluding TPL, for all claims in this section of the RA.
11.	<b>Total Payment:</b> the total amount voided for all claims in this section of the RA.

### In-Process Claims

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

If an in-process claim requires internal review by a Conduent or Alaska Department of Health and Social Services claims examiner, its processing is suspended. For example, a claim may:

- Exceed timely filing
- Have attached documentation that requires review
- Need to be manually priced

An in-process claim that is suspended is identified in the *Status* column as "S." No action is required by the provider while a claim is pended.

Claims that are fully adjudicated may also appear in this section if they were not processed prior to the payment cycle deadline. These claims will be identified in the *Status* column as "O", which is *to be paid*, or "C", which is *to be denied*. These claims are identified in this section for tracking purposes only. When adjudication is final, they will appear in the appropriate section of the RA with full processing details.

A sample RA page showing in-process claims is in the follow figure. An explanation of the circled items follows below.

Enterprise Operational Reports  
Report ID: OPR-PAY-L127

Alaska Department of Health and Social Services  
Remittance Advice  
Remittance No: 2987654  
08/05/2015

PROVIDER NO:1000000  
NPI :1234567890

Pay to: PROFESSIONAL PROVIDER  
FIREWEED PLACE  
ANCHORAGE, AK 99500-1234

Claim Type P - Professional

IN PROCESS CLAIMS

MEMBER ID	MEMBER NAME	CLAIM CONTROL#	PATIENT ACCT NBR	SERVICE DATES	BILLED	STATUS	EOB1	EOB2
EOB Codes								
0400000004	MADISON, JAMES	150068123400000040	3012345678S2C2019	07/21/13 - 07/21/13	\$1,182.69	S	1212	1994
EOB Codes								
0400000004	MADISON, JAMES	150068234500000040	3012345678S2C2019	06/17/13 - 06/17/13	\$964.65	S	1212	
EOB Codes								
0400000004	MADISON, JAMES	150264123400000043	3012345678S2C2019	02/19/13 - 02/19/13	\$3,536.74	S	9950	1212
EOB Codes								
0100000001	WASHINGTON, GEORGE	143048000000000012	3098765432S2C2019	12/27/13 - 12/30/13	-\$10,746.75	O	9379	
EOB Codes								
0100000001	WASHINGTON, GEORGE	143048000000000013	3098765432S2C2019	12/27/13 - 12/30/13	\$10,746.75	C	9379	
EOB Codes								
0100000001	WASHINGTON, GEORGE	150418000000000010	3098765432S2C2019	12/27/13 - 12/30/13	\$10,746.75	S	1882	3828
EOB Codes								
TOTAL PENDED CLAIMS	: 63	TOTAL CHARGES:	\$284,637.66					
TOTAL BUDGET FUNDED CLAIMS:	0	TOTAL CHARGES:	\$0.00					

#### In-process Claims Page of the Remittance Advice

Circled Item	In-Process Claims Page Explanation
1.	<b>Medicaid ID:</b> the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).
2.	<b>Member Name:</b> the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file. If the claim is denied because the recipient number on the claim is invalid, no name will appear on the RA.
3.	<b>Claim Control Number:</b> the 17-digit number assigned to the claim by Conduent for processing, based on the Julian Date calendar.
4.	<b>Patient Acct Nbr:</b> the number assigned to a recipient or a claim by the provider for reference purposes. If the provider has indicated a medical record number on the claim form, it is printed on the RA to help the provider identify the patient who received the services.
5.	<b>Service Dates:</b> the date or dates the services were performed.
6.	<b>Billed:</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
7.	<b>Status:</b> the disposition of each specific claim, e.g., paid, deny.

Circled Item	In-Process Claims Page Explanation
	<p><b>Suspended (S).</b> A suspended claim requires a review prior to adjudication. No action is required by the provider.</p> <p><b>To be Paid (O).</b> To be paid claim lines have passed preliminary adjudication. They may be paid as submitted or at reduced amounts according to the program's reimbursement methodology.</p> <p><b>To be Denied (C).</b> To be denied claim lines represent those services that are unacceptable for payment during preliminary adjudication. Denial may occur if claims information cannot be validated by Conduent, if the billed service is not a program benefit, or if line items fail the edit/audit process. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within filing time limits.</p>
8.	<b>EOB1 / EOB2:</b> Up to two EOB codes affecting the claim disposition. The descriptions for these codes are listed on a separate page at the end of the RA.
9.	<b>Total Pended Claims:</b> the total number of claims pended in this section of the RA.
10.	<b>Total Charges (Pended):</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
11.	<b>Total Budget Funded Claims:</b> the total number of approved claims that have had payment withheld temporarily due to budget constraints for this section of the RA.
12.	<b>Total Charges (Budget Funded):</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.

## Financial Transactions Pages

This section will only be included in the RA if there are active financial transactions. This section of the 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

This figure shows the Financial Transactions pages of the RA. The circled items on the sample page are explained below.

Pay to: PROFESSIONAL PROVIDER FIREWEED PLACE ANCHORAGE, AK 99500-1234		Remittance No: 2987654 08/05/2015		PROVIDER NO: 1000000 NPI : 1234567890	
<b>1 Financial Recoupments</b>					
<b>2</b> FCN: 2015021700000	<b>3</b> FRC: 119 - Receivable Claim Fiscal Agent	<b>4</b> ESTAB DATE: 02/16/15	<b>6</b> ORIGINAL BALANCE: \$0.020.41	<b>7</b> PRIOR BALANCE: \$0.00	
<b>5</b> FINANCIAL TCN 15345099912343210	<b>9</b> CYCLE DECREASE - \$0.020.41	<b>11</b> FINANCIAL REASON CODE 119 - Receivable Claim Fiscal Agent	<b>8</b> MEMBER ID	<b>10</b> MEMBER NAME	
<b>11</b> TOTAL FINANCIAL TRANSACTIONS: 1					

Pay to: PROFESSIONAL PROVIDER FIREWEED PLACE ANCHORAGE, AK 99500-1234		Remittance No: 2987654 08/12/2015		PROVIDER NO: 1000000 NPI : 1234567890	
<b>1 Financial Transactions - For Payment</b>					
<b>2</b> FIN CNTL NBR	<b>5</b> RELATED TCN	<b>4</b> ESTABLISHED DA	<b>3</b> REASON CODE - DESCRIPTION	<b>10</b> MEMBER ID	<b>12</b> AMOUNT
2015021700000	15001999912343220	03/18/15	224 - Claim Recoup of a Receivable		-\$682.20
2015021700001	15001999912343230	03/18/15	224 - Claim Recoup of a Receivable		-\$2,768.75
2015021700001	15001999912343240	03/18/15	224 - Claim Recoup of a Receivable		-\$2,768.75
2015021700001	15001999912343250	03/18/15	224 - Claim Recoup of a Receivable		-\$2,768.75
2015021700001	15001999912343260	03/18/15	224 - Claim Recoup of a Receivable		-\$31.96
<b>11</b> TOTAL FINANCIAL TRANSACTION = 5					

### Financial Transactions Pages of the Remittance Advice

Circled Item	Financial Transactions Pages Explanation
	<i>Fields apply to specific transaction types. Only fields that apply will be seen.</i>
1.	<b>Transaction Type:</b> the type of financial transaction shown in this section.
2.	<b>Financial Control Number (FCN):</b> an internal number to identify each financial transaction processed.
3.	<b>Financial Reason Code (FRC):</b> an internal code that indicates the reason for this financial transaction.
4.	<b>Established Date:</b> the date on which the financial transaction was submitted for processing.
5.	<b>Financial TCN / Related TCN:</b> the TCN related to the financial transaction, if applicable.
6.	<b>Original Balance:</b> the original balance of the financial transaction.
7.	<b>Prior Balance:</b> the balance of the financial transaction prior to the current payment cycle.
8.	<b>Forward Balance:</b> the balance of the financial transaction to be carried forward after the current payment cycle.
9.	<b>Cycle Decrease:</b> the amount the payment cycle will be adjusted. A negative number is a payment/overpayment to the provider. A positive number is a payment received from the provider.
10.	<b>Amount:</b> the amount of the financial transaction.
11.	<b>Total Financial Transaction:</b> the number of transactions and the total amount of money for the transaction type.
12.	<b>Total Amount:</b> the amount of all financial transactions in the section.

### EOB Description Page

This page lists all EOB (explanation of benefit) codes found on this RA and a brief description of each. 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, the provider should contact the Conduent Provider Inquiry Unit at 907.644.6800 or 800.770.5650 (toll-free in Alaska).

A sample RA page with EOB codes and descriptions is shown in the following figure. Please refer to the explanations of the circled items below.

Enterprise Operational Reports Report ID: OPR-PAY-L127	Alaska Department of Health and Social Services Remittance Advice Remittance No: 2987654 08/05/2015	PROVIDER NO:1000000 NPI :1234567890
Pay to: PROFESSIONAL PROVIDER FIREWEED PLACE ANCHORAGE, AK 99500-1234	EOB DESCRIPTIONS	
<p>1 EOB 2 EOB DESCRIPTION</p> <p>2950 Payment cannot be made. The Member is locked into another Provider.</p> <p>3155 Rendering Provider NPI ID is not on file.</p> <p>3301 The Rendering Provider ID is not valid for the Dates of Service on the claim.</p> <p>3305 The Rendering Provider does not have an active Enrollment Span that covers the Dates of Service on the claim.</p> <p>3320 The Rendering Provider Number is not affiliated with the Billing Provider Group.</p> <p>3321 The Rendering Provider Certification is Expired. Please provide updated Provider Certification information to Provider Relations.</p> <p>3325 The Rendering Provider License is Expired. Please provide updated Provider License information to Provider Relations.</p> <p>3326 The Rendering Provider License is Expired. Please provide updated Provider License information to Provider Relations.</p> <p>3666 The Rendering Provider ID and qualifier submitted on the claim are not on file.</p> <p>3800 This claim is suspended for further review.</p> <p>3801 This claim is suspended for further review.</p> <p>4105 The Diagnosis Code has been reviewed by the State and it has been determined that payment cannot be made.</p> <p>4406 There is a conflict between the Procedure Code and Modifier 1 submitted on the claim.</p> <p>4418 There is a conflict between the Procedure Code and Provider Specialty submitted on the claim.</p> <p>4433 This claim is suspended for further review.</p> <p>5010 The Service Authorization designated on the claim does not cover the Service (Procedure / Revenue) Code specified by the claim.</p> <p>6280 Our records indicate that the Member has other Insurance available. Please bill the appropriate Third Party Carrier.</p> <p>6430 The member has TPL coverage on file that applies to the claim, the claim has an EOB attached but the TPL amount on the claim is zero.</p> <p>6512 Code pairs found to be unbundled in accordance with National Correct Coding Initiative (NCCI).</p> <p>8050 SA limit unit of measure code does not equal claim unit of measure code.</p>		

### Explanation of Benefits (EOB) Page of the Remittance Advice

Circled Item	EOB Page Explanation
1.	<b>EOB Code:</b> an explanation of benefits code that explains the disposition of a claim.
2.	<b>EOB Description:</b> a written message that explains the disposition of a claim.

### Remittance Summary Page

The remittance summary shows the total weekly and year-to-date dollars paid to and collected from the provider. After the calendar year, Conduent sends each provider a 1099 tax information statement, showing total Medical Assistance reimbursement payments made during the year. The same information is sent to the IRS. This information will match the year-to-date total paid amount shown on the last RA issued for the calendar year. If the totals disagree, contact Conduent immediately.

The explanations below correspond to the circled items on the sample remittance summary in the following figure.

Enterprise Operational Reports Report ID: OPR-PAY-L127	Alaska Department of Health and Social Services Remittance Advice Remittance No: 2987654 08/05/2015	PROVIDER NO:1000000 NPI :1234567890
Pay to: PROFESSIONAL PROVIDER FIREWEED PLACE ANCHORAGE, AK 99500-1234	REMITTANCE ADVICE SUMMARY	
<p>1 FOR PAYMENT 2 HISTORY ONLY 14 PRIOR 15 CYCLE 16 CYCLE 17 NET 18 FORWARD</p> <p>3 COUNT 4 AMOUNT COUNT AMOUNT BALANCE INCREASE DECREASE CYCLE FORWARD</p>		
5 PAID ORIGINAL	39 \$43,380.14	0 \$0.00
6 PAID DEBIT ADJUSTMENT	0 \$0.00	0 \$0.00
7 PAID CREDIT ADJUSTMENT	0 \$0.00	0 \$0.00
8 PAID VOIDED CLAIMS	7 -\$7,170.38	0 \$0.00
9 DENIED (*)	8 \$155,804.00	0 \$0.00
10 SUSPENDED (*)	43 \$805,907.46	0 \$0.00
11 FINANCIAL TRANSACTIONS	5 -\$9,020.41	0 \$0.00
12 BUDGET FUNDED	0 \$0.00	0 \$0.00
13 NET CLAIM TXNS	102 \$988,700.81	0 \$0.00
<p>(*) = Includes Original Claims, Voids and Adjustments</p> <p>19 FINANCIAL TRANSACTIONS</p> <p>REFUNDS AND VOIDED CHECKS: \$0.00</p> <p>SYSTEM PAYOUTS: \$0.00</p> <p>MANUAL PAYOUTS: \$0.00</p> <p>RECOVERIES: \$0.00</p> <p>NET FINANCIAL TRANSACTIONS: \$9,020.41</p> <p>CHANGE IN ACCOUNT RECEIVABLES: -\$9,020.41</p>		
20 REMITTANCE CYCLE TOTAL:	\$27,189.35	CHECK NUMBER 45678901 WAS ISSUED FOR \$27,189.35 WITH THIS REMITTANCE
21 YEAR-TO-DATE CLAIMS COUNT:	337	22 YEAR-TO-DATE TOTAL PAID(1099): \$268,682.70

### Remittance Summary Page of the Remittance Advice



Circled Item	Remittance Summary Page Explanation
1.	<b>For Payment:</b> Claim counts and amounts in the two columns beneath <i>For Payment</i> were applied to the current payment cycle.
2.	<b>History Only:</b> Claim counts and amounts in the two columns beneath <i>History Only</i> were adjudicated, but not applied, during the current cycle.
3.	<b>Count:</b> the total claims applied to the current payment cycle.
4.	<b>Amount:</b> the total dollar amount applied to the current payment cycle.
5.	<b>Paid Original:</b> the total number of paid claims applied to the current payment cycle.
6.	<b>Paid Debit Adjustment:</b> the total number of debit adjustment claims applied to the current payment cycle.
7.	<b>Paid Credit Adjustment:</b> the total number of credit adjustment claims applied to the current payment cycle.
8.	<b>Paid Voided Claims:</b> the total number of voided claims applied to the current payment cycle.
9.	<b>Denied:</b> the total number of denied claims applied to the current payment cycle.
10.	<b>Suspended:</b> the total number of suspended claims during the current payment cycle.
11.	<b>Financial Transactions:</b> the total number of financial transactions applied to the current payment cycle.
12.	<b>Budget Funded:</b> the total number of claims in budget-funded status during the current payment cycle.
13.	<b>Net Claim TXNS (Transactions):</b> the total count of claim transactions and net dollar amounts applied to the current payment cycle.
<b>Financial Transactions</b>	
14.	<b>Prior Balance:</b> the financial transaction balance brought forward from previous cycle, indicating dollar amount yet to be received from the provider. Examples include the provider sending in an Adjustment/Void Request form for an overpayment without sending a refund check or a financial transaction generated by the state. Providers are notified of all state-initiated financial transactions.
15.	<b>Cycle Increase:</b> the dollar amount the account receivables increased during the current payment cycle.
16.	<b>Cycle Decrease:</b> the dollar amount the account receivables decreased during the current payment cycle.
17.	<b>Net Cycle:</b> the net difference in account receivable increase and decrease as applied during the current payment cycle.
18.	<b>Forward Balance:</b> the remaining account receivable balance after transactions from the current payment cycle have been applied. This will be the Prior Balance on the next payment cycle.
19.	<b>Financial Transactions:</b> the summary of financial transactions by type that are applied to the current payment cycle: refund and voided checks, system payouts, manual payouts, and recoveries.
<b>Summary</b>	





## Message Page

The first section of the RA, following the cover page, is used to relay messages from Conduent to the provider. The message page advises providers regarding:

- Changes in billing procedures or program coverage
- Billing procedure or program reminders
- Messages from the Department of Health and Social Services (DHSS) and Conduent
- Provider training schedules

Careful attention to this information will aid your claims processing.

*****ALASKA MEDICAID REMITTANCE*****		
<hr/>		
FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS AK 99701 Payee ID:1000000 NPI: 1234567890	ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES MEDICAID MANAGEMENT INFORMATION SYSTEM REMITTANCE ADVICE	DATE: 02/18/15 REMITTANCE:9876543 PAGE: 2
<hr/>		
2015 Third and Fourth Quarter Provider Training Schedules Now Available		
<p>Alaska Medicaid is pleased to announce that the third and fourth quarters of 2015 Provider Training classes are now open for registration. Training locations, dates and times of classes for 2015 may be viewed on the Learning Management System (LMS) at <a href="http://learn.medicaidalaska.com">http://learn.medicaidalaska.com</a>. For a complete list of courses and descriptions, log in to the LMS and select Provider Training from the Provider dropdown menu. For training dates and instructions for navigating the LMS, please see the provider flyers "2015 Third Quarter Provider Training Schedule Now Available" and "2015 Fourth Quarter Provider Training Schedule Now Available" in Health Enterprise (Documentation &gt; Documents &amp; Forms &gt; Provider Updates).</p>		
February Provider Newsletter Now Available		
<p>Xerox, in conjunction with the Division of Health Care Services, publishes a monthly newsletter. The purpose of this newsletter is to offer providers useful information, monthly reminders, and tips to make billing easier. The Alaska Medicaid newsletter for the month of February is available now at <a href="https://medicaidalaska.com/portals/wps/portal/NewsLetters">https://medicaidalaska.com/portals/wps/portal/NewsLetters</a> and <a href="http://manuals.medicaidalaska.com/docs/updates.htm">http://manuals.medicaidalaska.com/docs/updates.htm</a>.</p>		

### Message Page of the Remittance Advice

## Adjudicated Claims (Paid and Denied Claims Page)

This figure shows a sample RA page relating to adjudicated claims. To help you identify the information, note the circled number on the sample and refer to the corresponding explanation on the following pages.

Enterprise Operational Reports Report ID: OPR-PAY-L127				Alaska Department of Health and Social Services Remittance Advice Remittance No:9876543 02/18/2015				PROVIDER NO:1000000 NPI :1234567890					
Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701				Claim Type O - Outpatient				ADJUDICATED CLAIMS					
MEMBER ID CLAIM CONTROL# SERVICE DATES		MEMBER NAME PATIENT ACCT NBR REV HCPCS MOD		HCPCS DESCRIPTION		PAY MODE	COV DAYS	UNITS	BILLED	ALLOWED	DISALLOWED	EOB	STATUS
0300000003		JEFFERSON, THOMAS											
15043300000000030		305678901251C2019											
11/01/14 11/01/14		0250 J3460		DRUGS UNCLASSIFIED INJECTION				1.0	\$9.95	\$4.67		\$5.28	P
11/01/14 11/01/14		0250 J3460		DRUGS UNCLASSIFIED INJECTION				1.0	\$9.95	\$4.62		\$5.23	P
11/01/14 11/01/14		0300 87081		CULTURE SCREEN ONLY				1.0	\$209.84	\$9.35		\$200.49	P
11/01/14 11/01/14		0300 87880		STREP A ASSAY W/OPTIC				1.0	\$73.87	\$16.90		\$56.97	P
11/01/14 11/01/14		0450 99283		EMERGENCY DEPT VISIT				1.0	\$1,000.51	\$469.24		\$531.27	P
TPL \$0.00		PATIENT LIABILITY \$0.00		TOTAL CHARGE				5.0	\$1,394.02	\$504.78		\$850.24	
EOB Codes				CO-PAYMENT \$0.54				CONTRACTUAL \$0.00		PAYMENT \$504.78			
0400000004		MADISON, JAMES											
150068123400000040		301234567852C2019											
11/05/14 11/05/14		0250 J3460		DRUGS UNCLASSIFIED INJECTION				1.0	\$6.05	\$3.12		\$3.53	P
11/05/14 11/05/14		0250 J3460		DRUGS UNCLASSIFIED INJECTION				1.0	\$9.85	\$4.62		\$5.23	P
11/05/14 11/05/14		0250 J3460		DRUGS UNCLASSIFIED INJECTION				1.0	\$12.90	\$0.00		\$6.85	4350 D
11/05/14 11/05/14		0250 J0558		PENG BENZATHINE/PROCAINE INJ				1.0	\$137.50	\$64.49		\$73.01	P
11/05/14 11/05/14		0300 87880		STREP A ASSAY W/OPTIC				1.0	\$73.87	\$16.90		\$56.97	P
11/05/14 11/05/14		0450 99372		THER/PROPH/DIAG INJ SC/IM				1.0	\$122.58	\$57.49		\$65.09	P
11/05/14 11/05/14		0450 99283 25		EMERGENCY DEPT VISIT				1.0	\$1,000.51	\$469.24		\$531.27	P
TPL \$0.00		PATIENT LIABILITY \$0.00		TOTAL CHARGE				7.0	\$1,393.86	\$615.86		\$741.95	
EOB Codes				CO-PAYMENT \$0.54				CONTRACTUAL \$6.05		PAYMENT \$615.86			
0100000001		WASHINGTON, GEORGE											
143048000000000010		309876543252C2019											
02/04/15 02/04/15		0255 A9585		GADOBUTROL INJECTION				1.0	\$122.85	\$57.62		\$65.23	P
02/04/15 02/04/15		0612 72158		MRI LUMBAR SPINE W/O & W/DYE				1.0	\$2,079.22	\$975.15		\$1,104.07	P
TPL \$0.00		PATIENT LIABILITY \$0.00		TOTAL CHARGE				2.0	\$2,202.07	\$1,032.77		\$1,169.30	
EOB Codes				CO-PAYMENT -\$51.64				CONTRACTUAL \$51.64		PAYMENT \$981.13			
Total Adjudicated Claims: 382		Lines: 2352						\$785,315.72	\$258,695.06	\$479,473.94			
TPL \$0.00		PATIENT LIABILITY \$0.00		CO-PAYMENT -\$1,125.81				CONTRACTUAL \$48,422.67		PAYMENT \$257,419.11			
Run Date: 2/18/2015				Page 160 of 311				Run Time: 16:47:13					

### Adjudicated Claim Page of the Remittance Advice

Circled Item	Adjudicated Claim Page Explanation
1.	<b>Pay to:</b> the name to which payment is made for services rendered.
2.	<b>Provider Payee Address:</b> the street, city, state, and ZIP code of the provider who is paid for the services.
3.	<b>Provider No.:</b> the Medical Assistance identification number of the billing provider.
4.	<b>NPI:</b> the National Provider Identifier of the billing provider.
5.	<b>Remittance No.:</b> a control number used by Conduent in the production of RAs.
6.	<b>Date:</b> the date the RA was created (the remittance cycle date).
7.	<b>Claim Type and Class:</b> identifies the type of claim filed by the provider and the status being totaled (e.g., "adjudicated," "in-process," etc.).
8.	<b>Medicaid ID:</b> the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).
9.	<b>Member Name:</b> the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file. If the claim is denied because the recipient number on the claim is invalid, no name will appear on the RA.
10.	<b>Claim Control Number:</b> the 17-digit number assigned to the claim by Conduent for processing, based on the Julian Date calendar.
11.	<b>Patient Acct Nbr:</b> the number assigned to a recipient or a claim by the provider for reference purposes. If the provider has indicated a medical record number on the claim form, it is printed on the RA to help the provider identify the patient who received the services.
12.	<b>Pay Mode:</b> the rate of payment established by the Medicaid Rate Advisory Commission.

Circled Item	Adjudicated Claim Page Explanation
13.	<b>Cov Days:</b> the covered days allowed for the diagnosis.
14.	<b>Service Dates:</b> the date or dates the services were performed.
15.	<b>Rev/HCP/Mod:</b> the assigned revenue code or HCP for the services or procedure rendered to the patient and any associated modifier.
16.	<b>HCP Description:</b> the description of the services rendered. This is printed on the RA as it is described in the Procedure/Revenue Code File; therefore, it may not be the same as written on the claim when it was submitted.
17.	<b>Units:</b> the number of times/days that billed services were rendered.
18.	<b>Billed:</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
19.	<b>Allowed:</b> the dollar value for covered revenue codes, accounting for any accommodation cutback.
20.	<b>EOB:</b> EOB codes for each claim line. The descriptions for these codes are listed on a separate page at the end of the RA. For a denied claim line, the EOB indicates the reason for the denial.
21.	<p><b>Status:</b> the disposition of each specific claim, e.g., paid, deny.</p> <p><b>Paid (P).</b> Paid claim lines have passed final adjudication. They may be paid as submitted or at reduced amounts according to the program's reimbursement methodology.</p> <p><b>Deny (D).</b> Denied claim lines represent those services that are unacceptable for payment. Denial may occur if claims information cannot be validated by Conduent, if the billed service is not a program benefit, or if line items fail the edit/audit process. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within filing time limits.</p>
22.	<b>Total Charges Billed:</b> the total amount billed on the claim.
23.	<b>Total Charges Allowed:</b> the total allowed charges to which the payment percent (pay mode) is applied.
24.	<b>TPL:</b> the total amount paid by a third-party resource on the claim.
25.	<b>Patient Liability:</b> the amount the recipient is to pay for the claim (applies only for long-term care services).
26.	<b>Co-payment:</b> the copayment amount that the recipient has paid or is to pay on the claim.
27.	<b>Contractual:</b> the difference between the allowed amount and the calculated Medical Assistance payment (which has been reduced by other payment sources, such as TPL and copayment).
28.	<b>Payment:</b> the total allowed amount multiplied by the pay mode, less copayment and third-party payment.
29.	<b>EOB:</b> the principal EOB code for the claim in its current status. The descriptions for these codes are listed on a separate page at the end of the RA. For a denied claim line, the EOB indicates the reason for the denial.
30.	<b>Total Adjudicated Claims:</b> the number of claims totaled for each section of the RA.
31.	<b>Lines:</b> the number of claim lines totaled for each section of the RA.
32.	<b>Total Billed:</b> the total amount billed for all claims in each section of the RA.

Circled Item	Adjudicated Claim Page Explanation
33.	<b>Total Allowed:</b> the total amount allowed for all claims in each section of the RA.
34.	<b>Total TPL:</b> the total amount paid by a third-party resource for all claims in this section of the RA.
35.	<b>Total Patient Liability:</b> the total amount that recipients are to pay for all claims in this section of the RA.
36.	<b>Total Co-payment:</b> the total copayment amount that recipients have paid or have yet to pay on all claims in this section of the RA.
37.	<b>Total Contractual:</b> the difference between the total allowed amount and the calculated Alaska Medical Assistance payment (which has been reduced by other payment sources, such as TPL and copayment) for all claims in this section of the RA.
38.	<b>Total Payment:</b> the total amount paid for all claims in this section of the RA.

## Adjustment Claims Page

Previously paid claims may be adjusted if an error occurred in billing or processing. If payment is owed to the provider, an Adjustment/Void Request must be submitted within the 12-month timely filing period of the date services were rendered. If money is owed to Alaska Medical Assistance, there is no time limit for filing for an adjustment.

When an adjustment request results in a paid claim, the processed adjustment appears in two parts on the *Adjustment Claims Page* of your RA:

- **Credit.** Listed first in the transaction, the credit displays the original TCN details and reverses the original transaction. This portion adjusts the credits on the provider's 1099 by decreasing the paid amount.
- **Debit.** Listed second in the transaction, the debit displays the replacement TCN details, including the corrected information and payment. It also lists the former TCN associated with the credit above. The date with the Adjust TCN is the date of the remittance advice on which original payment was made. If additional adjustments are necessary, use the debit TCN.

This figure shows a sample adjustment claim page from an RA. The sample page identifies adjustment requests as they are processed. Note the circled numbers on the sample page and refer to the corresponding explanations after the sample page.

Enterprise Operational Reports Report ID: OPR-PAY-L127		Alaska Department of Health and Social Services Remittance Advice Remittance No: 9876543 02/18/2015				PROVIDER NO:1000000 NPI :1234567890				
Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701		Claim Type O - Outpatient		ADJUSTMENT CLAIMS						
MEMBER ID CLAIM CONTROL# SERVICE DATES	MEMBER NAME PATIENT ACCT NBR REV HCPCS MOD	HCPCS DESCRIPTION	PAY MODE	COV DAYS	UNITS	BILLED	ALLOWED	DISALLOWED	EOB	STATUS
1 01000000001 14304800000000012 05/28/14 05/28/14 05/28/14 05/28/14 05/28/14 05/28/14	WASHINGTON, GEORGE 3098765432S2C2019 0250 J3490 0255 Q9967 0350 70481 0450 99284 25	DRUGS UNCLASSIFIED INJECTION LOCM 300-399MG/ML IODINE 1ML CT ORBIT/EAR/FOSSA W/DYE EMERGENCY DEPT VISIT	0.0	0	-2.0 -1.0 -1.0 -1.0 -5.0	-\$9.85 -\$310.10 -\$1,056.55 -\$1,066.00 -\$2,442.50	\$0.00 -\$0.99 -\$495.52 -\$499.95 -\$996.46	-\$5.23 -\$309.11 -\$561.03 -\$566.05 -\$1,441.42		D P P P P
TPL \$0.00		PATIENT LIABILITY \$0.00		TOTAL CHARGE \$0.00		CONTRACTUAL -\$4.62		PAYMENT -\$996.46		
2 Adjust TCN: 14188300000000010	3 Dated: 07/14/14									
4 01000000001 14304800000000013 05/28/14 05/28/14 05/28/14 05/28/14 05/28/14 05/28/14	WASHINGTON, GEORGE 3098765432S2C2019 0250 J3490 0255 Q9967 0350 70481 0450 99284 25	DRUGS UNCLASSIFIED INJECTION LOCM 300-399MG/ML IODINE 1ML CT ORBIT/EAR/FOSSA W/DYE EMERGENCY DEPT VISIT	46.9	0	2.0 1.0 1.0 1.0 5.0	\$9.85 \$310.10 \$1,056.55 \$1,066.00 \$2,442.50	\$4.62 \$0.00 \$495.52 \$499.95 \$1,000.09	\$5.23 \$164.66 \$561.03 \$566.05 \$1,296.97		P D P P P
TPL \$0.00		PATIENT LIABILITY \$0.00		TOTAL CHARGE \$0.00		CONTRACTUAL \$145.44		PAYMENT \$1,000.09		
5 Adjust TCN: 14188300000000010	6 Dated: 07/14/14									
7 Total Adjusted Claims: 62	8 Lines: 613									
11 TPL \$0.00	12 PATIENT LIABILITY \$0.00	13 CO-PAYMENT -\$1,813.38	14 CONTRACTUAL \$3,271.30	9 \$26,312.40	10 -\$2,674.56	15 PAYMENT -\$2,618.88				

### Adjustment Claim Page of the Remittance Advice

Circled Item	Adjustment Claims Page Explanation
<b>Credit</b>	
1.	<b>Medicaid ID, Member Name, Claim Control Number, Patient Acct Nbr, Pay Mode, Cov Days, Service Dates, Rev/HCPCS/Mod, HCPCS Description, Units, Billed, Allowed, EOB, Status, Total Charges Billed, Total Charges Allowed, TPL, Patient Liability, Co-payment, Contractual, Payment:</b> the information in this section will reflect the originally submitted claim. All numeric details will be reflected as a negative number.  Status in this section reflects how each claim line adjudicated on the original claim.
2.	<b>Adjustment TCN:</b> the TCN of the original claim being adjusted.
3.	<b>Dated:</b> the payment date of the original claim now referenced as the credit.
<b>Debit</b>	
4.	<b>Medicaid ID, Member Name, Claim Control Number, Patient Acct Nbr, Pay Mode, Cov Days, Service Dates, Rev/HCPCS/Mod, HCPCS Description, Units, Billed, Allowed, EOB, Status, Total Charges Billed, Total Charges Allowed, TPL, Patient Liability, Co-payment, Contractual, Payment:</b> the information in this section will reflect the adjusted claim. All numeric details will be reflected as a postive numbers.  Status in this section reflects how each claim line adjudicated on the adjusted claim.
5.	<b>Adjustment TCN:</b> the TCN of the original claim being adjusted. This is duplicated to help providers keep track of all credits and associated debits for each adjusted claim.
6.	<b>Dated:</b> the payment date of the original claim now referenced as the credit.
<b>Section Totals</b>	
7.	<b>Total Adjusted Claims:</b> the number of claims totaled for each section of the RA.
8.	<b>Lines:</b> the number of claim lines totaled for each section of the RA.

Circled Item	Adjustment Claims Page Explanation
9.	<b>Total Billed:</b> the total amount billed for all claims in each section of the RA.
10.	<b>Total Allowed:</b> the total amount allowed for all claims in each section of the RA.
11.	<b>Total TPL:</b> the total amount paid by a third-party resource for all claims in this section of the RA.
12.	<b>Total Patient Liability:</b> the total amount that recipients are to pay for all claims in this section of the RA.
13.	<b>Total Co-payment:</b> the total copayment amount that recipients have paid or have yet to pay on all claims in this section of the RA.
14.	<b>Total Contractual:</b> the difference between the total allowed amount and the calculated Alaska Medical Assistance payment (which has been reduced by other payment sources, such as TPL and copayment) for all claims in this section of the RA.
15.	<b>Total Payment:</b> the total amount paid for all claims in this section of the RA.

## Voided Claims Page

A previously paid claim line can be voided and would result in a deduction from the provider's 1099 total. An Adjustment/Void Request is submitted by the provider. Instructions for submitting a void are discussed under *Adjustments and Voids*.

This figure shows the claim lines voided on the remittance cycle. Note the circled numbers on the sample page and refer to the corresponding explanations. All values in the voided section will be zero or negative representative of voiding the transaction from the payment history.



Enterprise Operational Reports Report ID: OPR-PAY-L127				Alaska Department of Health and Social Services Remittance Advice Remittance No:9876543 02/18/2015				PROVIDER NO:1000000 NPI :1234567890																																																																																																																																											
Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701				Claim Type O - Outpatient    VOIDED CLAIMS																																																																																																																																															
<table><thead><tr><th>MEMBER ID CLAIM CONTROL# SERVICE DATES TPL \$0.00</th><th>MEMBER NAME PATIENT ACCT NBR REV HCPCS MOD PATIENT LIABILITY \$0.00</th><th>HCPCS DESCRIPTION CO-PAYMENT -\$0.30</th><th>PAY MODE CONTRACTUAL</th><th>COV DAYS UNITS</th><th>BILLED -\$251.71</th><th>ALLOWED PAYMENT</th><th>DISALLOWED -\$3,591.86</th><th>EOB</th><th>STATUS</th></tr></thead><tbody><tr><td>0300000003 15043300000000031 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14</td><td>JEFFERSON, THOMAS 3056789012S1C2019 0300 87081 0300 87880 0320 73562 RT 0450 99283</td><td>CULTURE SCREEN ONLY STREP A ASSAY W/OPTIC X-RAY EXAM OF KNEE 3 EMERGENCY DEPT VISIT TOTAL CHARGE</td><td>0.0 0 -1.0 -1.0 -1.0 -4.0</td><td>0 -1.0 -1.0 -1.0 -4.0</td><td>-\$249.85 -\$68.40 -\$175.05 -\$926.40 -\$1,419.70</td><td>-\$9.42 -\$17.04 -\$82.10 -\$434.48 -\$543.04</td><td>-\$240.43 -\$51.36 -\$92.95 -\$491.92 -\$876.66</td><td></td><td>P P P P P</td></tr><tr><td colspan="12">Voided TCN: 14333300000013010    Dated: 06/02/14    EOB Codes</td></tr><tr><td colspan="12">TPL \$0.00    PATIENT LIABILITY \$0.00    CO-PAYMENT -\$0.30    CONTRACTUAL \$0.00    PAYMENT -\$543.04</td></tr><tr><td>0400000004 150068123400000041 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13</td><td>MADISON, JAMES 3012345678S2C2019 0250 J3490 0250 J3490 0250 J3490 0450 99283</td><td>DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION EMERGENCY DEPT VISIT TOTAL CHARGE</td><td>0.0 0 -2.0 -1.0 -2.0 -1.0 -6.0</td><td>0 -2.0 -1.0 -2.0 -1.0 -6.0</td><td>-\$9.85 -\$9.85 -\$9.85 -\$849.90 -\$879.45</td><td>\$0.00 \$0.00 \$0.00 \$0.00 -\$14.93</td><td>\$0.00 \$0.00 \$0.00 \$0.00 -\$451.30 -\$456.07</td><td></td><td>D P P P D</td></tr><tr><td colspan="12">Voided TCN: 14444400000014010    Dated: 05/12/14    EOB Codes</td></tr><tr><td colspan="12">TPL \$0.00    PATIENT LIABILITY \$0.00    CO-PAYMENT -\$25.10    CONTRACTUAL -\$408.45    PAYMENT -\$14.93</td></tr><tr><td>0100000001 143048000000000011 10/28/13 10/28/13 10/28/13 10/28/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/30/13 10/30/13 10/30/13 10/30/13 10/28/13 10/28/13</td><td>WASHINGTON, GEORGE 3098765432S2C2019 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0450 99285</td><td>DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION EMERGENCY DEPT VISIT TOTAL CHARGE</td><td>0.0 0 -2.0 -1.0 -2.0 -2.0 -2.0 -1.0 -1.0 -1.0 -1.0 -13.0</td><td>0 -2.0 -1.0 -2.0 -2.0 -2.0 -1.0 -1.0 -1.0 -1.0 -13.0</td><td>-\$18.90 -\$10.30 -\$18.90 -\$5.20 -\$29.00 -\$10.30 -\$9.85 -\$5.17 -\$14.50 -\$2,452.55 -\$2,569.50</td><td>\$0.00 -\$10.30 -\$10.05 -\$5.20 -\$29.00 -\$10.30 -\$5.17 -\$14.50 \$0.00 -\$84.52</td><td>-\$8.85 \$0.00 -\$8.85 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 -\$1,302.30 -\$1,324.68</td><td></td><td>D P P P P P P P P D</td></tr><tr><td colspan="12">Voided TCN: 14111100000011010    Dated: 06/09/14    EOB Codes</td></tr><tr><td colspan="12">TPL \$0.00    PATIENT LIABILITY \$0.00    CO-PAYMENT -\$6,911.59    CONTRACTUAL -\$1,160.30    PAYMENT -\$84.52</td></tr><tr><td colspan="12">4 Total Voided Claims: 6    5 Lines: 85    6 \$21,055.55    7 -\$6,297.53    -\$12,486.15</td></tr><tr><td colspan="12">8 TPL \$0.00    9 PATIENT LIABILITY \$0.00    10 CO-PAYMENT -\$6,937.29    11 CONTRACTUAL -\$2,271.87    12 PAYMENT -\$6,297.53</td></tr></tbody></table>												MEMBER ID CLAIM CONTROL# SERVICE DATES TPL \$0.00	MEMBER NAME PATIENT ACCT NBR REV HCPCS MOD PATIENT LIABILITY \$0.00	HCPCS DESCRIPTION CO-PAYMENT -\$0.30	PAY MODE CONTRACTUAL	COV DAYS UNITS	BILLED -\$251.71	ALLOWED PAYMENT	DISALLOWED -\$3,591.86	EOB	STATUS	0300000003 15043300000000031 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14 05/17/14	JEFFERSON, THOMAS 3056789012S1C2019 0300 87081 0300 87880 0320 73562 RT 0450 99283	CULTURE SCREEN ONLY STREP A ASSAY W/OPTIC X-RAY EXAM OF KNEE 3 EMERGENCY DEPT VISIT TOTAL CHARGE	0.0 0 -1.0 -1.0 -1.0 -4.0	0 -1.0 -1.0 -1.0 -4.0	-\$249.85 -\$68.40 -\$175.05 -\$926.40 -\$1,419.70	-\$9.42 -\$17.04 -\$82.10 -\$434.48 -\$543.04	-\$240.43 -\$51.36 -\$92.95 -\$491.92 -\$876.66		P P P P P	Voided TCN: 14333300000013010    Dated: 06/02/14    EOB Codes												TPL \$0.00    PATIENT LIABILITY \$0.00    CO-PAYMENT -\$0.30    CONTRACTUAL \$0.00    PAYMENT -\$543.04												0400000004 150068123400000041 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13 08/09/13	MADISON, JAMES 3012345678S2C2019 0250 J3490 0250 J3490 0250 J3490 0450 99283	DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION EMERGENCY DEPT VISIT TOTAL CHARGE	0.0 0 -2.0 -1.0 -2.0 -1.0 -6.0	0 -2.0 -1.0 -2.0 -1.0 -6.0	-\$9.85 -\$9.85 -\$9.85 -\$849.90 -\$879.45	\$0.00 \$0.00 \$0.00 \$0.00 -\$14.93	\$0.00 \$0.00 \$0.00 \$0.00 -\$451.30 -\$456.07		D P P P D	Voided TCN: 14444400000014010    Dated: 05/12/14    EOB Codes												TPL \$0.00    PATIENT LIABILITY \$0.00    CO-PAYMENT -\$25.10    CONTRACTUAL -\$408.45    PAYMENT -\$14.93												0100000001 143048000000000011 10/28/13 10/28/13 10/28/13 10/28/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/29/13 10/30/13 10/30/13 10/30/13 10/30/13 10/28/13 10/28/13	WASHINGTON, GEORGE 3098765432S2C2019 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0250 J3490 0450 99285	DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION DRUGS UNCLASSIFIED INJECTION EMERGENCY DEPT VISIT TOTAL CHARGE	0.0 0 -2.0 -1.0 -2.0 -2.0 -2.0 -1.0 -1.0 -1.0 -1.0 -13.0	0 -2.0 -1.0 -2.0 -2.0 -2.0 -1.0 -1.0 -1.0 -1.0 -13.0	-\$18.90 -\$10.30 -\$18.90 -\$5.20 -\$29.00 -\$10.30 -\$9.85 -\$5.17 -\$14.50 -\$2,452.55 -\$2,569.50	\$0.00 -\$10.30 -\$10.05 -\$5.20 -\$29.00 -\$10.30 -\$5.17 -\$14.50 \$0.00 -\$84.52	-\$8.85 \$0.00 -\$8.85 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 -\$1,302.30 -\$1,324.68		D P P P P P P P P D	Voided TCN: 14111100000011010    Dated: 06/09/14    EOB Codes												TPL \$0.00    PATIENT LIABILITY \$0.00    CO-PAYMENT -\$6,911.59    CONTRACTUAL -\$1,160.30    PAYMENT -\$84.52												4 Total Voided Claims: 6    5 Lines: 85    6 \$21,055.55    7 -\$6,297.53    -\$12,486.15												8 TPL \$0.00    9 PATIENT LIABILITY \$0.00    10 CO-PAYMENT -\$6,937.29    11 CONTRACTUAL -\$2,271.87    12 PAYMENT -\$6,297.53											
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Run Date: 2/18/2015      Page 187 of 311      Run Time: 16:47:13																																																																																																																																																			

### Voided Claim Page of the Remittance Advice

Circled Item	Voided Claims Page Explanation
1.	<b>Medicaid ID, Member Name, Claim Control Number, Patient Acct Nbr, Pay Mode, Cov Days, Service Dates, Rev/HCPCS/Mod, HCPCS Description, Units, Billed, Allowed, EOB, Status, Total Charges Billed, Total Charges Allowed, TPL, Patient Liability, Co-payment, Contractual, Payment:</b> the information in this section will reflect the originally submitted claim. All numeric details will be reflected as a negative number. Status in this section reflects how each claim line adjudicated on the original claim.
2.	<b>Voided TCN:</b> the TCN of the original claim being voided.
3.	<b>Dated:</b> the payment date of the original claim referenced in the void.
<b>Section Totals</b>	
4.	<b>Total Voided Claims:</b> the number of claims totaled for each section of the RA.
5.	<b>Lines:</b> the number of claim lines totaled for each section of the RA.
6.	<b>Total Billed:</b> the total amount billed for all claims in each section of the RA.
7.	<b>Total Allowed:</b> the total amount allowed for all claims in each section of the RA.
8.	<b>Total TPL:</b> the total amount paid by a third-party resource for all claims in this section of the RA.
9.	<b>Total Patient Liability:</b> the total amount that recipients are to pay for all claims in this section of the RA.
10.	<b>Total Co-payment:</b> the total copayment amount that recipients have paid or have yet to pay on all claims in this section of the RA.

Circled Item	Voided Claims Page Explanation
11.	<b>Total Contractual:</b> the difference between the total allowed amount and the calculated Alaska Medical Assistance payment (which has been reduced by other payment sources, such as TPL and copayment) for all claims in this section of the RA.
12.	<b>Total Payment:</b> the total amount voided for all claims in this section of the RA.

## In-Process Claims

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

If an in-process claim requires internal review by a Conduent or Alaska Department of Health and Social Services claims examiner, its processing is suspended. For example, a claim may:

- Exceed timely filing
- Have attached documentation that requires review
- Need to be manually priced

An in-process claim that is suspended is identified in the *Status* column as “S.” No action is required by the provider while a claim is pending.

Claims that are fully adjudicated may also appear in this section if they were not processed prior to the payment cycle deadline. These claims will be identified in the *Status* column as “O”, which is *to be paid*, or “C”, which is *to be denied*. These claims are identified in this section for tracking purposes only. When adjudication is final, they will appear in the appropriate section of the RA with full processing details.

A sample RA page showing in-process claims is in the following figure. An explanation of the circled items follows below.

Enterprise Operational Reports Report ID: OPR-PAY-L127			Alaska Department of Health and Social Services Remittance Advice Remittance No:9876543 02/18/2015			PROVIDER NO:1000000 NPI :1234567890		
Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701			Claim Type C - Part B UB Crossover IN PROCESS CLAIMS					
MEMBER ID MEMBER NAME		CLAIM CONTROL#	PATIENT ACCT NBR	SERVICE DATES	BILLED	STATUS	EOB1	EOB2
1	EOB Codes 0430	2						
3	0400000004 MADISON, JAMES	15006812340000040	4	3012345678S2C2019	5	07/21/13 - 07/21/13	6	\$1,182.69
8	EOB Codes					7	S	1212 1994
	0400000004 MADISON, JAMES	15006823450000040		3012345678S2C2019		06/17/13 - 06/17/13		\$964.65
	EOB Codes						S	1212
	0400000004 MADISON, JAMES	15026412340000043		3012345678S2C2019		02/19/13 - 02/19/13		\$3,536.74
	EOB Codes 1994 1922 4000 9854						S	9950 1212
	0100000001 WASHINGTON, GEORGE	14304800000000012		3098765432S2C2019		12/27/13 - 12/30/13		-\$10,746.75
	EOB Codes						O	9379
	0100000001 WASHINGTON, GEORGE	14304800000000013		3098765432S2C2019		12/27/13 - 12/30/13		\$10,746.75
	EOB Codes						C	9379
	0100000001 WASHINGTON, GEORGE	15041800000000010		3098765432S2C2019		12/27/13 - 12/30/13		\$10,746.75
	EOB Codes 1110						S	1882 3828
9	TOTAL FUNDED CLAIMS : 63		10	TOTAL CHARGES: \$264,637.66				
11	TOTAL BUDGET FUNDED CLAIMS: 0		12	TOTAL CHARGES: \$0.00				

## In-process Claims Page of the Remittance Advice

Circled Item	In-Process Claims Page Explanation
1.	<b>Medicaid ID:</b> the 10-digit Medical Assistance identification number assigned to the patient who received the services (the recipient).



Circled Item	In-Process Claims Page Explanation
2.	<b>Member Name:</b> the name of the patient. The name appearing on the RA is the recipient's name as contained in the eligibility file. If the claim is denied because the recipient number on the claim is invalid, no name will appear on the RA.
3.	<b>Claim Control Number:</b> the 17-digit number assigned to the claim by Conduent for processing, based on the Julian Date calendar.
4.	<b>Patient Acct Nbr:</b> the number assigned to a recipient or a claim by the provider for reference purposes. If the provider has indicated a medical record number on the claim form, it is printed on the RA to help the provider identify the patient who received the services.
5.	<b>Service Dates:</b> the date or dates the services were performed.
6.	<b>Billed:</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
7.	<p><b>Status:</b> the disposition of each specific claim, e.g., paid, deny.</p> <p><b>Suspended (S).</b> A suspended claim requires a review prior to adjudication. No action is required by the provider.</p> <p><b>To be Paid (O).</b> To be paid claim lines have passed preliminary adjudication. They may be paid as submitted or at reduced amounts according to the program's reimbursement methodology.</p> <p><b>To be Denied (C).</b> To be denied claim lines represent those services that are unacceptable for payment during preliminary adjudication. Denial may occur if claims information cannot be validated by Conduent, if the billed service is not a program benefit, or if line items fail the edit/audit process. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within filing time limits.</p>
8.	<b>EOB1 / EOB2:</b> Up to two EOB codes affecting the claim disposition. The descriptions for these codes are listed on a separate page at the end of the RA.
9.	<b>Total Pended Claims:</b> the total number of claims pended in this section of the RA.
10.	<b>Total Charges (Pended):</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.
11.	<b>Total Budget Funded Claims:</b> the total number of approved claims that have had payment withheld temporarily due to budget constraints.
12.	<b>Total Charges (Budget Funded):</b> the amount billed to Medical Assistance for the services rendered. If the units billed are greater than one, the amount reflects the total charge for all units.

## Financial Transactions Pages

This section will only be included in the RA if there are active financial transactions. This section of the 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

This figure shows the Financial Transactions pages of the RA. The circled items on the sample page are explained below.

Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701		Remittance No: 9876543 02/18/2015		PROVIDER NO: 1000000 NPI : 1234567890	
1 Financial Recoupments					
2 FCN: 20150217000001	3 FRC: 119 - Receivable Claim Fiscal Agent	4 ESTAB DATE: 02/18/15	6 ORIGINAL BALANCE: \$9,020.41	7 PRIOR BALANCE: \$0.00	
5 FINANCIAL TCN 15345699912343210	9 CYCLE DECREASE - \$9,020.41 Total Decrease: - \$9,020.41	119 - Receivable Claim Fiscal Agent		8 MEMBER ID	MEMBER NAME
11 TOTAL FINANCIAL TRANSACTIONS: 1					

Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701		Remittance No: 9876544 02/25/2015		PROVIDER NO: 1000000 NPI : 1234567890	
1 Financial Transactions - For Payment					
2 FIN CNTL NBR	5 RELATED TCN	4 ESTABLISHED DATE	3 REASON CODE - DESCRIPTION	10 MEMBER ID	MEMBER NAME
20150217000001	15001999912343220	03/18/15	224 - Claim Recoup of a Receivable		
20150217000001	15001999912343230	03/18/15	224 - Claim Recoup of a Receivable		
20150217000001	15001999912343240	03/18/15	224 - Claim Recoup of a Receivable		
20150217000001	15001999912343250	03/18/15	224 - Claim Recoup of a Receivable		
20150217000001	15001999912343260	03/18/15	224 - Claim Recoup of a Receivable		
11 TOTAL FINANCIAL TRANSACTION = 5					12 AMOUNT
					- \$682.20
					- \$2,768.75
					- \$2,768.75
					- \$2,768.75
					- \$31.96
					- \$9,020.41

#### Financial Transactions Pages of the Remittance Advice

Circled Item	Financial Transactions Pages Explanation <i>Fields apply to specific transaction types. Only fields that apply will be seen.</i>
1.	<b>Transaction Type:</b> the type of financial transaction shown in this section.
2.	<b>Financial Control Number (FCN):</b> an internal number to identify each financial transaction processed.
3.	<b>Financial Reason Code (FRC):</b> an internal code that indicates the reason for this financial transaction.
4.	<b>Established Date:</b> the date on which the financial transaction was submitted for processing.
5.	<b>Financial TCN / Related TCN:</b> the TCN related to the financial transaction, if applicable.
6.	<b>Original Balance:</b> the original balance of the financial transaction.
7.	<b>Prior Balance:</b> the balance of the financial transaction prior to the current payment cycle.
8.	<b>Forward Balance:</b> the balance of the financial transaction to be carried forward after the current payment cycle.
9.	<b>Cycle Decrease:</b> the amount the payment cycle will be adjusted. A negative number is a payment/overpayment to the provider. A positive number is a payment received from the provider.
10.	<b>Amount:</b> the amount of the financial transaction.
11.	<b>Total Financial Transaction:</b> the number of transactions and the total amount of money for the transaction type.
12.	<b>Total Amount:</b> the amount of all financial transactions in the section.

## EOB Description Page

This page lists all EOB (explanation of benefit) codes found on this RA and a brief description of each. 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, the provider should contact the Conduent Provider Inquiry Unit at 907.644.6800 or 800.770.5650 (toll-free in Alaska).

A sample RA page with EOB codes and descriptions is shown in the following figure. Please refer to the explanations of the circled items below.

Enterprise Operational Reports Report ID: OPR-PAY-127		Alaska Department of Health and Social Services Remittance Advice Remittance No: 9876543 02/18/2015		PROVIDER NO: 1000000 NPI: 1234567890
Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701		EOB DESCRIPTIONS		
1	EOB DESCRIPTION			
2	1066 This claim is suspended for further review. 1068 This claim is suspended for further review. 1110 This claim is suspended for further review. 1130 The From Service Date on Claim Header is Missing or Invalid. 1140 The Through Service Date on Claim Header is Missing or Invalid. 1151 The From Date of Service on Claim Line is after the Through Date of Service on Claim Line. 1212 Crossover Claim exceeds timely filing and no proof of timely filing attached. 1250 The Revenue Charge is missing or invalid. 1260 The sum of the line item(s) billed charges is not equal to the total submitted charges. 1420 The Type of Bill is missing or invalid. 1450 The Admitting Diagnosis is missing. 1500 The Line Item Date of Service is outside the Header From or Through Dates. 1520 The Patient Status conflicts with billing frequency. 1570 The Discharge Hour is missing or invalid. 1580 The Operating Physician Number is missing. 1620 The 1st Value Code is Invalid. 1621 The 2nd Value Code is Invalid. 1622 The 3rd Value Code is Invalid. 1650 The 1st Value Code requires a Valid Amount or the Valid Amount requires a valid Value Code. 1682 Claim exceed timely filing and no proof of timely filing attached. 1691 The Requested Void or Replacement TCN is Missing or Invalid. The Request cannot be processed. 1692 The Requested Void or Replacement is already in process for this Claim. The Request cannot be processed. 1693 The Member ID on the Requested Void or Replacement TCN does not match the Member ID on the TCN. 1694 The Requested Void or Replacement is already in process for this Claim. The Request cannot be processed. 1695 The TCN to be Replaced or Voided does not match a previously "Paid" or "Denied" Claim in history. 1922 EOMB requires review.			

### Explanation of Benefits (EOB) Page of the Remittance Advice

Circled Item	EOB Page Explanation
1.	<b>EOB Code:</b> an explanation of benefits code that explains the disposition of a claim.
2.	<b>EOB Description:</b> a written message that explains the disposition of a claim.

## Remittance Summary Page

The remittance summary shows the total weekly and year-to-date dollars paid to and collected from the provider. After the calendar year, Conduent sends each provider a 1099 tax information statement, showing total Medical Assistance reimbursement payments made during the year. The same information is sent to the IRS. This information will match the year-to-date total paid amount shown on the last RA issued for the calendar year. If the totals disagree, contact Conduent immediately.

The explanations below correspond to the circled items on the sample remittance summary in the following figure.

Pay to: FAIRBANKS HOSPITAL FAIRBANKS HOSPITAL 1234 ALASKA ST FAIRBANKS, AK 99701				Remittance No: 9876544 02/25/2015				PROVIDER NO: 1000000 NPI :1234567890											
REMITTANCE ADVISE SUMMARY																			
<b>1 FOR PAYMENT</b>				<b>2 HISTORY ONLY</b>				<b>14 PRIOR BALANCE</b>		<b>15 CYCLE INCREASE</b>		<b>16 CYCLE DECREASE</b>		<b>17 NET CYCLE</b>		<b>18 FORWARD BALANCE</b>			
<b>3 COUNT</b>				<b>4 AMOUNT</b>															
<b>5 PAID ORIGINAL</b>				39 \$43,380.14				0 \$0.00		\$9,020.41		\$0.00		\$9,020.41		-\$9,020.41 \$0.00			
<b>6 PAID DEBIT ADJUSTMENT</b>				0 \$0.00				0 \$0.00											
<b>7 PAID CREDIT ADJUSTMENT</b>				0 \$0.00				0 \$0.00											
<b>8 PAID VOIDED CLAIMS</b>				7 -\$7,170.38				0 \$0.00											
<b>9 DENIED (*)</b>				8 \$155,604.00				0 \$0.00											
<b>10 SUSPENDED (*)</b>				43 \$805,907.46				0 \$0.00											
<b>11 FINANCIAL TRANSACTIONS</b>				5 -\$9,020.41				0 \$0.00											
<b>12 BUDGET FUNDED</b>				0 \$0.00				0 \$0.00											
<b>13 NET CLAIM TXNS</b>				102 \$988,700.81				0 \$0.00											
(*) = Includes Original Claims, Voids and Adjustments																			
<b>20 REMITTANCE CYCLE TOTAL:</b>				\$27,189.35															
<b>21 YEAR-TO-DATE CLAIMS COUNT:</b>				337															
												<b>22 CHECK NUMBER 45678901 WAS ISSUED FOR \$27,189.35 WITH THIS REMITTANCE</b>		<b>23</b>					
												<b>24 YEAR-TO-DATE TOTAL PAID(1099):</b>		\$298,682.70					

### Remittance Summary Page of the Remittance Advice

Circled Item	Remittance Summary Page Explanation
1.	<b>For Payment:</b> Claim counts and amounts in the two columns beneath For Payment were applied to the current payment cycle.
2.	<b>History Only:</b> Claim counts and amounts in the two columns beneath History Only were adjudicated, but not applied, during the current cycle.
3.	<b>Count:</b> the total claims applied to the current payment cycle.
4.	<b>Amount:</b> the total dollar amount applied to the current payment cycle.
5.	<b>Paid Original:</b> the total number of paid claims applied to the current payment cycle.
6.	<b>Paid Debit Adjustment:</b> the total number of debit adjustment claims applied to the current payment cycle.
7.	<b>Paid Credit Adjustment:</b> the total number of credit adjustment claims applied to the current payment cycle.
8.	<b>Paid Voided Claims:</b> the total number of voided claims applied to the current payment cycle.
9.	<b>Denied:</b> the total number of denied claims applied to the current payment cycle.
10.	<b>Suspended:</b> the total number of suspended claims during the current payment cycle.
11.	<b>Financial Transactions:</b> the total number of financial transactions applied to the current payment cycle.
12.	<b>Budget Funded:</b> the total number of claims in budget-funded status during the current payment cycle.
13.	<b>Net Claim TXNS (Transactions):</b> the total count of claim transactions and net dollar amounts applied to the current payment cycle.
<b>Financial Transactions</b>	
14.	<b>Prior Balance:</b> the financial transaction balance brought forward from previous cycle, indicating dollar amount yet to be received from the provider. Examples include the provider sending in an Adjustment/Void Request form for an overpayment without sending a refund check or a financial transaction generated by the state. Providers are

Circled Item	Remittance Summary Page Explanation
	notified of all state-initiated financial transactions.
15.	<b>Cycle Increase:</b> the dollar amount the account receivables increased during the current payment cycle.
16.	<b>Cycle Decrease:</b> the dollar amount the account receivables decreased during the current payment cycle.
17.	<b>Net Cycle:</b> the net difference in account receivable increase and decrease as applied during the current payment cycle.
18.	<b>Forward Balance:</b> the remaining account receivable balance after transactions from the current payment cycle have been applied. This will be the Prior Balance on the next payment cycle.
19.	<b>Financial Transactions:</b> the summary of financial transactions by type that are applied to the current payment cycle: refund and voided checks, system payouts, manual payouts, and recoveries.
<b>Summary</b>	
20.	<b>Remittance Cycle Total:</b> the positive or negative net amount as a result of claim and financial transaction activity applied to the current payment cycle.
21.	<b>Year-to-date Claims Count:</b> the total number of original, debit, credit, and voided claims paid for the tax year.
22.	<b>Check Number:</b> the number of the check issued to the provider associated with the current payment cycle.
23.	<b>Check Amount:</b> the dollar amount of the check issued to the provider associated with this RA.
24.	<b>Year-to-date Total Paid (1099):</b> the net amount paid to the provider by Alaska Medical Assistance for the tax year.

Updated 06/08/2018

## Responding to a Denied Claim

If a claim was denied, you should:

- Look at the reason it denied (indicated by the four-digit code in the EOB column; the matching description is listed on the EOB page)
- Compare the denial reason with your records

### Example



If the claim was denied because the recipient was not eligible for Alaska Medical Assistance when services were provided, you should check your records for any information on the patient's eligibility as well as to make sure the correct date of service was entered on the claim.

If you have any questions about why the claim denied, you should contact the Tribal Organization Coordinator. The coordinator can help resolve problems in many areas, including:

- Retroactive eligibility (a recipient becomes eligible for a time period in the past)

- Service Authorization discrepancies
- Third-party liability discrepancies
- Procedure code denials

If the Tribal Organization Coordinator is unable to resolve the problem, you could file an appeal of the denial. Refer to [Appeals](#) for more information.

Updated 06/08/2018

## 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). 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 rate 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.

- 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 [Adjusting or Voiding a Claim](#) in this section). The payment amount will be recalculated based upon the corrected claim information.
- 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.

Updated 03/09/2017

## Appeal Levels

There are three levels to the appeals process:

- First-level Appeal
- Second-level Appeal
- Commissioner Review of Second-Level Appeal Decision

## First-Level Appeal

A provider may request a first-level appeal if payment of an original claim or service was denied or reduced, or if payment was reduced due to a recoupment action. First-level appeals must be filed within **180** days of the adverse decision date indicated on the remittance advice for a claim. Exception: First-level appeals relating to a disputed recoupment of an overpayment must be filed within **60** days of the overpayment notice.

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, visit the Centers for Medicare and Medicaid Services (CMS) website at <http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/>.

## 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
- A denied enrollment or disenrollment
- A service authorization decision

Second-level appeals must be filed within **60** days of the first-level appeal decision, and should be submitted to the applicable division or office based on the type of appeal.

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

## Commissioner Review of Second-Level Appeal Decision

Requests for Commissioner review of second-level appeal decisions must be in writing and postmarked within 60 days of the date of the second-level appeal decision. Commissioner reviews are only available after second-level appeals have been denied by the Alaska Department of Health and Social Services (DHSS). Providers may only appeal a second-level decision to the Commissioner DHSS when it relates to denial of **an untimely filed claim**.



Any appeal submitted after the allowed time period **will not be considered**.

Updated 03/09/2017

## Appeals for Timely Filing of Claims

All claims must be filed within 12 months of the date services were provided to the recipient. The 12-month timely filing limit applies to all claims, including those that must first be filed with a third-party carrier. An appeal based on the provider's failure to file the claim before the billing deadline must be submitted no later than **180 days** after the date on the remittance advice. If the provider's claim was not filed within the required time limit, the appeal will be denied. However, if (1) the department committed an error on the claim previously submitted by the provider for the same service to the same recipient on the same day; or



(2) the claim was timely filed but not processed; or (3) the provider is able to prove good cause for failure to submit the claim before the billing deadline, then the appeal will be approved.

The timely filing limit may be extended for **good cause** when an unexpected or uncontrollable event takes place that prevents a provider from submitting a timely claim. Good cause examples are weather conditions causing mail delays or a disaster such as a fire, flood, or earthquake. Good cause does not include errors made by the provider or provider's billing staff.

Updated 03/09/2017

## How to File an Appeal

### First-Level Appeal

Refer to the table *Types of First-Level Appeals and Where They Should be Sent* to determine what type of appeal to file and where.

Providers must file first-level appeals directly with Qualis Health for services listed on the [Select Diagnoses/Procedures Review Guidelines](#). For instructions on filing an appeal with Qualis, refer to the [Qualis Health Alaska Medicaid Provider Manual](#).

Follow these steps to file a first-level appeal.

1. Complete the [Provider First-Level Appeal Request Form](#) (located under Other Forms) for a claim appeal or submit, in writing, the following information:
  - Provider's name
  - Provider's Alaska Medicaid ID Number
  - Name of person Conduent can contact regarding the appeal
  - Phone number of the contact person
  - Recipient's name related to the appeal (if applicable)
  - Recipient's Alaska Medicaid ID number
  - Date of service related to the appeal (if applicable)
  - Procedure code(s) related to the appeal (if applicable)
  - Reason for the appeal**Note:** Providers may not file a first-level appeal by fax, telephone, or any other oral communication.
2. Attach all relevant supporting documentation listed in the table *Types of First-Level Appeals and What to Attach When Submitting* based on the type of first-level appeal being submitted.
3. Send the first-level appeal with the supporting documentation to the address specified in the table *Types of First-Level Appeals and Where They Should be Sent* based on the type of first-level appeal being submitted.

You will be notified in writing regarding the results of the first-level appeal.



First-level appeals must be filed within **180 days** of the adverse decision date indicated on the RA. **Exception:** Appeals disputing the recovery of an overpayment must be filed within **60 days**. All appeals must be submitted in writing, or using the [Provider First-Level Appeals Request](#) form. Do not attempt to initiate an appeal by fax, telephone, or any other oral communication.



## Types of First-Level Appeals and What to Attach When Submitting

Types of First-Level Appeals	Required Attachments
Claim Denial or Payment Reductions	<ul style="list-style-type: none"> <li>• Copy of the remittance advice showing the claim denial or payment reduction</li> <li>• Copy of the original claim (including attachments) that was denied or reduced</li> <li>• Any other supporting documentation considered relevant to the appeal</li> </ul>
Recoupment of Overpayment Notice	<ul style="list-style-type: none"> <li>• Copy of the remittance advice showing the claim denial or payment reduction</li> <li>• Copy of the original claim (including attachments) that was denied or reduced</li> <li>• Any other supporting documentation considered relevant to the appeal</li> </ul>
Non-Certification of Hospital Admission or LOS	<ul style="list-style-type: none"> <li>• Complete copy of recipient's medical records that support hospital admission or length of stay</li> <li>• Copy of original non-certification notice and attachments</li> <li>• Any supporting documentation considered relevant to the appeal</li> </ul>
Denied or Reduced Service Authorization	<ul style="list-style-type: none"> <li>• Any supporting documentation considered relevant to the appeal</li> </ul>
Non-Certified of a Service	<ul style="list-style-type: none"> <li>• Any supporting documentation considered relevant to the appeal</li> </ul>
Denied enrollment or Disenrollment	<ul style="list-style-type: none"> <li>• Any supporting documentation considered relevant to the appeal</li> </ul>

## Types of First-Level Appeals and Where They Should be Sent

Types of First-Level Appeals	Address for First-Level Appeals
<ul style="list-style-type: none"> <li>• Denied or reduced claim decision</li> <li>• Recoupment of overpayment request</li> <li>• Denied or reduced service authorization request for the following services: <ul style="list-style-type: none"> <li>– Durable medical equipment; prosthetics, orthotics; and selected pharmaceutical drugs</li> <li>– All non-emergent, medically necessary transportation and accommodation services</li> <li>– Selected professional services as indicated in the fee schedules</li> </ul> </li> </ul>	Conduent Attn: Appeals P.O. Box 240808 Anchorage, AK 99524-0808

Types of First-Level Appeals	Address for First-Level Appeals
<ul style="list-style-type: none"> <li>– Services in excess of annual or periodic service limitations (vision, mental health, etc.)</li> <li>– All respiratory therapy, home healthcare services, private duty nursing, and hospice care</li> <li>– Chronic and Acute Medical Assistance (CAMA) program recipients requiring outpatient radiation and chemotherapy</li> <li>– Certain maternal/newborn admissions (administrative SAs issued by Conduent). Please refer to <a href="#">Maternal/Newborn Stay Prior Authorization (PA) Chart</a></li> </ul>	
<p>Non-Certification of Selected Inpatient and/or Outpatient Procedures and Diagnoses</p> <ul style="list-style-type: none"> <li>• Regardless of length of stay. The <i>Select Diagnoses/Procedures Review Guidelines</i> may be obtained at <a href="http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/provider-resources">http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/provider-resources</a> under <i>Provider Resources &gt; Review Guidelines and Questionnaires</i>. Select the appropriate guidelines for the date of service.</li> <li>• Non-certification of an inpatient hospital stay that exceeded three days</li> <li>• All outpatient Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) scans, and Emission Computerized Tomography (SPECT) scans</li> <li>• Denied or reduced service authorization request for certain maternal/newborn admissions. Please refer to the <a href="#">Maternal/Newborn Stay Prior Authorization (PA) Chart</a></li> </ul>	<p>Qualis Health Attn: Care Management Dept/Appeal Review P.O. Box 33400 Seattle, WA 98133-0400 Fax: 800.826.3630</p>
<p>Residential and Psychiatric Treatment Admissions and Continued Stay Reviews</p> <ul style="list-style-type: none"> <li>• Psychiatric admissions and continued stays</li> <li>• Residential Psychiatric Treatment Center (RPTC) admissions and continued stays</li> </ul>	<p>Qualis Health Attn: Care Management Dept/Appeal Review P.O. Box 243609 Anchorage, AK 99524-3609 Phone: 907.550.7620 Toll-Free: 877.200.9046 Fax: 907.550.7621 Toll-Free Fax: 877.200.9047</p>
<ul style="list-style-type: none"> <li>• Denied or reduced service authorization request for substance abuse rehabilitation services in excess of annual or periodic service limitations</li> </ul>	<p>Dept. of Health and Social Services Division of Behavioral Health Attn: Claims Appeal Section 3601 C Street, Suite 878 Anchorage, AK 99503-5923</p>
<ul style="list-style-type: none"> <li>• Denied or reduced service authorization request for the following services <ul style="list-style-type: none"> <li>– Administrative wait and swing bed stays at acute care facilities</li> </ul> </li> </ul>	<p>Dept. of Health and Social Services Division of Senior and Disabilities Services Attn: Claims Appeal Section 550 W. 8th Avenue</p>

Types of First-Level Appeals	Address for First-Level Appeals
<ul style="list-style-type: none"> <li>– All Long Term Care (LTC) facility admissions and continued stays</li> <li>– Home and Community-Based Waiver services</li> <li>– Personal Care Assistant (PCA) services</li> </ul>	Anchorage, AK 99501-3518
<ul style="list-style-type: none"> <li>• Denied enrollment or disenrollment</li> </ul>	Refer to the appropriate address for the type of service you provide from the table below: <a href="#">Types of Second-Level Appeals and Where They Should Be Sent.</a>

## Second-Level Appeal

Follow these steps to file a second-level appeal.

1. Submit in writing, the following information:
  - Provider's name
  - Provider's Alaska Medicaid ID Number
  - Name of person the Alaska Division of Health Care Services can contact regarding the appeal
  - Phone number of the contact person
  - Recipient's name related to the appeal (if applicable)
  - Recipient's Alaska Medicaid ID number (if applicable)
  - Date of service related to the appeal (if applicable)
  - Procedure code(s) related to the appeal (if applicable)
  - Description of the issue or decision being appealed
  - Reason for the appeal
  - All information and materials for proper consideration
2. Attach the following to the appeal:
  - Copy of the first-level appeal decision or a copy of the enrollment or service authorization decision being appealed
  - Copy of denial or payment notice
  - Copy of the original submitted claim
  - Any supporting documentation considered relevant to the appeal
3. Send the second-level appeal with supporting documentation to the address specified in table *Types of Second-Level Appeals and Where They Should Be Sent* based on the type of appeal being submitted.

You will be notified in writing of the results of the second-level appeal.

Except for timely filing appeals, the decision by the Department of Health and Social Services is a final administrative decision. The provider has the right to appeal to the Superior Court under the Alaska Rules of Appellate Procedure.



Second-level appeals must be in writing and postmarked within **60 days** of the date of the first-level appeal decision. Do not attempt to initiate an appeal by fax, telephone, or any other oral communication.

## Types of Second-Level Appeals and Where They Should Be Sent

Types of Second-Level Appeals	Addresses for Second-Level Appeals
<ul style="list-style-type: none"> <li>• Inpatient Psychiatric and Residential Psychiatric Facility Services</li> <li>• Behavioral Rehabilitation Services</li> <li>• Community Behavioral Health Services (treatment of mental health and/or substance use disorder)</li> <li>• Mental health physician clinics</li> </ul>	<p>Dept. of Health and Social Services Division of Behavioral Health Attn: Claims Appeal Section 3601 C Street, Suite 878 Anchorage, AK 99503-5923</p>
<ul style="list-style-type: none"> <li>• Home and Community-based Waiver services</li> <li>• Personal Care Assistant (PCA) services</li> <li>• Skilled Nursing Facility (SNF)</li> <li>• Intermediate Care Facility (ICF)</li> <li>• Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD) and persons with related conditions</li> </ul>	<p>Dept. of Health and Social Services Division of Senior and Disabilities Services Attn: Claims Appeal Section 550 W. 8<sup>th</sup> Avenue Anchorage, AK 99501-3518</p>
<ul style="list-style-type: none"> <li>• Tribal Inpatient Hospital</li> <li>• Tribal Outpatient Hospital</li> <li>• Tribal Clinic</li> </ul>	<p>Dept. of Health and Social Services Office of the Commissioner, Tribal Programs Attn: Claims Appeal Section PO Box 110601 Juneau, AK 99811-0601</p>
<ul style="list-style-type: none"> <li>• Targeted Case Management for children eligible under 7 AAC 23.080 (Infant Learning Program)</li> </ul>	<p>Dept. of Health and Social Services Office of Children Services, Infant Learning Program Attn: Claims Appeal Section PO Box 240249 Anchorage, AK 99524-0249</p>
<ul style="list-style-type: none"> <li>• Ambulatory surgery center</li> <li>• Chiropractic services</li> <li>• Dental care</li> <li>• Direct-entry midwife services</li> <li>• Durable medical equipment and supplies, respiratory therapy services, and prosthetic devices</li> <li>• Early periodic screening, diagnosis, and treatment (EPSDT) services</li> <li>• End stage renal disease (dialysis) clinic</li> <li>• Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)</li> <li>• Home health care</li> <li>• Hospice</li> <li>• Hospital - inpatient and outpatient</li> <li>• Laboratory and imaging</li> <li>• Nutrition services</li> <li>• Occupational therapy</li> <li>• Pharmacy</li> <li>• Physical therapy</li> </ul>	<p>Dept. of Health and Social Services Division of Healthcare Services Attn: Claims Appeal Section 4501 Business Park Boulevard, Suite 24 Anchorage, AK 99503-7167</p>

Types of Second-Level Appeals	Addresses for Second-Level Appeals
<ul style="list-style-type: none"> <li>• Physician, advanced nurse practitioner, and physician assistant services</li> <li>• Physician clinic</li> <li>• Podiatry services</li> <li>• Private duty nursing</li> <li>• Psychologist services</li> <li>• School-based services</li> <li>• Speech, hearing and language</li> <li>• Transportation (emergent and non-emergent) and accommodation services</li> <li>• Vision care services</li> </ul>	

## Commissioner Review of Second-Level Appeal Decision

To request a Commissioner review, follow these guidelines:

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. Include a clear description of the untimely filing cause and the reason for the appeal.
2. Send this request to  
Commissioner's Office  
Department of Health and Social Services  
PO Box 110601  
Juneau, AK 99811-0601

Updated 06/08/2018

# Claim Payment

## The Encounter Rate

The tribal encounter rate, also known as the "All-Inclusive Rate" (AIR) or "IHS rate," is used to pay tribally-operated facilities if they opt for this rate.

In 1996, CMS (formerly known as HCFA) and the IHS issued a Memorandum of Understanding to implement 100 percent federal reimbursement to states for Medicaid services to Medicaid eligible AI/AN at tribally-operated facilities on the IHS Facility list.

Tribally-operated facilities may choose to be certified as an FQHC and receive the FQHC rate set by the state. Tribally-operated facilities may also opt for the lower outpatient/clinic rate and bill physician fees in addition to the facility rate. This requires notification to the State Department of Health and Social Services so they can implement system modifications to pay the correct rate.

Tribal providers receiving Alaska Medicaid encounter reimbursement will not have a contractual adjustment applied to TPL payment.

Payment for services under the agreement will be based on the guidelines in the following table:

## Reimbursement Rates for Services Billed Separately

Types of Service	Reimbursement Rate
Physician services	Alaska Medical Assistance Physician Fee Schedule
Outpatient Hospital services	A <b>reduced</b> encounter rate
Ambulatory Surgical Care services	Medicaid ASC Fee Schedule; claims for services provided by physicians, anesthesiologists, radiologists and dentists must be submitted separately from claims for ambulatory surgical center services.

If your facility chooses this option, you must enroll each physician individually in Alaska Medical Assistance in order to bill physician services separately.



**Note:** Tribal facilities that opt for the lower Hospital (HS), Outpatient (OP), or Clinic (CL) encounter rate may bill for physician services under the Health Professional Group (HPG) to receive the Fee for Services (FFS) per fee schedule. They may also opt for the further reduced encounter rate and bill for physician and midlevel services under the HPG to receive FFS for their services.

Tribal facilities that do not opt for the lower rate cannot bill for physician and/or midlevel services separate from the encounter.

For each service category, the encounter rate is paid per patient, per day, per Alaska Medical Assistance enrollment number and is payment for all services received at the clinic. Multiple encounters can occur on the same date of service if delivered by rendering providers enrolled under different provider types at different designated facilities.

### Example



An Alaska Medical Assistance AI/AN beneficiary could receive a clinic service at a primary care setting, a dental service, and a behavioral health service if provided by providers enrolled with Alaska Medical Assistance at distinctly separate clinic locations.

Updated 06/08/2018

## Medicaid Cost Sharing



A tribal facility cannot charge American Indians or Alaska Natives for services.

Eligible, non-Native (non-Tribal beneficiaries) who are enrolled in Alaska Medical Assistance are responsible for paying the following cost-sharing amounts to tribal health facilities which treat or provide services to non-Tribal beneficiaries:

- \$50 per day or \$200 per admission (whichever is less) for inpatient hospital services
- Five percent of allowable charges for outpatient hospital services
- \$3 per day for physician services
- Pharmacies and dispensing providers should collect \$0.50 for each prescription that is filled or refilled with a payment for service of \$50 or less, or \$3.50 for each prescription that is filled or refilled with a payment for service of greater than \$50

Providers are responsible for collecting this fee from the recipient; however, you cannot deny services to a recipient if he or she cannot pay the cost-sharing amount when you provide the services.

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

Tribal health facilities should NOT collect a cost share for the following services, which are exempt from cost sharing requirements:

- Services provided to an American Indian or an Alaska Native by a tribal health program
- Services provided to an American Indian or an Alaska Native that have been referred from a tribal health program
- 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 (see 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 of “11” on the recipient’s eligibility coupon)
- Services and supplies for family planning
- Hospice services
- Services provided to an individual who is eligible for both Alaska Medical Assistance 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. (See claim form instructions for field 24H, requiring that specific codes be entered to exempt patients receiving emergency services)

- Blindness and disability exam services, identified by the eligibility codes “15” and “25” on the recipient’s eligibility coupon

## Payment for Out-of-State Services

Alaska Medical Assistance recipients may be eligible for payment 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 services provided to Alaska Medical Assistance recipients outside the state of Alaska is limited to the lesser of:

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

The provider must also maintain active enrollment in Alaska Medical Assistance and the Medicaid program in his or her state; for details see [Enrollment Requirements for Tribal Health Providers](#).

Updated 08/18/2016

# Tribal Clinics

## What is a Tribal Clinic?

A Tribal Clinic is a facility that provides healthcare services and is owned or leased by Indian Health Service (IHS) or a tribal organization that has a 638 contract or compact.

Updated 06/04/2013

## Enrolling a Tribal Clinic



Mental health clinics, substance abuse clinics, and dental clinics must be enrolled separately from a tribal clinic provider type.

To enroll as a Tribal Clinic provider type, the healthcare facility must:

- Be owned or leased by Indian Health Service or a tribal organization with a 638 contract or compact.
- Be listed on the Tribal Facilities List, which is produced by the Alaska Area Office, Indian Health Service, and Division of Program Statistics.
- Offer at least one of the following services: Physician, advanced nurse practitioner, physician assistant, nurse midwife, physical therapy, speech-language pathology, occupational therapy, audiology, optometry, radiology, or podiatry.
- Enroll each rendering provider of service individually with Alaska Medical Assistance and cross reference them with the enrolled clinic.
- Ensure each healthcare provider employed by the clinic or under contract with the clinic is licensed or certified in the State of Alaska, except for physicians who are Commissioned Corps Officers; they must maintain licensure in a state or territory of the United States. Refer to [Enrolling a Tribal Clinic](#).
- Tribal facilities may choose to be designated as FQHCs. For more information regarding FQHCs see the FQHC Provider Billing Manual.

Updated 06/08/2018

## Enrolling a Dispensing Provider

If you have a pharmacy onsite which is staffed by a licensed pharmacist, you must enroll the pharmacy separately from the Tribal Clinic provider type. Refer to the [Pharmacy Provider Billing Manual](#) for additional information. If a pharmacy is not onsite and you are dispensing take-home drugs, you must enroll either the tribal clinic or the individual healthcare professional (who can dispense drugs within the scope of his or her license) as a dispensing provider.



If you are enrolling as a dispensing tribal clinic, include the DEA number of the prescribing physician and include their license and certificates with the enrollment documents. Dispensing drugs must be covered within the scope of this individual's license.

Updated 06/08/2018



# Tribal Clinic Services

Tribal clinics must offer at least one, and may bill for any of the following services covered by Alaska Medical Assistance:

- Physician services
- Physician Assistant services
- Advanced Nurse Practitioner services
- Nurse Midwife services
- Physical Therapy
- Speech-language pathology, including licensed Speech-language Pathologist Assistant services
- Occupational therapy, including licensed occupational therapy assistant services
- Audiology services
- Optometry services (Optometrist only)
- Podiatry services
- Radiology services



**Note:** Chiropractic, Registered Nurse (RN), and certified nurse anesthetist services are not billable under tribal clinics.

Clinic services may be provided at:

- The clinic
- The residence of the patient
- An appropriate community setting

The specific procedures for which tribal providers can bill are limited by the CPT and HCPCS codes covered by Alaska Medical Assistance. For additional coverage limitations, refer to the specific provider type billing manual.



**Note:** Some services are not covered by Alaska Medical Assistance. Refer to [Service Not Covered by Alaska Medicaid Assistance](#) in the *Quick Reference* section for general guidelines.

## Newborn Bloodspot Screening

The Department of Health and Social Services (DHSS) requires that all babies born in Alaska receive a newborn bloodspot screening. The provider attending the birth of the baby is required to collect the sample within 48 hours of birth. A parent or guardian's refusal to allow the screening must be reported to the Division of Public Health (DPH).

The newborn bloodspot test (84030) is performed at a single laboratory designated by DHSS. The department will not reimburse for costs incurred by use of a non-designated laboratory for the testing of the specimen. Providers are charged a single fee per newborn, which includes all required specimens and repeat specimen collections necessary due to poor quality or abnormal results. The fee includes all costs associated with the screening (e.g., the specimen card, shipping and handling, laboratory fees). For additional information about the Newborn Bloodspot Screening Program requirements, refer to the [Division of Public Health](#).

## Births in a Hospital Setting

Alaska Medicaid covers newborn bloodspot screening performed in a hospital through the hospital's prospective per diem rate. The hospital must include the screening as a line item on their inpatient claim using procedure code S3620. No additional reimbursement is allowed to the healthcare provider collecting the sample or for additional samples collected outside of the inpatient hospital setting. If the sample is not collected by the hospital, another healthcare provider may collect the sample outside of the hospital setting and be reimbursed for the newborn bloodspot screening.

## Births Outside of a Hospital Setting

For babies delivered outside of a hospital setting, tribal clinics and free-standing birth centers are reimbursed for the incidental service of a newborn bloodspot screenings (S3620) only if core service is part of the encounter. No additional reimbursement is allowed for the collection of the sample.

For additional information on the newborn bloodspot screening requirements, visit DPH's [Newborn Bloodspot Screening Program](#) webpage.

## Long Acting Reversible Contraception

Alaska Medicaid covers long acting reversible contraception (LARC) devices and the insertion of these devices. Service authorization is not required for LARC insertions or the LARC device.

LARC Reimbursement by Setting			
	Inpatient Hospital Setting/IPP*	Outpatient Hospital	Free Standing Birth Center/IPP* or Office/Clinic
Device	<p><b>IP hospitals</b> are reimbursed a prospectively determined per diem rate established by the Office of Rate Review. No additional reimbursement is allowed for the LARC device as it is already included in the per diem rate.</p> <p><b>Tribal IP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of inpatient hospital services, excluding physician services. No additional reimbursement is allowed for the LARC device.</p>	<p><b>OP hospitals</b> are reimbursed for the device at the percent of billed charges rate established by the Office of Rate Review.</p> <p><b>Tribal OP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of outpatient hospital services. No additional reimbursement is allowed for the LARC device.</p>	<p><b>Free standing birth centers</b> are not reimbursed for the LARC device. The attending healthcare provider may be reimbursed for the device separately.</p> <p><b>Healthcare providers</b> are reimbursed at the wholesale acquisition cost (WAC) plus one percent.</p> <p><b>Tribal health clinics</b> are reimbursed an all-inclusive rate (AIR), posted in the Federal Register and calculated by the Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of clinic services. No additional reimbursement is allowed for the LARC device.</p>
Insertion	<p><b>IP hospitals</b> are reimbursed a prospectively determined</p>	<p><b>OP hospitals</b> are reimbursed for the insertion of the device</p>	<p><b>Free standing birth centers</b> are not reimbursed for the</p>

LARC Reimbursement by Setting			
	Inpatient Hospital Setting/IPP*	Outpatient Hospital	Free Standing Birth Center/IPP* or Office/Clinic
	<p>per diem rate established by the Office of Rate Review. The attending healthcare provider may be reimbursed at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal IP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of inpatient hospital services excluding the services of a physician. The attending physician services may be reimbursed under the Health Professional Group to receive the fee for service rate indicated on their fee schedule.</p>	<p>at the percent of billed charges rate established by the Office of Rate Review. The attending healthcare provider may be reimbursed at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal OP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review, Tribal OP Hospitals that have opted for the reduced or further reduced encounter rate may bill for the attending physician service under the Health Professional Group to receive the fee for service rate indicated on their fee schedule. Tribal facilities that do not opt for the reduced rates cannot bill for physician services separately from the AIR.</p>	<p>insertion. The attending healthcare provider may be reimbursed separately for the insertion.</p> <p><b>Healthcare providers</b> are reimbursed for the insertion of the device at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal health clinics</b> are reimbursed an all-inclusive rate (AIR), posted in the Federal Register and calculated by the Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of clinic services. No additional reimbursement is allowed for the LARC insertion.</p>

\*Immediate postpartum placement of LARC

## National Drug Code Requirements

Outpatient hospitals, birthing centers, and healthcare clinics must bill the National Drug Code (NDC) to receive reimbursement for the LARC device. For additional information on NDC billing requirements and examples, refer to [National Drug Code/J-Code Billing](#) in the Billing Guidelines section.

## Procedure Codes and Modifiers

Providers must use the correct CPT and ICD-10 codes for the service(s) provided. In some cases it will be necessary to add a modifier to the procedure code to receive reimbursement. Please see the [LARC Quick Coding Guide](#) published by ACOG for further information.

## Multiple Procedure Cutback

A multiple procedure cutback may apply; refer to the [Physician, ANP, PA Billing Manual](#) for further guidance on multiple surgical procedures.

LARC Device and Insertion Procedure Codes			
CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
11976	Remove Contraceptive Capsule	76998	Ultrasound Guide Intraoperative
11981	Insert Drug Implant Device	J7296	Kyleena
11982	Remove Drug Implant Device	J7297	Liletta
11983	Remove/Insert Drug Implant	J7298	Mirena
58300	Insert Intrauterine Device	J7300	ParaGard
58301	Remove Intrauterine Device	J7301	Skyla
76830	Transvaginal Ultrasound Non-OB	J7307	Nexplanon
76857	Ultrasound Exam Pelvic Limited		



**Note:** An encounter that includes only an incidental service(s) is not a stand-alone billable visit for Tribal Clinics.

Updated 03/12/2019

## Billing for Tribal Clinic Services

Tribal clinic providers can bill their services under the tribal clinic NPI and they will be paid at the current IHS/OMB encounter rate published in the Federal Register. An encounter is a face-to-face contact between a health care professional and a Medicaid beneficiary in order to provide Medicaid covered services through an IHS or Tribal 638 facility. The encounter rate is per patient, per day, per Alaska Medical Assistance enrollment number and is payment for all services received at the clinic. This includes on-site laboratory, x-ray services, drugs, and medical supplies **incidental to** the patient's visit.

**“Incidental to”** means a service or supply that is an integral part of the physician's professional service. Incident to services and supplies may include, but are not limited to, bandages, oxygen, drugs that are not self-administered, etc. The services and supplies incident to a physician service must result from the member's encounter with the physician and rendered within a medically appropriate timeframe.

Incidental services are covered only when performed in conjunction with a core service. A claim for an incidental service must also include the core service that was performed. Claims submitted with only an incidental service will be denied for edit exception code 4675, *Service Must be Billed with Core Service*.



**Note:** Incidental services (i.e. blood draws, immunizations, labs, x-rays, radiology services) must be billed using the same date of service as the associated professional service.

There may be times when a clinic encounter will result in billable services that are not considered “incidental to” the clinic visit. See the following examples:

## Examples

**Durable Medical Equipment (DME):** A patient comes into the clinic with a sprain. The clinic treats the patient and prescribes crutches. The sprain treatment is billed under the clinic with the rendering provider. The crutches are billed under a separate DME provider.

**Prescription Medication:** A patient being treated for an inflammatory condition is prescribed Humira. The doctor writes the prescription and shows the patient how to administer the drug. The patient has the prescription filled at the pharmacy and takes the medication home to administer the shot weekly as instructed by the doctor. The office visit is billed under the clinic with the rendering provider. The Humira medication is billed under the separate pharmacy provider.

**Dental:** A patient comes into the clinic with a broken tooth and bleeding upper lip after being struck with a baseball. The clinic stitches the opened wound on the patient's lip and refers the patient to a dentist to repair the broken tooth. The wound care is billed under the clinic with the rendering provider. The repaired tooth is billed under a separate dental provider.



**Asthma Treatment:** A patient comes into the clinic with severe uncontrolled asthma symptoms. The asthma diagnosis is confirmed and an oral corticosteroid and nebulized albuterol are administered to control the symptoms. The doctor prescribes medication self-administered through an inhaler to treat future attacks. The office visit, including the administered corticosteroid and albuterol, is billed under the clinic with the rendering provider. The inhaler medication is billed under the separate pharmacy provider.

**Physical Therapy:** A patient is receiving physical therapy after a stroke. The physical therapist decides use of a cane would be beneficial. The physical therapy is billed under the clinic with the physical therapist as the rendering provider. The cane is billed under a separate DME provider.

**Optometry:** An optometrist sees a patient for their yearly eye exam and determines that he needs glasses. The actual eye exams are billed under the clinic with the optometrist as the rendering provider. Rochester Optical, the state-contracted eyewear provider, bills the glasses separately. Providers cannot bill for shipping and handling of eyeglasses.

**Note:** Tribal facilities that are reimbursed the encounter rate on the initial optometry visit may not seek additional encounter rate reimbursement at the time of dispensing; however, they may opt to bill fee for service and receive the lower payment per the Alaska Medical Assistance Physician's Fee Schedule under their physician group billing NPI.

## Behavioral Health Services

Behavioral health services rendered by a healthcare professional at the tribal clinic within their scope of practice are tribal clinic services. These services include any behavioral health service in the Alaska Medical Assistance fee schedule applicable to physicians, physician assistants or advanced nurse practitioners. Behavioral health services billable under the clinic are:

- Psychotherapy
- Psychiatric Assessments
- Pharmacologic Management
- SBIRT (Screening, Brief Intervention, and Referral to Treatment)

To bill under the clinic the services must be provided by a:

- Physician

- Physician Assistant
- Advanced Nurse Practitioner

**Note:** BH Services provided by the above provider types within the Tribal Clinic are not subject to the annual service limits and the patient is not required to meet qualifying criteria as is required in the Community Behavioral Health Service (CBHS) clinics.

Follow these steps to bill for services by a Tribal Clinic provider type:

- Complete the CMS-1500 Professional Claim form. Refer to [How to Complete the CMS-1500](#) in the Billing Guidelines section for specific information on how to fill out the form as well as which fields are required.
- **Field 24d:** List all services provided using CPT or HCPCS procedure codes in the Procedures, Services or Supplies field in field 24d. Covered codes for a particular type of provider are listed in the individual provider manuals and fee schedules.
- **Field 24j:** This is the location for the rendering provider's NPI. The NPI number is entered in the unshaded section. The taxonomy code is entered in the shaded section. The taxonomy code qualifier ZZ is entered in the shaded section of field 24i.
- **Field 33a:** This is the billing NPI; you must enter the NPI for the Tribal Clinic provider type in this field. Refer to Guidelines below if you are billing for dispensing take-home drugs.
- **Field 33b:** The billing provider's taxonomy code is entered in field 33b, preceded by qualifier code ZZ. Refer to [Billing Guidelines](#).



Refer to the [Billing Guidelines](#) section for more information on general billing.

Updated 03/27/2019

## Billing for Dispensing Services

The provider must bill for the dispensing services using the NPI submitted on their dispensing provider enrollment application. There are several options for billing as a dispensing provider depending on enrollment.

**For providers without an onsite pharmacy:** Bill the professional services of the provider using the non-dispensing NPI (the individual NPI under Rendering Provider field in 24J and the clinic NPI under the Billing Provider field in 33a). Bill the pharmacy services by entering the dispensing NPI in the Rendering Provider field in 24J and the billing provider (the medical group or clinic) in field 33a. Medical group or clinic billing must have the group or the clinic as a Billing Provider in field 33a.

**For providers with an onsite pharmacy:** Bill the professional services of the provider using the non-dispensing NPI (the individual NPI under Rendering Provider field in 24J and the clinic NPI under the Billing Provider field in 33a). Pharmacy services should be billed under Pharmacy.

**For sole proprietors dispensing drugs:** the provider may bill with the individual NPI in both the Rendering Provider field in 24J and the Billing Provider field in 33a.

## Guidelines

If you are billing for any of the following services, use the guidelines below:

- **Dispensing take-home drugs:** Drugs not included in the encounter rate are maintenance drugs and drugs that require more than one dose, oral, topical, rectal, or ophthalmic, up to a 30-day supply. These include pain medications, antibiotics, antivirals, oral chemotherapy, antipsychotics,



antiepileptics, birth control and antihypertensives. To be paid for these drugs you must bill according to pharmacy billing instructions using the NPI for the pharmacy or dispensing provider.

For additional information about billing dispensed drugs, refer to the [Pharmacy Provider Billing Manual](#).

- **Drugs incident to a visit:** Drugs included in the encounter rate are those provided at the time of the visit at a clinic, outpatient facility or physician's office that are incidental to the visit such as infusion therapy drugs, prescription implants, or Synagis, these are not to be billed separately.
- **Anesthesia services:** 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.
- 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.

The following is an example of single-line billing and the reimbursement you would receive:

24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.	G.	H.
	From			To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)				DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
	MM	DD	YY	MM	DD	YY			CPT/HCPCS		MODIFIER					
	01	24	17	01	24	17	22		01400		AA		1	728.75	70	

*Procedure 01400 completed in 70 minutes on January 24, 2017 in an outpatient setting*

Base Value Units for procedure code 01400	=	4
4 base value units X \$42.90 per unit	=	\$171.60
70 minutes of time X \$3.60 per minute	=	\$252.00
Alaska Medical Assistance total reimbursement	=	\$423.60

- **Immunizations.** Use the appropriate CPT-4 codes to bill for administering the immunization. Alaska Medicaid covers the Gardasil 9 vaccine under CPT 90651 – *9v HPV Vaccine* for recipients through age 45.

**How to Bill Immunization CPT Code 90460 and 90461 for ages 0-18 years:** Alaska Medical Assistance will pay for no more than one 90460 claim per day, regardless of the number of injections given. Additionally, a multi-component vaccine, such as MMR, is considered one vaccine, and qualifies as a single 90460 injection only (unless a separate injection has already been billed as a 90460 that same day, in which case the MMR could qualify for a single unit of 90461).



**Note:** Immunizations by Registered Nurses are not reimbursable.



#### Example

If a recipient received MMR, DTaP/TdaP and pneumococcal vaccines on the same day, the claim would be submitted for one unit of 90460, and two units of 90461.

## Laboratory and X-ray Services

Laboratory or radiology services can be divided into two payment components distinguished by modifiers that indicate if the service is “professional” (such as a radiologist reading an x-ray and writing a report) or “technical” (such as the technician taking the x-ray image).

To bill the professional component of diagnostic lab services, use modifier -26. You may be reimbursed for diagnostic laboratory services performed in your own laboratory if you have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certificate. To bill the technical component of diagnostic lab services, use the modifier TC.

#### Example



A clinic sees a patient and draws blood for diabetes testing. The clinic has the appropriate CLIA certificate on file and is able to perform the blood draw and subsequent blood test. Both the blood draw (technical component) and test (professional component) are billed as a single, global service using the "draw" date as the date of service for both components and may be reimbursed at an encounter rate.

See below notes regarding the encounter rate and clinic location.



**Note:** Do not bill an encounter rate for an individual component of a global service. Encounter reimbursement would be payment for both professional and technical components.



**Note:** If a tribal clinic is in the same location as the hospital, all services including laboratory and x-ray services must be billed under the outpatient hospital NPI.

Tribal facilities that opt for the lower Hospital (HS), Outpatient (OP), or Clinic (CL) encounter rate may bill for physician services under the Health Professional Group (HPG) to receive the Fee for Services (FFS) per fee schedule. They may also opt for the further reduced encounter rate and bill for physician and midlevel services under the HPG to receive FFS for their services.

Tribal facilities that do not opt for the lower rate cannot bill for physician and/or midlevel services separate from the encounter.

Updated 04/09/2019



# Health Professional Group

## Enrolling a Health Professional Group

Each member of a health professional group must first enroll individually with the Alaska Medicaid 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-Chiropractist
- 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:

- Behavioral Health Aide (BHA)
- Community Health Aid/Practitioner (CHA/P)
- Physician assistant
- Occupational therapy assistant
- Physical therapy assistant
- Speech language pathology assistant

A BHA and CHA/P must be enrolled under the supervision of an enrolled physician; however the supervising physician is not required to be a member of the same health professional group as the BHA or CHA/P.

### 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 06/08/2018

# Behavioral Health Aides

## Enrolling a BHA

Behavioral Health Aides (Levels, I, II, III, and Practitioner) must enroll individually in Alaska Medicaid.

To be reimbursed for services, these providers must meet the following conditions:

- Have a current certification by the Community Health Aide Program Certification Board
- Be employed by a tribal organization that is owned or leased by the Indian Health Service, or a tribal organization with a 638 contract or compact which operates a Behavioral Health Aide Program in Alaska under the Indian Self-Determination and Education Assistance Act
- Supervised by a licensed physician who is:
  - Enrolled separately as a physician in Alaska Medicaid
  - Willing to assume professional responsibility for the BHA services and ensure that the services are medically necessary



**Note:** A BHA rendering services solely through a Community Behavioral Health Clinic as a clinical associate does not require enrollment in Alaska Medicaid. However, they must maintain their certification and be supervised by a licensed clinician willing to assume professional responsibility for those services and ensure they are medically necessary.

## Enrollment Documentation

All required documentation must be submitted during enrollment to complete the enrollment process as an Alaska Medicaid provider:

- A copy of a current certification must be submitted during enrollment and maintained in the provider file for the BHA to remain an actively enrolled provider
- An original signed BHA, CHA/P and DHAT Provider Enrollment Agreement must also be submitted with the provider enrollment documentation



**Note:** If enrolling as a dual certified BHA and CHA/P, provider must meet all BHA and CHA/P enrollment requirements and submit appropriate documentation for both provider types.

Mail all documents to Conduent Provider Enrollment at:

Conduent State Healthcare, LLC  
Attn: Provider Enrollment  
P.O. Box 240649  
Anchorage, AK 99524-0649

Updated 06/08/2018

# BHA Services

The procedures listed in Appendix [G-BHA and HCPCS Codes](#) are services approved by the Community Health Aide Program Board and the State of Alaska. These services are separated into those that may be rendered through a Health Professional Group, those that may be rendered through a Community Behavioral Health Clinic, and those that can be rendered through either. They are the only services covered by Alaska Medicaid for BHA providers and must be rendered and billed through the appropriate entity to be considered for reimbursement.



**Note:** Some services are not covered by Alaska Medicaid. Refer to [Services Not Covered by Alaska Medical Assistance](#) in the *Quick Reference* section for general guidelines.

Updated 06/08/2018

## Billing for BHA Services

BHA services rendered through a Community Behavioral Health Clinic (CBHC) should be billed using standard CBHC billing procedures. Follow these steps to bill BHA services rendered through a health professional group (HPG):

- Complete the CMS-1500 Health Insurance Claim form. (Refer to the [CMS-1500 Version 02/12 Claim Form Instructions](#).)



BHA services rendered through an HPG must be billed under the affiliated physician's medical group NPI that has assumed responsibility for the services. BHA services rendered through a CBHC must be billed under the licensed clinician's CBHC NPI that has assumed responsibility for their services. Therefore, you cannot bill BHA services using a Provider ID for a Tribal Clinic provider type or any other tribal facility.

Itemize the services using the CPT or HCPCS codes listed on the BHA Covered Codes list in field 24d. Refer to Appendix [G-BHA CPT and HCPCS Codes](#).

- Enter the rendering BHA's NPI number in field 24j.
- Enter the BHA's credentials in field 31 with a signature.
- Enter the billing provider NPI (the health professional group the BHA is affiliated to) in field 33a.
- Enter the billing provider taxonomy code preceded by the qualifier ZZ in field 33b.

The HPG may cover BHA services in multiple locations, and should use the address of the HPG as the servicing address.



BHA services are not payable by **Medicare or any other insurance carrier**.

Updated 06/08/2018

## How BHAs are Paid

BHA services are reimbursed using the Office of Rate Review rate setting methodology.

Updated 06/08/2018

# Community Health Aides and Community Health Practitioners (CHA/Ps)

## Enrolling a CHA/P

Community Health Aides (all levels) and Community Health Practitioners (CHA/P) must enroll individually in Alaska Medicaid.

To be reimbursed for services, these providers must meet the following conditions:

- Have current certification by the Community Health Aide Program Certification Board
- Be employed by a tribal organization that is owned or leased by the Indian Health Service, or a tribal organization with a 638 contract or compact which operates a Community Health Aide Program in Alaska under the Indian Self-Determination and Education Assistance Act
- Supervised by a licensed physician who is:
  - Enrolled separately as a physician in Alaska Medicaid
  - Willing to assume professional responsibility for the CHA/P services and to ensure that the services are medically necessary.

## Enrollment Documentation

All required documentation must be submitted during enrollment to complete the enrollment process as an Alaska Medicaid provider:

- A copy of a current certification must be submitted during enrollment and maintained in the provider file for the CHA/P to remain an actively enrolled provider
- An original signed CHA/P and DHAT Provider Enrollment Agreement must also be submitted with the provider enrollment documentation



**Note:** If enrolling as a dual certified BHA and CHA/P, provider must meet all BHA and CHA/P enrollment requirements and submit appropriate documentation for both provider types.

Mail all documents to Conduent Provider Enrollment at:

Conduent State Healthcare, LLC  
Attn: Provider Enrollment  
P.O. Box 240649  
Anchorage, AK 99524-0649



If billing for lab services provided by a CHA/P, the Clinical Laboratory Improvement Amendments (CLIA) certificate for the associated health professional group must be on file with Alaska Medicaid.

**Note:** A Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or certificate of registration from the Section of Certification and Licensing, Division of Public Health, must be submitted to the Enrollment Department in order to be reimbursed for laboratory services. A CLIA certificate issued through a waiver process to a laboratory of a tribal health program may include one or more village clinic laboratories that perform limited testing (limited testing means that no more than 15 tests are performed at all sites per year). The tribal health program must include the village clinics to be covered under the waiver process in the CLIA application and renewal processes.

Updated 06/08/2018

## CHA/P Services

The procedures listed in appendix H-CHA/P CPT, CDT, & HCPCS Codes are services approved by the Community Health Aide Program Board and the State of Alaska. They are the only services covered by Medicaid for CHA/P providers. CHA/P services may be provided at the village clinic, the residence of a patient, or any other appropriate community location.



**Note:** Some services are not covered by Alaska Medicaid. Refer to [Services Not Covered by Alaska Medical Assistance](#) in the Quick Reference section for general guidelines.

For further policy clarification on CHA/P covered services, refer to the appropriate provider type-specific Section I.

Updated 06/08/2018

## Billing for CHA/P Services

Follow these steps to bill CHA/P services.

- Complete the CMS-1500 Health Insurance Claim form. (Refer to [CMS-1500 Version 02/12 Claim Form Instructions](#).)



CHA/P services must be billed under the affiliated physician's medical group NPI that has assumed responsibility for the services. Therefore, you cannot bill CHA/P services using a Provider ID for a Tribal Clinic provider type or any other tribal facility.

Itemize the services using the CPT or HCPCS codes listed on the CHA/P Covered Codes list in field 24d. Refer to appendix [H-CHA/P CPT, CDT, & HCPCS Codes](#).

- Enter the rendering CHA/P's NPI number in field 24j.
- Enter the rendering CHA/P's credentials and signature in field 31.
- Enter the billing provider NPI (the health professional group the CHA/P is affiliated to) in field 33a.
- Enter the billing provider taxonomy code preceded by the qualifier ZZ in field 33b.

The Health Professional Group (HPG) may cover CHA/P services in multiple locations, and should use the address of the HPG as the servicing address.



CHA/P services are not payable by **Medicare or any other insurance carrier**.

Updated 06/08/2018

# How CHA/Ps are Paid

CHA/P services are reimbursed using the Office of Rate Review rate setting methodology.

Updated 06/08/2018

# Dental Health Aides (DHAs)

## Enrolling a DHA

Primary Dental Health Aides (PDHAs), Dental Health Aides (DHAs) and Dental Health Therapists must enroll individually in Alaska Medical Assistance.

To be reimbursed for services, these providers must meet the following conditions:

- Have current certification as a DHA by the Community Health Aide Program Certification Board
- Be employed by a tribal organization owned or leased by the Indian Health Service or a tribal organization with a 638 contract or compact which operates a community health aide program in Alaska under the Indian Self-Determination and Education Assistance Act
- Be supervised by a licensed dentist who is:
  - Enrolled separately as a dentist in Alaska Medical Assistance.
  - Willing to assume professional responsibility for the DHA services and to ensure that the services are medically necessary.

Updated 06/04/2013

## DHA Services

### Enhanced Dental Services for Adults

Since April 1, 2007, Alaska Medical Assistance has covered preventive and restorative services for eligible Alaska Medical Assistance adults. All Enhanced Dental Services for Adults require a Service Authorization (SA); in some cases service authorization can also authorize dental services retroactively.

Recipients are allowed \$1,150 per fiscal year (July 1 – June 30). If the \$1,150 is not used, it will not carry over to the following year.

Covered services include cleanings, exams, crowns, root canals and dentures. Emergent dental services are covered, but do not count against the annual cap.

Key features of the Enhanced Dental Services for Adults are:

- Once a patient's annual \$1,150 limit is spent, they are responsible for additional costs (this does not affect services covered as emergent).
- Recipients requiring upper and lower dentures and/or partials may be eligible to obtain both during one fiscal year. Eligible recipients age 21 and over may use two years worth of dental benefits in order to obtain both an upper and lower dentures/partial at the same time. Service authorizations for these services must include a request for both an upper and lower denture and/or partial.
- Obtain service authorization before providing any Enhanced Dental Services for Adults. This allows the SA to track all provider charges to the recipient, and to stay within the recipient's annual cap for services.
- Bill promptly; if the dentist has not billed for services, other payments may consume the maximum allowable amount for rendered services.

- Providers should work with recipients to help prioritize their dental care needs. If a recipient's annual allowed amount for dental services is exceeded, they will be responsible for the balance, at the Alaska Medical Assistance reimbursement rate. Recipients are responsible for any subsequent nonemergency services, to be charged at the regular rate, rather than the Alaska Medical Assistance reimbursement rate.

The Enhanced Dental Services for Adults program will cover the following services or procedures up to the limit of \$1,150:

1. Diagnostic examination or radiographs necessary for routine dental care
2. Preventive care, including:
  - a. Prophylaxis, including necessary scaling, polishing, and instructions
  - b. Topical fluoride application and
  - c. An anterior removable space maintainer
3. Restorative care, including amalgams, resins, stainless steel crowns, and full crowns for restoration of decayed or fractured teeth; temporary restorations, cement bases, and local anesthesia are considered components of a complete restorative procedure and may not be billed separately
4. Endodontics, with the following limitations:
  - a. Palliative and sedative treatments may not exceed two times per tooth before a definitive treatment
  - b. Pulp capping must be necessary for a direct pulp cap of an exposed pulp of a permanent tooth
  - c. Root canal therapy must include tooth preparation, filling of the root canal, and follow-up
  - d. A separate claim may be made for pin retention and restoration, not to exceed five surfaces per tooth
5. Periodontics, including treatment of pain or acute infection of supporting tissues of the teeth, including gingivitis, periodontitis, and periodontal abscess
6. Prosthodontics, including complete or partial dentures and denture repair or relines; the department will pay for replacement of complete or partial dentures only once per five calendar years
7. Oral surgery; local anesthesia, materials, and routine post-operative care are considered components of a complete surgical procedure and may not be billed separately
8. Professional consultation, if medically necessary or as requested by the department

Effective January 1, 2011, tobacco cessation counseling provided by dentists is covered under the Alaska Medical Assistance Adult Enhanced Dental program. Procedure code D1320, Tobacco counseling for the control and prevention of oral disease, must be used when filing a claim for this service.

Under the Enhanced Dental Services for Adults program, providers may bill a recipient for the difference between the full reimbursement and the amount remaining in the recipient's annual limit if the annual limit would provide less than the full reimbursement for the service.

If a recipient's annual limit of \$1,150 has already been reached or if the amount due will cause their annual limit to be exceeded, providers need to inform them prior to performing the procedure of the recipient's obligation to pay for the service. Notification that this information was conveyed to the recipient and that the recipient agreed to pay for any balance above the allowed \$1,150 must be documented in the recipient's personal health record. If the provider has a policy to charge recipients for missed appointments, the provider may charge the recipient and the recipient is responsible for payment. Missed appointments are not covered by Alaska Medical Assistance.

For a PDF of the regulations see: [www.hss.state.ak.us/publicnotice/PDF/192.PDF](http://www.hss.state.ak.us/publicnotice/PDF/192.PDF)





**Note:** Some services are not covered by Alaska Medical Assistance. Refer to [Services Not Covered by Alaska Medical Assistance](#) in the *Quick Reference* section for general guidelines.

Also, provider billing manuals for the specific type of provider (for example, physicians, physical therapists, or advanced nurse practitioners) include additional information about coverage limitations.

## Service Authorization for Enhanced Dental Services for Adults

Before Enhanced Dental Services for Adults are rendered, a service authorization must be obtained. The Enhanced Dental Services for Adults are subject to a \$1,150 annual expenditure cap per state fiscal year (July 1 to June 30). The service authorization is required to assist in monitoring of the annual cap. Dentists may request a service authorization by faxing the Service Authorization form (AK-SA) to Conduent.

### Tips Regarding Service Authorization for Enhanced Dental Services for Adults

- Fax in your Service Authorization requests for enhanced dental services for adults for faster and more efficient service. You will quickly receive a faxed response for your record of what was approved, the effective dates of service, and the provider ID number for which you requested the SA and the Service Authorization number so that you can enter all the correct information on your claims.
- If you are treating a recipient and need a service authorization for Enhanced Dental Services for Adults, you can indicate on the fax cover sheet that the patient is in the office for an expedited response.
- If you need to amend the SA, you can accomplish this by fax with the word “remove” next to the procedure that is no longer needed or the word “add” next to the procedures that you wish to add.
- Faxed SA requests arriving before 8 a.m. the following day will be credited for the previous day.
- Providers must fax Conduent all requests for retroactive SAs for Enhanced Dental Services for adults. Reserve the use of the telephone to inquire about units and dollars remaining on a SA prior to faxing in your SA request.

## DHA Services Coverage

DHAs must follow these guidelines regarding procedure codes:

- Only those procedures listed in Appendix J: Covered Dental Health Aide Codes are covered for the indicated types of DHAs.
- Some procedure codes require a tooth code and/or surface code when billing for the service.

Refer to Appendix J: Dental Health Aide Codes of DHA-covered services. To see a full list of the CDT codes in the Enhanced Adult Dental Services coverage category, go to Conduent’s web site, <http://medicaidalaska.com>, click on Documentation, Documents & Forms, Fee Schedules. Choose the most recently updated Alaska Medical Assistance Dental Fee Schedule; in it, you will find sections for children and adults (Enhanced Adult Dental Services and Emergent Dental Services).



Dental telemedicine services do not require use of the telemedicine modifiers.

Updated 01/03/2017

# Billing for DHA Services



- DHA services must be billed under the affiliated dental group. Therefore, you cannot bill DHA services using the NPI for a Tribal Clinic provider type or any other provider number.
- DHATs in preceptorship must continue billing with the supervising dentist's NPI in field 54 of the ADA claim form.

To bill DHA services, complete the ADA Dental claim form (J430 ©2012). Refer to [How to Complete the Dental Claim Form](#) in the Billing Guidelines section. When billing for DHA services, you will need to:

1. Enter the tooth code and/or surface code as required. Tooth numbers or letters in field 27 and tooth surfaces in field 28. Refer to the fee schedule in the Dental Services manual for information on which procedure codes require this information.
2. List services provided using the CDT procedure codes listed as covered codes for DHAs in field 29.
3. Enter any required remarks in field 35. Remarks are required if the procedure requires medical justification or if you provided emergency services. Refer to the fee schedule in the *Dental Services* manual for information on which procedure codes require medical justification.
4. Bill services using the dental group NPI and related taxonomy in field 49 and the individual DHA's NPI in field 54.
5. Keep a photocopy of the ADA claim form for your records and mail the original form to:

Conduent  
PO Box 240769  
Anchorage, AK 99524-0769

Updated 01/03/2017

## How DHAs are Paid

DHA Services for enhanced adult dental services and orthodontia are reimbursed at 100 percent the Alaska Medical Assistance Dental Fee Schedule. Emergent services and services for children are paid per encounter. To access the fee schedules, visit <http://manuals.medicaidalaska.com/medicaidalaska/providers/FeeSchedule.asp>.

Updated 06/04/2013

# Tribal Outpatient Hospitals

## What is a Tribal Outpatient Hospital?

A hospital operated by a tribal health organization may qualify to enroll with Alaska Medical Assistance as any type of hospital facility for which they qualify (General Acute Care, Critical Access, etc.) and be paid according to the payment methodology applicable to that type of hospital under state regulations.

Updated 06/04/2013

## Enrolling a Tribal Outpatient Hospital

To enroll as a tribal outpatient hospital, the hospital must meet the following conditions:

- Is owned or leased by Indian Health Service or a tribal organization with a 638 contract or compact
- Is listed on the Tribal Facilities List, which is produced by the Alaska Area Office, Indian Health Service, and Division of Program Statistics
- Does not provide patients with room and board for a continuous 24-hour period

Updated 06/04/2013

## Outpatient Hospital Services

Outpatient hospital services are billed on a UB-04 form using the appropriate Revenue or HCPCS procedure code covered by Alaska Medical Assistance for outpatient hospitals.

Refer to the applicable *Alaska Medical Assistance Fee Schedule* available on the Conduent web site for Outpatient Hospitals. The revenue codes listed in Covered Revenue Codes for Tribal Outpatient Hospitals later in this section are the only revenue codes covered for tribal outpatient hospitals by Alaska Medical Assistance.

The following general guidelines apply to all outpatient hospital services:

- Services must be medically necessary
- Treatment for outpatient hospital services must be ordered in writing by an attending physician

Standard outpatient hospital services covered by Alaska Medical Assistance include:

- Emergency room services
- Operating room services and surgical supplies
- Anesthesia
- Recovery room
- X-ray
- Laboratory
- Physical therapy

- Occupational therapy
- Speech-language pathology
- Audiology services and evaluations and related diagnostics
- Respiratory therapy
- Electrocardiography (EKG/ECG)
- Electroencephalography (EEG)
- Magnetic Resonance Imaging (MRI)/Positron Emission Tomography
- Drugs prescribed by the attending physician
- Tobacco cessation therapy, services and products
- Central service supplies, which are included with the cost of services
- Use of equipment ordered by attending physician
- Clinic services
- Observation room
- Services for spontaneous abortions, or miscarriages

## Long Acting Reversible Contraception

Alaska Medicaid covers long acting reversible contraception (LARC) devices and the insertion of these devices. Service authorization is not required for LARC insertions or the LARC device.

LARC Reimbursement by Setting			
	Inpatient Hospital Setting/IPP*	Outpatient Hospital	Free Standing Birth Center/IPP* or Office/Clinic
<b>Device</b>	<p><b>IP hospitals</b> are reimbursed a prospectively determined per diem rate established by the Office of Rate Review. No additional reimbursement is allowed for the LARC device as it is already included in the per diem rate.</p> <p><b>Tribal IP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of inpatient hospital services, excluding physician services. No additional reimbursement is allowed for the LARC device.</p>	<p><b>OP hospitals</b> are reimbursed for the device at the percent of billed charges rate established by the Office of Rate Review.</p> <p><b>Tribal OP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of outpatient hospital services. No additional reimbursement is allowed for the LARC device.</p>	<p><b>Free standing birth centers</b> are not reimbursed for the LARC device. The attending healthcare provider may be reimbursed for the device separately.</p> <p><b>Healthcare providers</b> are reimbursed at the wholesale acquisition cost (WAC) plus one percent.</p> <p><b>Tribal health clinics</b> are reimbursed an all-inclusive rate (AIR), posted in the Federal Register and calculated by the Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of clinic services. No additional reimbursement is allowed for the LARC device.</p>
<b>Insertion</b>	<b>IP hospitals</b> are reimbursed	<b>OP hospitals</b> are reimbursed	<b>Free standing birth centers</b>

LARC Reimbursement by Setting			
	Inpatient Hospital Setting/IPP*	Outpatient Hospital	Free Standing Birth Center/IPP* or Office/Clinic
	<p>a prospectively determined per diem rate established by the Office of Rate Review. The attending healthcare provider may be reimbursed at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal IP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of inpatient hospital services excluding the services of a physician. The attending physician services may be reimbursed under the Health Professional Group to receive the fee for service rate indicated on their fee schedule.</p>	<p>for the insertion of the device at the percent of billed charges rate established by the Office of Rate Review. The attending healthcare provider may be reimbursed at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal OP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review, Tribal OP Hospitals that have opted for the reduced or further reduced encounter rate may bill for the attending physician service under the Health Professional Group to receive the fee for service rate indicated on their fee schedule. Tribal facilities that do not opt for the reduced rates cannot bill for physician services separately from the AIR.</p>	<p>are not reimbursed for the insertion. The attending healthcare provider may be reimbursed separately for the insertion.</p> <p><b>Healthcare providers</b> are reimbursed for the insertion of the device at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal health clinics</b> are reimbursed an all-inclusive rate (AIR), posted in the Federal Register and calculated by the Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of clinic services. No additional reimbursement is allowed for the LARC insertion.</p>

\*Immediate postpartum placement of LARC

## National Drug Code Requirements

Outpatient hospitals, birthing centers, and healthcare clinics must bill the National Drug Code (NDC) to receive reimbursement for the LARC device. For additional information on NDC billing requirements and examples, refer to [National Drug Code/J-Code Billing](#) in the Billing Guidelines section.

## Procedure Codes and Modifiers

Providers must use the correct CPT and ICD-10 codes for the service(s) provided. In some cases it will be necessary to add a modifier to the procedure code to receive reimbursement. Please see the [LARC Quick Coding Guide](#) published by ACOG for further information.

## Multiple Procedure Cutback

A multiple procedure cutback may apply; refer to the [Physician, ANP, PA Billing Manual](#) for further guidance on multiple surgical procedures.

LARC Device and Insertion Procedure Codes			
CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
11976	Remove Contraceptive Capsule	76998	Ultrasound Guide Intraoperative
11981	Insert Drug Implant Device	J7296	Kyleena
11982	Remove Drug Implant Device	J7297	Liletta
11983	Remove/Insert Drug Implant	J7298	Mirena
58300	Insert Intrauterine Device	J7300	ParaGard
58301	Remove Intrauterine Device	J7301	Skyla
76830	Transvaginal Ultrasound Non-OB	J7307	Nexplanon
76857	Ultrasound Exam Pelvic Limited		

Updated 03/12/2019

## Outpatient Hospital Services Requiring Service Authorization

Some procedures, services, supplies, equipment, and drugs also require authorization. Refer to information related to service authorizations for each type of provider in this or the [Inpatient/Outpatient Hospital Billing Manual](#), on your fee schedule, or by contacting the Conduent Provider Inquiry Unit at 907.644.6800 or 800.770.5650 (toll-free in Alaska).

Updated 06/08/2018

## Billing for Tribal Outpatient Hospital Services

Outpatient Hospitals use the UB-04 form when billing for outpatient hospital services. Refer to the [UB-04 Claim Form Instructions](#) for specific information on how to fill out the form as well as which fields are required. When billing on the UB-04:

- Enter the Revenue Code and Description in fields 42 and 43.
- Enter the billing provider's NPI in field 56.
- List services provided by using the Revenue Codes and descriptions listed later in this section.



When billing for diagnostic laboratory procedures, HCPCS codes should be used to identify the specific procedure. CPT codes in the range of 80002 to 89399 may be used to identify any laboratory services (revenue codes 300-319).

- Enter the Service Authorization number in field 63 if the claim includes a service that requires authorization. Refer to the [Service Authorization](#) section.
- Enter 0 to indicate ICD-10 diagnosis codes in field 66.



### ICD-10-CM

ICD-10-CM is the coding classification system used to describe diseases and operations. It serves an important function for physician reimbursement, hospital payments, quality review and benchmarking measurement.

- Enter the ICD-10 diagnosis code in field 67 for the primary discharge diagnosis:
- Enter an appropriate ICD-10 surgical procedure code if you list a charge for the operating room or for a surgical procedure. Enter the Principal Procedure Code in field 74.
- Include any needed attachments. Refer to [What to Attach to a Claim](#) in the Billing Guidelines section.

## Guidelines

If you are a physician who is eligible to bill for any of the following services separately, use the guidelines below.

- **Anesthesia services** 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.
- 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.

The following is an example of single-line billing and the reimbursement you would receive:

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Entry Plan
MM	DD	YY	MM	DD	YY			CPT/HCPCS	I	MODIFIER				
01	24	17	01	24	17	22		01400	AA		1	728.75	70	

*Procedure 01400 completed in 70 minutes on January 24, 2017 in an outpatient setting*

Base Value Units for procedure code 01400 = 4

4 base value units X \$42.90 per unit = \$171.60

70 minutes of time X \$3.60 per minute = \$252.00

Alaska Medical Assistance total reimbursement = \$423.60

- **Durable Medical Equipment:** Claims for durable medical equipment submitted with revenue code 0290 must include the appropriate CPT/HCPCS code.



- **Laboratory services.** Do not bill an encounter rate for an individual component of a global service. Encounter reimbursement would be payment for both professional and technical components. To bill the professional component of diagnostic lab services, use modifier 26. Providers must have the appropriate Clinical Laboratory Improvement Amendments (CLIA) certificate on file to be reimbursed for diagnostic laboratory services performed in their own laboratory.
- **Operating Room for Dental Services:** When billing for an operating room with revenue code 036x for dental services:
  - Use revenue code 0360 with procedure code 41899, *Unlisted procedure, dentaoalveolar structures*, on a single claim line to account for dental-related operating room charges.
  - Submit an operative report supporting the unlisted procedure as a claim attachment.
  - Do **not** bill revenue code 0360 for dental-related operating room services on multiple claim lines.
  - Do **not** use Current Dental Terminology (CDT) codes in place of procedure code 41899.
- **Operating Room Services:** Claims for operating room services submitted with revenue code 036x must include the appropriate CPT/HCPCS code.
- **Surgical Assistants.** Physicians acting as surgical assistants must submit a separate claim for their services, using a CPT modifier (-SA, -80, -81, or -82). If the claim is for a second surgical assistant, you must attach an explanation from the surgeon explaining the need for a second assistant. This is a covered service only for a tribal hospital selecting a reduced or further reduced outpatient encounter rate (see [The Encounter Rate](#)) in order to bill physician services separately from facility charges.



**Note:** Tribal facilities that opt for the lower Hospital (HS), Outpatient (OP), or Clinic (CL) encounter rate may bill for physician services under the Health Professional Group (HPG) to receive the Fee for Services (FFS) per fee schedule. They may also opt for the further reduced encounter rate and bill for physician and midlevel services under the HPG to receive FFS for their services.

Tribal facilities that do not opt for the lower rate cannot bill for physician and/or midlevel services separate from the encounter.

Updated 03/14/2019

## How Tribal Outpatient Hospitals are Paid

Tribal outpatient hospital services are reimbursed on an encounter rate, which is published in the Federal Register by the Indian Health Service. The three categories of encounter rates are medical, dental, and behavioral health. Each encounter category may only be reimbursed once in a 24-hours period.

The encounter rate will be reduced by any other amount you have been paid for services, such as payments from other health insurance companies (third-party liability) or copayments from recipients if they are not Alaskan Natives or American Indians (non-tribal beneficiaries). Refer to the [Billing Third-Party Liability](#) section.

### Exceptions

- If you have completed the separate written agreement to accept the reduced outpatient rate or further reduced outpatient rate, negotiated between IHS and the Centers for Medicare & Medicaid Services, then you may bill for the physician and/or midlevel services separately. You must notify the Department if you opt for a different reimbursement methodology.
- If you choose to enroll separately as an Ambulatory Surgical Center (ASC), the facility fees are reimbursed per the Medicaid ASC Fee Schedule; professional fees for physicians, anesthesiologists



and radiologists must be billed separately using the CMS-1500. Dentists must bill separately using the ADA claim form.

Updated 06/08/2018

# Covered Revenue Codes for Tribal Outpatient Hospitals

## Revenue Codes<sup>1</sup>: Outpatient Hospitals Only

0490	0519	0771	0822	0829	0833	0840	0844	0851	0855	0969
0510	0760	0780	0823	0830	0834	0841	0845	0852	0859	0981
0514	0761	0820	0824	0831	0835	0842	0849	0853	0940	0982
0516	0769	0821	0825	0832	0839	0843	0850	0854	0963	0983

## Revenue Codes<sup>1</sup>: Inpatient and Outpatient Hospitals

0001	0275	0307	0340	0380	0412	0444	0530	0621	0731	0921
0250	0276	0309	0341	0381	0413	0449	0531	0622	0732	0922
0251	0278	0310	0342	0382	0419	0450	0539	0623	0739	0923
0252	0279	0311	0343	0383	0420	0451	0550	0631	0740	0924
0254	0280	0312	0344	0384	0421	0452	0551	0632	0750	0925
0255	0289	0314	0349	0385	0422	0456	0552	0633	0762	0929
0257	0290	0319	0350	0386	0423	0459	0559	0634	0790	0943
0258	0291	0320	0351	0387	0424	0460	0560	0635	0811	0960
0259	0292	0321	0352	0389	0429	0469	0561	0636	0814	0964
0260	0293	0322	0359	0390	0430	0470	0562	0637	0819	0971
0261	0294	0323	0360	0391	0431	0471	0569	0700	0880	0972
0262	0299	0324	0361	0399	0432	0472	0610	0710	0881	0973
0263	0300	0329	0362	0400	0433	0479	0611	0720	0889	0974
0264	0301	0330	0367	0401	0434	0480	0612	0721	0901	0975
0269	0302	0331	0369	0402	0439	0481	0614	0722	0914	0976
0270	0303	0332	0370	0403	0440	0482	0615	0723	0915	0978
0271	0304	0333	0371	0404	0441	0483	0616	0724	0916	0979
0272	0305	0335	0372	0409	0442	0489	0618	0729	0918	0985
0274	0306	0339	0379	0410	0443	0499	0619	0730	0920	0986

<sup>1</sup>Revenue codes and UB-04 claim form information is copyright 2017 American Hospital Association. Copyright for the members of the National Uniform Billing Committee (NUBC) by the American Hospital Association (AHA).

Updated 06/08/2018

# Tribal Inpatient Hospitals

## What is a Tribal Inpatient Hospital?

A hospital operated by a tribal health organization may qualify to enroll with Alaska Medical Assistance as any type of hospital facility for which they qualify (General Acute Care, Critical Access, etc.) and be paid according to the payment methodology applicable to that type of hospital under state regulations.

Updated 06/04/2013

## Enrolling a Tribal Inpatient Hospital

To enroll as a tribal inpatient hospital, the hospital must meet the following conditions:

- Is owned or leased by Indian Health Service or a tribal organization with a 638 contract or compact.
- Is listed on the Tribal Facilities List, which is produced by the Indian Health Service.



If eligible, providers must be enrolled in Alaska Medical Assistance individually and separately from the tribal facility.

Updated 06/08/2018

## Inpatient Hospital Services

Inpatient hospital services are billed on a UB-04 form using the appropriate Revenue or HCPCS procedure code covered by Alaska Medical Assistance for inpatient hospitals.

Refer to the applicable *Alaska Medical Assistance Fee Schedule* available on the Conduent web site for inpatient hospitals. The revenue codes listed in [Covered Revenue Codes for Tribal Inpatient Hospitals](#) later in this section are the only tribal inpatient hospital services covered by Alaska Medical Assistance.

Updated 06/08/2018

## Inpatient Professional Services

Provided services in any tribal inpatient hospital by a physician, advanced nurse practitioner, physician assistant, nurse midwife, or certified registered nurse anesthetist (CRNA) are billable services separate from the inpatient hospital encounter rate.

Enroll each physician, advanced nurse practitioner, nurse midwife, physician assistant and certified registered nurse anesthetist individually and cross-reference the provider with the health professional group enrollment number. Mid-level providers, including physician assistants and certified registered nurse anesthetists must be enrolled with Alaska Medical Assistance, and can bill under their health professional group number.

In addition, the following general guidelines apply to all inpatient hospital services.

- Services must be medically necessary
- Admission and treatment services at an inpatient hospital must be ordered in writing by an attending physician
- Admission for surgery must be on the date of surgery except for an emergency or when the recipient's physical or mental condition requires extensive preoperative preparation or therapy



Private room accommodations are not covered unless justification of medical necessity is submitted with the claim. You can use the *Certificate of Medical Necessity* form in the [Forms](#) section.

Standard inpatient hospital services covered by Alaska Medical Assistance include:

- Routine daily hospital services (includes room, linen service, meals, special diets, general nursing service, medical records and admitting service, use of ordinary hospital equipment and instruments, routine treatments, routine drugs, and routine supplies)
- Drugs prescribed by the attending physician
- Central service supplies (includes the cost of preparing, handling, and storing supplies)
- Treatment trays, dressings, use of equipment ordered by the attending physician
- Operating room (includes most standard surgical supplies)
- Anesthesia
- Recovery room
- Normal and cesarean delivery (includes routine supplies)
- X-ray
- Laboratory
- Physical therapy
- Occupational therapy
- Speech-language pathology
- Hearing (audiology) services and evaluations
- Respiratory therapy
- Electrocardiography (EKG/ECG)
- Electroencephalography (EEG)
- Professional ancillary services
- Services for spontaneous abortions, or miscarriages
- The department may make payment for organ transplants and requisite related medical care for:
  - Kidney and corneal transplants; service authorization is not required
  - Skin and bone transplants for which the department has given service authorization; however, dental implants are not covered
  - Bone marrow transplants for which the department has given service authorization
  - Liver transplants for which the department has given service authorization, for persons with biliary atresia or other forms of end-stage liver disease
  - Heart, lung, and heart-lung transplants for which the department has given service authorization



**Note:** Some services are not covered by Alaska Medical Assistance. Refer to [Services Not Covered by Alaska Medical Assistance](#) in the Quick Reference section for general guidelines.

## Newborn Bloodspot Screening

The Department of Health and Social Services (DHSS) requires that all babies born in Alaska receive a newborn bloodspot screening. The provider attending the birth of the baby is required to collect the sample within 48 hours of birth. A parent or guardian's refusal to allow the screening must be reported to the Division of Public Health (DPH).

The newborn bloodspot test (84030) is performed at a single laboratory designated by DHSS. The department will not reimburse for costs incurred by use of a non-designated laboratory for the testing of the specimen. Providers are charged a single fee per newborn, which includes all required specimens and repeat specimen collections necessary due to poor quality or abnormal results. The fee includes all costs associated with the screening (e.g., the specimen card, shipping and handling, laboratory fees). For additional information about the Newborn Bloodspot Screening Program requirements, refer to the [Division of Public Health](#).

### Births in a Hospital Setting

Alaska Medicaid covers newborn bloodspot screening performed in a hospital through the hospital's prospective per diem rate. The hospital must include the screening as a line item on their inpatient claim using procedure code S3620. No additional reimbursement is allowed to the healthcare provider collecting the sample or for additional samples collected outside of the inpatient hospital setting. If the sample is not collected by the hospital, another healthcare provider may collect the sample outside of the hospital setting and be reimbursed for the newborn bloodspot screening.

### Births Outside of a Hospital Setting

For babies delivered outside of a hospital setting, tribal clinics and free-standing birth centers are reimbursed for the incidental service of a newborn bloodspot screenings (S3620) only if core service is part of the encounter. No additional reimbursement is allowed for the collection of the sample.

For additional information on the newborn bloodspot screening requirements, visit DPH's [Newborn Bloodspot Screening Program](#) webpage.

## Long Acting Reversible Contraception

Alaska Medicaid covers long acting reversible contraception (LARC) devices and the insertion of these devices. Service authorization is not required for LARC insertions or the LARC device.

LARC Reimbursement by Setting			
	Inpatient Hospital Setting/IPP*	Outpatient Hospital	Free Standing Birth Center/IPP* or Office/Clinic
Device	<p><b>IP hospitals</b> are reimbursed a prospectively determined per diem rate established by the Office of Rate Review. No additional reimbursement is allowed for the LARC device as it is already included in the per diem rate.</p> <p><b>Tribal IP Hospitals</b> are reimbursed at the all-inclusive</p>	<p><b>OP hospitals</b> are reimbursed for the device at the percent of billed charges rate established by the Office of Rate Review.</p> <p><b>Tribal OP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or</p>	<p><b>Free standing birth centers</b> are not reimbursed for the LARC device. The attending healthcare provider may be reimbursed for the device separately.</p> <p><b>Healthcare providers</b> are reimbursed at the wholesale acquisition cost (WAC) plus one percent.</p>

LARC Reimbursement by Setting			
	Inpatient Hospital Setting/IPP*	Outpatient Hospital	Free Standing Birth Center/IPP* or Office/Clinic
	rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of inpatient hospital services, excluding physician services. No additional reimbursement is allowed for the LARC device.	using the prospective payment process through the Office of Rate Review. AIR is all inclusive of outpatient hospital services. No additional reimbursement is allowed for the LARC device.	<b>Tribal health clinics</b> are reimbursed an all-inclusive rate (AIR), posted in the Federal Register and calculated by the Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of clinic services. No additional reimbursement is allowed for the LARC device.
Insertion	<p><b>IP hospitals</b> are reimbursed a prospectively determined per diem rate established by the Office of Rate Review. The attending healthcare provider may be reimbursed at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal IP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of inpatient hospital services excluding the services of a physician. The attending physician services may be reimbursed under the Health Professional Group to receive the fee for service rate indicated on their fee schedule.</p>	<p><b>OP hospitals</b> are reimbursed for the insertion of the device at the percent of billed charges rate established by the Office of Rate Review. The attending healthcare provider may be reimbursed at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal OP Hospitals</b> are reimbursed at the all-inclusive rate (AIR), posted in the Federal Register and calculated by Office of Management and Budget or using the prospective payment process through the Office of Rate Review, Tribal OP Hospitals that have opted for the reduced or further reduced encounter rate may bill for the attending physician service under the Health Professional Group to receive the fee for service rate indicated on their fee schedule. Tribal facilities that do not opt for the reduced rates cannot bill for physician services separately from the AIR.</p>	<p><b>Free standing birth centers</b> are not reimbursed for the insertion. The attending healthcare provider may be reimbursed separately for the insertion.</p> <p><b>Healthcare providers</b> are reimbursed for the insertion of the device at the fee for service rate indicated on their fee schedule.</p> <p><b>Tribal health clinics</b> are reimbursed an all-inclusive rate (AIR), posted in the Federal Register and calculated by the Office of Management and Budget or using the prospective payment process through the Office of Rate Review. AIR is all inclusive of clinic services. No additional reimbursement is allowed for the LARC insertion.</p>

\*Immediate postpartum placement of LARC

## National Drug Code Requirements

Outpatient hospitals, birthing centers, and healthcare clinics must bill the National Drug Code (NDC) to receive reimbursement for the LARC device. For additional information on NDC billing requirements and examples, refer to [National Drug Code/J-Code Billing](#) in the Billing Guidelines section.

## Procedure Codes and Modifiers

Providers must use the correct CPT and ICD-10 codes for the service(s) provided. In some cases it will be necessary to add a modifier to the procedure code to receive reimbursement. Please see the [LARC Quick Coding Guide](#) published by ACOG for further information.

## Multiple Procedure Cutback

A multiple procedure cutback may apply; refer to the [Physician, ANP, PA Billing Manual](#) for further guidance on multiple surgical procedures.

LARC Device and Insertion Procedure Codes			
CPT/HCPCS Code	Description	CPT/HCPCS Code	Description
11976	Remove Contraceptive Capsule	76998	Ultrasound Guide Intraoperative
11981	Insert Drug Implant Device	J7296	Kyleena
11982	Remove Drug Implant Device	J7297	Liletta
11983	Remove/Insert Drug Implant	J7298	Mirena
58300	Insert Intrauterine Device	J7300	ParaGard
58301	Remove Intrauterine Device	J7301	Skyla
76830	Transvaginal Ultrasound Non-OB	J7307	Nexplanon
76857	Ultrasound Exam Pelvic Limited		



**Note:** An encounter that includes only an incidental service(s) is not a stand-alone billable visit for Tribal Clinics.

Updated 03/12/2019

# Inpatient Hospital Services Requiring Service Authorization

Service authorization from Qualis Health is needed for:

- Selected inpatient hospital procedures and services related to selected diagnoses:
  - a list of these procedures and services, titled Select Diagnosis/Procedures Review Guidelines, may be found at: <http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-health-care-services/provider-resources>
  - See [Service Authorization](#) for more information

- Patient stays that are longer than 3 days (except maternal and newborn stays)
- Maternal and newborn stays over:
  - 48 hours from the date of a vaginal delivery
  - 96 hours from the date of a cesarean delivery

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

Mode of Delivery	Submit Claims as Payable without SA	Administrative SA from Conduent	Medical Necessity Review from Qualis
Vaginal	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	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

To request an administrative SA from Conduent, fax the following information to Conduent:

- Provider name
- Medical Assistance provider identification number
- Recipient name
- Recipient Medicaid ID
- Diagnosis Code
- Procedure Code (if applicable)
- Date of Service Range (Admit to Discharge)
- Date of Delivery/Birth
- Contact name
- Phone number
- Return fax number

Refer to [Authorization from Qualis Health](#) in the Service Authorization section for additional information on requesting a service authorization for inpatient hospital services.



The physician or hospital is responsible for receiving service authorization before admitting a patient to the hospital. If the admission is urgent or an emergency, you must contact Qualis Health via iExchange ([Authorization from Qualis Health](#)) within 24 hours or one business day.

Updated 06/08/2018

# Billing for Tribal Inpatient Hospital Services



Alaska Medical Assistance is the "payer of last resort," which means that you must bill all other people, companies, or organizations who might pay for the services before billing Alaska Medical Assistance.

Inpatient Hospitals use the UB-04 form when billing for inpatient hospital services, and the CMS-1500 for physician services related to the inpatient hospitalization. Complete the UB-04 form for inpatient hospital services (do not bill physician services on the UB-04; refer to step 2 below). Refer to the [UB-04 Claim Form Instructions](#) for specific information on how to fill out the form as well as which fields are required. When billing on the UB-04:

- Enter the Revenue Code and Description in fields 42 and 43. List services provided by using the revenue codes listed later in this section.
- Enter the inpatient hospital NPI in field 56.
- Enter the Service Authorization number, if applicable. Enter the Service Authorization Codes in field 63 (refer to [How to Get a Service Authorization](#) in the Quick Reference section).
- Enter the ICD indicator appropriate for the date of service in field 66.



## **ICD-10-CM:**

ICD-10-CM is the coding classification system used to describe diseases and operations. It serves an important function for physician reimbursement, hospital payments, quality review and benchmarking measurement.

- Enter the principal diagnosis that is causing hospitalization in field 67.
- Enter an appropriate ICD-9 or ICD-10 surgical procedure code if you list a charge for the operating room or for a surgical procedure. Enter the Principal Procedure Code in field 74.
- Include any needed attachments. Refer to [What to Attach to a Claim](#) in the Billing Guidelines section.

Complete the CMS-1500 for physician services related to the inpatient hospitalization. When billing for the physician services, you will need to:

- List the services provided using the CPT or HCPCS procedure codes in field 24d. Refer to the [Alaska Medical Assistance Physician Fee Schedule](#) for valid codes.
- Enter the rendering physician's NPI in field 24J.
- Enter the NPI in field 33a for the physician group practice enrollment. Provide the qualifier ZZ and the taxonomy code for the group practice in field 33b.
- Bill only for services the physician has personally provided.

The services of a physician, advanced nurse practitioner, physician assistant, nurse midwife or certified registered nurse anesthetist provided to an inpatient in a hospital must be billed separately. Refer to [Enrolling a Tribal Inpatient Hospital](#) in this section.

## **Billing Guidelines for Professional Inpatient Services**



Physician services are reimbursed under the [Alaska Medicaid Physician Fee Schedule](#).

If you are billing for any of the following services, use the guidelines below.



- **Anesthesia services:** 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.
- 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.

The following is an example of single-line billing and the reimbursement you would receive:

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.
From To						PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)			DIAGNOSIS POINTER	\$ CHARGES	DAYS OR UNITS	EPSOT Family Plan
MM	DD	YY	MM	DD	YY			CPT/HCPCS		MODIFIER				
01	24	17	01	24	17	22		01400	AA		1	728.75	70	

*Procedure 01400 completed in 70 minutes on January 24, 2017 in an outpatient setting*

Base Value Units for procedure code 01400	=	4
4 base value units X \$42.90 per unit	=	\$171.60
70 minutes of time X \$3.60 per minute	=	\$252.00
Alaska Medical Assistance total reimbursement	=	\$423.60

- **Durable Medical Equipment:** Claims for durable medical equipment submitted with revenue code 0290 must include the appropriate CPT/HCPCS code.
- **Obstetrical Care.** Routine global obstetrical care CPT procedure codes 59400 (vaginal delivery) and 59510 (cesarean delivery) are covered only when the patient has third-party insurance coverage. If the patient does not have third-party insurance, bill for routine obstetrical care with the procedure codes listed in the CPT manual.
  - If you provided ante partum care services - bill the appropriate evaluation and management procedure code(s).
  - If you only performed the delivery - bill procedure code 59409 (vaginal delivery only) or 59514 (cesarean delivery only).
  - If you performed the delivery and gave postpartum care - bill procedure code 59410 (vaginal delivery only, including postpartum care) or 59515 (cesarean delivery only, including postpartum care).
- **Operating Room for Dental Services:** When billing for an operating room with revenue code 036x for dental services:

- Use revenue code 0360 with procedure code 41899, *Unlisted procedure, dentaoalveolar structures*, on a single claim line to account for dental-related operating room charges.
- Submit an operative report supporting the unlisted procedure as a claim attachment.
- Do **not** bill revenue code 0360 for dental-related operating room services on multiple claim lines.
- Do **not** use Current Dental Terminology (CDT) codes in place of procedure code 41899.
- **Operating Room Services:** Claims for operating room services submitted with revenue code 036x must include the appropriate CPT/HCPCS code.
- **Surgical Assistants.** Physicians, physician assistants and advanced nurse practitioners acting as surgical assistants must submit a separate claim for their services, using a CPT modifier (-80, -81, or -82). If you submit a claim for a second surgical assistant, you must attach an explanation from the surgeon explaining the need for a second assistant.
- **Physicians, Physician Assistants or Certified Registered Nurse Anesthetists.**
  - Use the supervising physician's, the physician assistant's or certified registered nurse anesthetist's NPI in field 24J.
  - Bill a physician service under the group NPI in field 33a with the qualifier ZZ and group practice taxonomy code in field 33b.
- **Advanced Nurse Practitioner or Nurse Midwife.** ANP/NMWs are required to enroll with Alaska Medical Assistance and will be reimbursed based on that enrollment. Refer to the [Physician, Advanced Nurse Practitioner/Nurse Midwife](#) billing manual for specific billing guidelines, and to the appropriate provider billing manual when billing for other covered ANP/NMW services. Dispensing Advanced Nurse Practitioners, for instance, shall bill according to the covered services and billing guidelines found in the [Pharmacy Services Provider Billing Manual](#).

Updated 03/14/2019

## How Tribal Inpatient Hospitals are Paid

Inpatient hospital services are reimbursed on a per day (per diem) rate basis. The rate, which is published annually in the Federal Register and/or Office of Rate Review, is payment for all inpatient hospital services, except the services of a physician, advanced nurse practitioner, physician assistant, nurse midwife and a certified registered nurse anesthetist, provided to one recipient on one day at one tribal inpatient hospital. The Per-Diem rate is paid per patient, per day and is payment for all services received at the hospital.



**Note:** The services of a physician, advanced nurse practitioner, physician assistant, nurse midwife or certified registered nurse anesthetist must be billed separately on a CMS-1500 claim form.

Inpatient hospital services will be reimbursed only for the approved number of days (refer to [Inpatient Hospital Services Requiring Service Authorization](#) earlier in this section). The rate will be reduced by any other amount you have been paid for services, such as payments from other health insurance companies or from recipients if they are not Alaskan Natives or American Indians.

Updated 06/08/2018

# Covered Revenue Codes for Tribal Inpatient Hospitals

## Revenue Codes<sup>1</sup>: Inpatient Hospitals Only

0100	0116	0124	0132	0150	0158	0172	0204	0213	0803	0903
0101	0117	0125	0133	0151	0159	0173	0206	0214	0804	0904
0110	0118	0126	0134	0152	0160	0174	0207	0219	0809	0911
0111	0119	0127	0135	0153	0164	0179	0208	0650	0810	0919
0112	0120	0128	0136	0154	0167	0200	0209	0657	0812	0984
0113	0121	0129	0137	0155	0169	0201	0210	0800	0813	
0114	0122	0130	0138	0156	0170	0202	0211	0801	0900	
0115	0123	0131	0139	0157	0171	0203	0212	0802	0902	

## Revenue Codes<sup>1</sup>: Inpatient and Outpatient Hospitals

0001	0275	0307	0340	0380	0412	0444	0530	0621	0731	0921
0250	0276	0309	0341	0381	0413	0449	0531	0622	0732	0922
0251	0278	0310	0342	0382	0419	0450	0539	0623	0739	0923
0252	0279	0311	0343	0383	0420	0451	0550	0631	0740	0924
0254	0280	0312	0344	0384	0421	0452	0551	0632	0750	0925
0255	0289	0314	0349	0385	0422	0456	0552	0633	0762	0929
0257	0290	0319	0350	0386	0423	0459	0559	0634	0790	0943
0258	0291	0320	0351	0387	0424	0460	0560	0635	0811	0960
0259	0292	0321	0352	0389	0429	0469	0561	0636	0814	0964
0260	0293	0322	0359	0390	0430	0470	0562	0637	0819	0971
0261	0294	0323	0360	0391	0431	0471	0569	0700	0880	0972
0262	0299	0324	0361	0399	0432	0472	0610	0710	0881	0973
0263	0300	0329	0362	0400	0433	0479	0611	0720	0889	0974
0264	0301	0330	0367	0401	0434	0480	0612	0721	0901	0975
0269	0302	0331	0369	0402	0439	0481	0614	0722	0914	0976
0270	0303	0332	0370	0403	0440	0482	0615	0723	0915	0978
0271	0304	0333	0371	0404	0441	0483	0616	0724	0916	0979
0272	0305	0335	0372	0409	0442	0489	0618	0729	0918	0985
0274	0306	0339	0379	0410	0443	0499	0619	0730	0920	0986

<sup>1</sup> Revenue codes and UB-92, UB-04 claim form information is copyright 2005, 2007, 2008 American Hospital Association. Copyright for the members of the National Uniform Billing Committee (NUBC) by the American Hospital Association (AHA)

Updated 06/08/2018

# Administrative Wait Beds

## What is an Administrative Wait Bed?

An Administrative Wait Bed provider offers nursing home care to a patient authorized by Senior and Disabilities Services (SDS) as requiring a nursing home level of care and is “waiting” in an acute institution for services to be available. This allows the acute setting to receive some reimbursement for the bed. Tribal hospitals should apply for administrative wait bed status since there are fewer requirements for administrative wait beds than swing beds, outlined as follows:

- Administrative wait beds are a Medicaid/Alaska Medical Assistance-only program (Medicare does not pay for this service).
- If a hospital meets the enrollment requirements for inpatient hospital for Alaska Medical Assistance, they can enroll as an Administrative Wait (AW) provider (does require additional enrollment and billing number).
- The State administers the program under the same rules as swing beds: Status must follow an acute stay of at least 3 days and patients are certified to meet nursing home level of care. Hospitals must provide proof that the recipient has been accepted at a long term care facility, but the bed is not available. Forms for authorization of long term care services are the same as for swing beds and must be submitted to Long-Term Care Authorizations prior to admission to the bed.
- There are no further federal or state documentation or reporting requirements.
- The reimbursement rate is the same as swing beds and covers room, board and services.

Updated 06/08/2018

## Enrolling an Administrative Wait Bed

The facility must already be a currently enrolled inpatient hospital provider for Alaska Medical Assistance. The hospital must then complete the enrollment process with Conduent to be an AW provider.

After completing the enrollment process, the facility should contact the Department of Health and Social Services (DHSS), Division of Senior and Disabilities Services (SDS) to receive instructions for submitting paperwork to authorize a nursing home stay. SDS will use a software application to enter client information for patients for whom facilities are requesting Long Term Care (LTC). The information is used by SDS for tracking clients and is in addition to the forms that are sent via Direct Source Messaging (DSM) to the division.

Long Term Care Authorizations

Phone: 907.334.2672

Email: [dsds.ltcauthorization@direct.dhss.akhie.com](mailto:dsds.ltcauthorization@direct.dhss.akhie.com)

Updated 06/08/2018

# Administrative Wait Bed Services

If a patient in a hospital inpatient setting no longer requires an acute level of care, but will require a skilled or intermediate level of care, whether the care will be received in a nursing home setting or a home setting, the transferring facility must complete and fax the following to the Alaska Department of Health and Social Services, Senior and Disabilities Service prior to transfer:

1. Long Term Care Authorization Form (LTC-01),
2. Pre-Admission Screening and Resident Review (PASRR) Level I (LTC-2)
3. Long Term Care (LTC) Travel authorization Request (LTC-03)
  - LTC-03 is only required when a patient must travel from a swing bed or a wait bed facility to an LTC facility.

All forms and their instructions are available at <http://dhss.alaska.gov/dsds/Pages/provider/pr-skillednursing.aspx>



**Note:** The Long Term Care Facility Authorization Form and PASRR must be completed by the transferring hospital.

Submit completed Long-Term Care Facility Authorization requests to the Division of Senior and Disabilities Services via DSM email at [DSDS.LTCauthorizations@direct.dhss.akhie.com](mailto:DSDS.LTCauthorizations@direct.dhss.akhie.com).

Sign up for Direct Secure Messaging at <http://www.ak-ehealth.org/forproviders/direct-secure-messaging>.

If the patient wishes to receive Home and Community-Based Waiver services and is qualified under the Alaska Medical Assistance Program, the hospital should complete the form and contact the Nursing Facility Transition Program Coordinator, who will work with the hospital and SDS to facilitate waiver services. If a Skilled Nursing Facility (SNF) bed becomes available, the hospital may decline that placement while waiting for more suitable waiver services.

Contact:

Health Program Manager III – Grants Unit Program  
PO Box 110680  
Juneau, Alaska 99811-0680  
[Lisa.Morley@alaska.gov](mailto:Lisa.Morley@alaska.gov)  
Phone: 907.465.4996

For further information: [www.dhss.alaska.gov/dsds/pages/nursing/default.aspx](http://www.dhss.alaska.gov/dsds/pages/nursing/default.aspx)

Once a patient receives authorization for this continuing level of skilled care, the facility may be reimbursed for AW beds for the authorized date through the date the patient is admitted to a nursing home, or the date that the patient's Choice Waiver assessment is completed by the Alaska Department of Health and Social Services, or its designee and the patient is approved to begin receiving services in the home/community setting.

Administrative wait days can be authorized in 30-day segments for a maximum period of three months.

Updated 06/08/2018

# Billing for Administrative Wait Bed Services

Refer to [How to Complete the UB-04 Claim Form](#) found in *Billing Guidelines* section of this manual.

Updated 06/04/2013

## Long Term Care Authorization Form (LTC-01) Instructions

Authorization for long term care facility services is requested by the receiving facility on a *Long Term Care Authorization* form (LTC-01).

If the request is for an initial LTC authorization or if a resident exhibits a significant change in status, the LTC-2 form **must** be completed.

All forms and completion instructions are available at <http://dhss.alaska.gov/dsds/Pages/provider/pr-skillednursing.aspx>.

Updated 06/08/2018

## How Administrative Wait Beds are Paid

The skilled nursing portion of an Administrative Wait Bed patient's care is reimbursed at the average Alaska Medical Assistance per diem rate for skilled nursing facilities. This rate covers room, board, and ancillary services.

Updated 06/08/2018

## Administrative Wait Bed Revenue Codes and Descriptions

Code Range	Description						
001	Total Charge						
18X	Leaves of Absence Charges [including zero charges] for holding a room while the patient is temporarily away from the provider.						
	<table><tr><th>Subcategory ("X"=)</th><th>Standard Abbreviation</th></tr><tr><td>2 = Patient Convenience - charges "billable" (Social leave/Payable; up to 12 days per rolling year)</td><td>"LOA/PT CONV CHARGES"</td></tr><tr><td>5 = Nursing Home (for hospitalization) (Acute Care/Non-payable)</td><td>"LOA/NURS HOME"</td></tr></table>	Subcategory ("X"=)	Standard Abbreviation	2 = Patient Convenience - charges "billable" (Social leave/Payable; up to 12 days per rolling year)	"LOA/PT CONV CHARGES"	5 = Nursing Home (for hospitalization) (Acute Care/Non-payable)	"LOA/NURS HOME"
Subcategory ("X"=)	Standard Abbreviation						
2 = Patient Convenience - charges "billable" (Social leave/Payable; up to 12 days per rolling year)	"LOA/PT CONV CHARGES"						
5 = Nursing Home (for hospitalization) (Acute Care/Non-payable)	"LOA/NURS HOME"						
19X							
	<table><tr><th>Subcategory ("X"=)</th><th>Standard Abbreviation</th></tr><tr><td>1 = SNF Level of Care</td><td>N/A</td></tr><tr><td>2 = ICF Level of Care</td><td>N/A</td></tr></table>	Subcategory ("X"=)	Standard Abbreviation	1 = SNF Level of Care	N/A	2 = ICF Level of Care	N/A
Subcategory ("X"=)	Standard Abbreviation						
1 = SNF Level of Care	N/A						
2 = ICF Level of Care	N/A						

Code Range	Description	
	3 = IDD	N/A
	4 = AW/Swing Bed	N/A
<b>25X</b>	<b>Pharmacy</b> Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of licensed pharmacist.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	7 = Non-prescription	"DRUGS/NONPSCRIPT"
<b>26X</b>	<b>IV Therapy</b> Charges for equipment or administration of intravenous solution by specially trained personnel to individuals requiring such treatment; used only when a discrete service unit exists.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	1 = Infusion Pump	"IV THERAPY/INFSN PUMP"
	4 = IV Therapy/Supplies	"IV THERAPY/SUPPLIES"
	9 = Other IV Therapy	"IV THERAPY/OTHER"
<b>27X</b>	<b>Medical/Surgical Supplies and Devices</b> Charges for supply items required for patient care.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification (Use "270" for continuous flow oxygen)	"MED-SUR GENERAL"
	1 = Non-sterile Supply	"MED-SUR SUPPLIES"
	2 = Sterile Supplies	"STERILE SUPPLY"
	4 = Prosthetic/Orthotic Devices	"PROSTHETIC DEVICES"
	9 = Other Supplies/Devices	"OTHER SUPPLIES/DEVICES"
<b>41X</b>	<b>Respiratory Services</b> Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy, through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"RESPIRATORY SVC"
	2 = Inhalation Service	"INHALATION SVC"
	9 = Other Respiratory Services	"OTHER RESPIR SVS"
<b>42X</b>	<b>Physical Therapy</b> Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"PHYSICAL THERP"

Code Range	Description	
	1 = Visit Charge	"PHYS THERP/VISIT"
	2 = Hourly Charge	"PHYS THERP/HOUR"
	3 = Group Rate	"PHYS THERP/GROUP"
	4 = Evaluation or Re-evaluation	"PHYS THERP/EVAL"
	9 = Other Physical Therapy	"OTHER PHYS THERP"
<b>43X</b>	<b>Occupational Therapy</b> Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"OCCUPATION THER"
	1 = Visit Charge	"OCCUP THERP/VISIT"
	2 = Hourly Charge	"OCCUP THERP/HOUR"
	3 = Group Rate	"OCCUP THERP/GROUP"
	4 = Evaluation or Re-evaluation	"OCCUP THERP/EVAL"
	9 = Other Occupational Therapy	"OTHER OCCUP THER"
<b>44X</b>	<b>Speech-Language Pathology</b> Charges for services provided to persons with impaired functional communications skills.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"SPEECH PATHOL"
	1 = Visit Charge	"SPEECH PATH/VISIT"
	2 = Hourly Charge	"SPEECH PATH/HOUR"
	3 = Group Rate	"SPEECH PATH/GROUP"
	4 = Evaluation or Re-evaluation	"SPEECH PATH/EVAL"
	9 = Other Speech-Language	"OTHER SPEECH PAT" Pathology
<b>97X</b>	<b>Professional Fees [extension of "96X"]</b> Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	7 = Physical Therapy	"PRO FEE/PHYSI"

Updated 06/08/2018



# Swing Bed Providers

## What is a Swing Bed?

A Swing Bed (SB) provider is a rural hospital that is permitted by CMS to provide post-acute nursing home level of care as needed. Swing Beds allow an individual who is certified as meeting the nursing home level of care to remain in or return to their own community. Rural hospitals have less than 100 beds, with no skilled nursing homes within a 50-mile radius. A tribal hospital that is a Critical Access Hospital (CAH) and is Medicare/Medicaid certified, should enroll as a Swing Bed Provider. This enables them to be reimbursed by both Medicare and Alaska Medicaid for dual-eligible patients. Swing beds provide increased access to Long Term Care services for rural residents, and are one method to utilize a surplus of acute care hospital beds.

Updated 06/08/2018

## Financial Considerations

Each hospital will need to examine the financial feasibility of adding swing beds:

- Swing beds allow hospitals to receive some revenue for an otherwise non-paid bed.
- Swing beds will not affect Critical Access status: Swing beds are exempt from the 96-hour length of stay limitation.
- Hospitals have to determine individual staffing capability, i.e., nurses and CNAs to provide this service. Is staff available? Is it cost-effective to add these beds?
- Swing beds will be more financially sound under CAH Medicare allowances if patients are eligible.

Updated 06/08/2018

## Service/Staffing Requirements

In addition to the regular provision of nursing and personal care, the facility must provide activities, social services, discharge planning, specialized rehabilitative services, and dental services, as needed by patient.

Updated 06/04/2013

## Hospital Records Requirements

Medicaid providers are required to maintain accurate and complete financial, clinical, and other records in compliance with 7 AAC 105.230 and necessary to support the services for which the provider requests payment, including resident rights, admission, transfer and discharge rights, resident behavior and facility practices, and a separate area in the chart for swing bed stays. Providers are also responsible for ensuring that their staff, billing agents, and other entities in charge of provider record maintenance meet these requirements.

Providers are encouraged to review 7 AAC 105.230 and their records regularly to ensure continued compliance. Failure to maintain proper documentation could lead to denial of provider claims and recoupment of provider payments.

Updated 06/08/2018

# Federal Regulations for Swing Beds

**Skilled nursing facility services:** The facility is substantially in compliance with the following skilled nursing facility requirements contained in subpart B of part 483 of this chapter:

- Resident rights
- Admission, transfer, and discharge rights
- Resident behavior and facility practices
- Patient activities
- Social services
- Discharge planning
- Specialized rehabilitative services
- Dental services

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## Swing Beds Data Requirements

Swing bed hospitals are required to collect federally mandated information on each resident as part of the Minimum Data Set (MDS). This is used as a data collection tool for both of the Medicare and Medicaid payment systems. The MDS is a two-page assessment form that reflects the acuity of the residents, including diagnoses, treatments and an evaluation of residents' functional status. The Swing Bed Minimum Data Set (SB-MDS) uses the MDS and two subsets of information used to track patient readmission and discharge.

The SB-MDS is completed by a registered nurse, according to the same schedule used by skilled nursing facilities for the SNF PPS. The admission is day one of the stay. The schedule includes a 5-day, 14-day, 30-day, 60-day and 90-day assessment. Off-cycle assessments are completed to report a clinical change or at the discontinuance of therapies. A readmission/return assessment is required after any new acute hospital stay. The SB-MDS must be submitted electronically to CMS for Medicare patients.

- Contact State of Alaska coordinator for MDS is at 907.334.2482.
- Critical Access Hospitals are exempt from the MDS requirement for swing beds.

Updated 06/08/2018

## Enrolling a Swing Bed

Once a hospital has policies and procedures in place for the provision of Long Term Care services as designated in 42 CFR 482.58, they may submit a request to the State of Alaska, Department of Health and Social Services, Division of Health Care Services, Health Facilities Licensing & Certification (HFLC). Prior to scheduling a survey, HFLC reviews the hospital's request ensuring that they are Medicare/Medicaid certified and have met the basic requirements of a swing bed hospital. If all the requirements are met and the hospital has begun to provide swing bed services, HFLC will schedule an onsite survey. No hospital may receive initial swing bed approval without an onsite survey of the actual provision of services; it is not possible to adequately assess a hospital's compliance until it provides the services.

After certification for swing bed provision is approved, the hospital must then complete the enrollment process with Conduent to be a Swing Bed Provider.

In order for a patient to be eligible for coverage of post-hospital swing bed status, they must have been hospitalized for medically necessary inpatient treatment for three consecutive calendar days, and be 65 years old, disabled, or have end-stage renal disease.

Swing bed services:

- must be ordered by a physician.
- require the skills of technical or professional personnel.
- must be furnished directly or under the supervision of these personnel.
- must be provided on a daily basis as needed by the patient.

Alaska regulations for admitting patients to swing beds are the same as for skilled nursing placement found in 07 AAC 140.525-535. The hospital must complete the *Long Term Care (LTC) Facility Authorization form (LTC-01)* and *Pre-Admission Screening and Resident Review (PASRR) Level I form (LTC-2)* submit it to Senior and Disabilities Services for approval of the patients' level of care. The authorization form should include specifics about the patient's need for skilled nursing care and an explanation of why they will use a swing bed instead of SNF placement. Authorizations are approved for 3-month segments.

Swing bed admission must follow at least a three-day acute hospital stay. Hospitals must use the LTC-01 and LTC-2 forms for authorization of long term care services.

Updated 06/08/2018

# Nursing Home Authorization and Reauthorization

## Nursing Facility Responsibilities

### Initial Admission

1. *Long Term Care (LTC) Facility Authorization (LTC-01)* form and the *Pre-Admission Screening and Resident Review (PASRR) Level I (LTC-2)* must be completed by and signed by the attending physician.
2. Once the LTC-01 and LTC-2 are completed, the Hospital will email the completed packet of forms to the Division of Senior and Disabilities Services via DSM email at [DSDS.LTCauthorizations@direct.dhss.akhie.com](mailto:DSDS.LTCauthorizations@direct.dhss.akhie.com).
  - Sign up for Direct Secure Messaging at <http://www.ak-ehealth.org/forproviders/direct-secure-messaging>.
3. Approval cannot be given retroactively for admissions prior to the date of the MI/MR (PASRR) screening.

### Reauthorizations

LTC-01 must be completed and emailed to DSDS. The LTC-2 form is required for residents exhibiting significant changes.

### Transfers and/or Corrections

Process is the same as that outlined for initial admissions.

## Retroactive Requests

The Hospital can submit retroactive requests by completing an LTC-01 as described in the initial admission segment. The Hospital can be reimbursed retroactively 1 year. The Hospital may not be reimbursed retroactively for services rendered before the LTC-2 PASRR screening was completed.

Updated 06/08/2018

# Billing for Swing Bed Services

Refer to [How to Complete the UB-04 Claim Form](#) found in the *Billing Guidelines* section of this manual.

Updated 06/04/2013

## How Swing Beds are Paid

- Payment for swing bed services will be made only for services which are considered post-hospital extended care services that would be provided by a nursing home.
- For Alaska Medical Assistance patients the skilled nursing portion of the patient's care is reimbursed at the weighted average per patient day of the Alaska Medical Assistance rate paid to nursing homes in the previous calendar year. This payment covers room, board and ancillary services. For payment rates, refer to the rate sheet provided by the [Office of Rate Review](#).
- Any acute care services provided to the patient while in swing bed status are reimbursed at the normal inpatient hospital rates.
- When Medicare beneficiaries have exhausted their benefits or do not meet Medicare's benefit requirements, a Notice of Medicare Non-Coverage (NOMNC) is required to be submitted to the Division of Health Care Services. Fax to the DHCS LTC Coordinator at 907.561.1684. The form is available at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>.

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## Swing Bed Revenue Codes and Descriptions

Code Range	Description
001	Total Charge
18X	Leaves of Absence (Charges [including zero charges] for holding a room while the patient is temporarily away from the provider.)
	Subcategory ("X"=)
	Standard Abbreviation
	2 = Patient Convenience - charges "billable" (Social leave/Payable; up to 12 days per rolling year)
	"LOA/PT CONV CHARGES"
	5 = Nursing Home (for hospitalization) (Acute Care/Non-payable)
	"LOA/NURS HOME"
19X	
	Subcategory ("X"=)
	Standard Abbreviation

Code Range	Description
	1 = ICF Level of Care N/A
	2 = SNF Level of Care N/A
	3 = IDD N/A
	4 = AW/Swing Bed N/A
<b>25X</b>	<b>Pharmacy</b> (Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of licensed pharmacist.)
	<b>Subcategory ("X"=)</b> <b>Standard Abbreviation</b>
	7 = Non-prescription                      "DRUGS/NONPSCRIPT"
<b>26X</b>	<b>IV Therapy</b> (Charges for equipment or administration of intravenous solution by specially trained personnel to individuals requiring such treatment; used only when a discrete service unit exists.)
	<b>Subcategory ("X"=)</b> <b>Standard Abbreviation</b>
	1 = Infusion Pump                      "IV THERAPY/INFSN PUMP"
	4 = IV Therapy/Supplies                      "IV THERAPY/SUPPLIES"
	9 = Other IV Therapy                      "IV THERAPY/OTHER"
<b>27X</b>	<b>Medical/Surgical Supplies and Devices</b> (Charges for supply items required for patient care.)
	<b>Subcategory ("X"=)</b> <b>Standard Abbreviation</b>
	0 = General Classification (Use "270" for continuous flow oxygen)                      "MED-SUR GENERAL"
	1 = Non-sterile Supply                      "MED-SUR SUPPLIES"
	2 = Sterile Supplies                      "STERILE SUPPLY"
	4 = Prosthetic/Orthotic Devices                      "PROSTHETIC DEVICES"
	9 = Other Supplies/Devices                      "OTHER SUPPLIES/DEVICES"
<b>41X</b>	<b>Respiratory Services</b> (Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy, through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.)
	<b>Subcategory ("X"=)</b> <b>Standard Abbreviation</b>
	0 = General Classification                      "RESPIRATORY SVC"
	2 = Inhalation Service                      "INHALATION SVC"
	9 = Other Respiratory Services                      "OTHER RESPIR SVS"
<b>42X</b>	<b>Physical Therapy</b> (Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities.)

Code Range	Description	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"PHYSICAL THERP"
	1 = Visit Charge	"PHYS THERP/VISIT"
	2 = Hourly Charge	"PHYS THERP/HOUR"
	3 = Group Rate	"PHYS THERP/GROUP"
	4 = Evaluation or Re-evaluation	"PHYS THERP/EVAL"
	9 = Other Physical Therapy	"OTHER PHYS THERP"
<b>43X</b>	<b>Occupational Therapy</b> (Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity.)	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"OCCUPATION THER"
	1 = Visit Charge	"OCCUP THERP/VISIT"
	2 = Hourly Charge	"OCCUP THERP/HOUR"
	3 = Group Rate	"OCCUP THERP/GROUP"
	4 = Evaluation or Re-evaluation	"OCCUP THERP/EVAL"
	9 = Other Occupational Therapy	"OTHER OCCUP THER"
<b>44X</b>	<b>Speech-Language Pathology</b> (Charges for services provided to persons with impaired functional communications skills.)	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"SPEECH PATHOL"
	1 = Visit Charge	"SPEECH PATH/VISIT"
	2 = Hourly Charge	"SPEECH PATH/HOUR"
	3 = Group Rate	"SPEECH PATH/GROUP"
	4 = Evaluation or Re-evaluation	"SPEECH PATH/EVAL"
	9 = Other Speech-Language	"OTHER SPEECH PAT" Pathology
<b>97X</b>	<b>Professional Fees [extension of "96X"]</b> (Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.)	
	<b>Subcategory ("X"=)</b>	<b>Standard Abbreviation</b>
	7 = Physical Therapy	"PRO FEE/PHYSI"

Updated 06/08/2018

# Long Term Care Facility

## In-State LTC Facility Enrollment Requirements

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

- be actively licensed under [AS 47.32](#) as a nursing facility.
- meet all federal utilization control and Medicare long-term care facility requirements under [42 CFR 456 and 42 CFR 483](#).

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## LTC Admission Authorization

The following long-term care facilities must obtain LTC Authorization before Alaska Medicaid will cover long-term care services:

- Intermediate care facility
- Skilled nursing facility

Senior and Disabilities Services (SDS) is responsible for oversight of the long term care facility authorization process, whereby the Division approves or denies requests for nursing home placement and maintains records associated with these actions. To request LTC Authorization, the receiving facility and referring provider must submit appropriate documentation to the Division of Senior and Disability Services (DSDS).

The referring facility must submit the following forms **prior** to the transfer and admission of a recipient.

### [Pre-Admission Screening and Resident Review \(PASRR\)](#)

Senior and Disabilities Services (SDS) must ensure that each individual, regardless of payment source, is screened and/or evaluated for mental illness (MI), intellectual disability (ID) or related condition (RC) before they are admitted into a Medicaid certified long term care facility. These federal requirements are found in 42 CFR 483.100 - 483.138 which detail the Pre Admission Screening and Resident Review (PASRR) regulations. The information provided on this form helps the State in determining whether the proposed long term care facility placement is appropriate to the particular individual's needs.

- The Pre-Admission Screening and Resident Review form is only required at the time of new admission, inter-facility transfer or a resident review. The form is not required for continued placement/reauthorization unless the resident has experienced a significant change in condition (resident review).
- All Sections are required to be filled out for the form to be considered complete. Incomplete or missing information will cause the form to be returned for corrections

## [Long-Term Care Facility Authorization form \(LTC-01\)](#)

The Division gives prior authorization to an individual's placement in a Medicaid certified facility. Long term care facility authorization request forms may be submitted to SDS through the Direct Secure Messaging (DSM) system to DSDS.LTC Authorizations. The LTC facility Authorization request form is required at the time of new admission and resident review if the resident has Medicaid. It is also required for continued placement/reauthorization.

When a long-term care facility determines that a recipient must continue services beyond the time period authorized by the Division of Senior and Disability Services (DSDS), the facility may submit an application for continued stay using the [Long-Term Care Facility Authorization form](#). Follow the procedures outlined in [LTC Admission Authorization](#) of the Long Term Care Facility Manual.

**Reauthorization requests should be submitted one month prior to the end of the current authorization period.**

Long term care authorization request forms must be submitted to SDS through the Direct Secure Messaging (DSM) system to DSDS. LTC Authorizations. Form and instructions can be found; <http://dhss.alaska.gov/dsds/Pages/provider/pr-skillednursing.aspx>.

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# Level of Care Authorization

The Division of Senior and Disability Services (DSDS) determines the appropriate level of care when reviewing a [Long-Term Care Authorization Form](#). DSDS considers the following factors to determine the appropriate level of care:

- Type of care required
- Qualifications of the person who will provide direct care
- Stability of the recipient's overall condition

In order for DSDS to make the best level of care determination the receiving facility and referring provider should submit all appropriate documentation. Oral information will not be accepted to support a level of care decision. Long-term care services will only be authorized for facilities that can provide the appropriate level of care to the admitted patient.

DSDS will evaluate the level of care requested and concur with the applicant or request additional information. When the requestor does not adequately justify the proposed level of care, the receiving facility must transfer or discharge the recipient to a location which provides the level of care authorized for the recipient (higher/lower level of care or home).

- For recipients transferred from acute care, the facility will have no more than 10 days to transfer or discharge the recipient
- For recipients transferred from non-acute care, the facility will have no more than 30 days to transfer or discharge the recipient.

When determining level of care for a recipient in an acute care setting (e.g., hospital or inpatient psychiatric facility), a preliminary evaluation must accompany the authorization request submitted to DSDS. For additional information, refer to [Transfers](#) in this section.

Updated 06/08/2018



# LTC Transfer Authorization

## Transfer from Acute Care to LTC

The Division of Senior and Disabilities Services (DSDS) may authorize long-term care facility (LTC) placement for recipients who are transferring from an acute care hospital or inpatient psychiatric hospital.

The following must occur for DSDS to authorize the transfer:

- The recipient's transfer must be planned cooperatively by parties from the hospital and long-term care facility, including
  - The attending physician
  - Nursing facility medical and nursing directors
  - Relevant specialists
  - Hospital discharge coordinator
- The recipient's level of care needs must be evaluated by the acute care facility discharge coordinator and the nursing facility's director of nursing
- The attending physician, the director of nursing, and any therapist, specialist, or other professional involved in planning for the care of the recipient conduct a primary evaluation of the recipient's need for long-term care facility placement
- The long-term care facility submits the preliminary evaluation in addition to the [Long-Term Care Authorization form \(AK-LTC\)](#)

The preliminary evaluation and authorization form must be sent via DSM to DSDS before the date of the recipient's admission to the long-term care facility.

## Transfer from Non-Acute Care to LTC

When a non-acute care recipient may require placement in a long-term care facility or placement in a different long-term care facility, DSDS must authorize the recipient's transfer. DSDS may authorize a transfer when the long-term care facility submits a completed [Long-Term Care Authorization form \(AK-LTC\)](#) on behalf of the recipient. The authorization request form must also include the long-term care facility's utilization review committee's evaluation of the recipient's level of care needs.

## Level of Care Transfer within Same Facility

When a long-term care facility transfers a recipient to another level of care within the same facility, the facility must submit to DSDS a [Long-Term Care Authorization form \(AK-LTC\)](#) within seven days of the transfer.

## Transfer from LTC to Other Facility

If a long-term care facility plans to transfer a recipient to a different long-term care facility or hospital, then the following parties must be notified by the transferring facility at least 10 days before the transfer:

- The recipient
- The recipient's family or guardian, when applicable
- The attending physician

- The Division of Health Care Services (DHCS)
- The Division of Senior and Disability Services (DSDS)
- The long-term care facility, if DSDS requests the transfer

## Discharge

When a long-term care facility's utilization review determines that a recipient does not require continued placement, the facility must provide written notice at least 10 days before the date of proposed discharge. This notice must be sent to:

- The recipient
- The recipient's family or guardian, if applicable
- The attending physician
- The Division of Health Care Services (DHCS)
- The Division of Senior and Disability Services (DSDS)

In cases where DSDS determines a recipient no longer requires continued placement, DSDS will provide 10-day written notice to the long-term care facility and all other parties listed above.

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# Medicaid-Covered Services

## Revenue Codes

Long-term care services are identified by specific revenue codes published by the National Uniform Billing Committee (NUBC). To review all published revenue codes, refer to the UB-04 Data Specifications Manual available from the American Hospital Association at <http://www.nubc.org>.

Subject to a provider's scope of certification, license, or accreditation, Alaska Medical Assistance covers the following revenue codes for long-term care facilities:

0001	0182	0185	0191	0192	0193	0194	0257	0261	0264	0269
0270	0271	0272	0274	0279	0410	0412	0419	0420	0421	0422
0423	0424	0429	0430	0431	0432	0433	0434	0439	0440	0441
0442	0443	0444	0449	0977						

## Covered Days

Chargeable days for billing purposes include the day of admission to the facility but not the day of discharge, transfer, or death. [Transfer](#) can mean either a shift between levels of care in the same facility or to a different facility.

## Leaves of Absence

Alaska Medicaid will pay a long-term care facility for reserving a bed when recipients take a planned temporary absence of no more than 12 days per rolling 12-month period. During an approved, planned temporary absence, the recipient may visit family and friends or participate in therapeutic or rehabilitative programs.

Document the purpose and plan of all therapeutic or rehabilitative leave in the recipient's plan of care. Therapeutic or rehabilitative programs may include:

- Trial visits to alternative care settings for the purpose of determining if permanent placement is feasible.
- Gradual increased length of visits to prepare recipients for returning to their home or community.
- Extended absences to participate in workshop evaluation for rehabilitative programs.

Alaska Medicaid limits payment for planned leaves of absence to 12 days per 12-month period\* without service authorization (SA). The facility may request authorization for additional leaves of absence from the Division of Senior and Disability Services (DSDS). The facility must obtain authorization before the leave period begins.

**\*"12-month period" refers to a rolling 12 months from the first leave day.**

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## Claim Submission

### All-Inclusive Pricing for LTC Services

Alaska Medicaid reimburses long-term care facilities for providing standard nursing services with an all-inclusive rate established by the Department of Health and Social Services' Office of Rate Review (ORR). Any services included in the all-inclusive rate cannot be paid by Alaska Medicaid directly to any other provider regardless of the place of service. Payment will be reduced by the recipient's [cost-of-care](#) liability.

The long-term care all-inclusive rate includes:

- Rehabilitative nursing care
- Non-prescription drugs
- Direct physical or occupational therapy services to a recipient as prescribed by a physician
- Non-physician consultation, training, or other non-direct recipient care regardless of whether the consultant or trainer is employed by the facility or on contract with the facility
- Periodic oxygen
- All transportation related to the recipient's care and recreation in a facility-owned vehicle
- Routine annual physical exams

### Separately Payable Services

Other services may be covered by Alaska Medicaid separately, subject to service authorization requirements. Some of these separate long-term care facility services include:

- Health care services provided by a professional not employed by or under contract with the facility

- Personal items paid for by personal funds
- Non-periodic, heavy use of [oxygen](#)
- Prescribed legend drugs and biologicals
- X-ray and laboratory procedures provided in or out of the facility
- Essential transportation for recipients to and from the source of medical care (payment will be made directly to the carriers)
- Physician services, except one routine annual physical exam
- Dental services

It is important to report accurate ancillary charges to Alaska Medicaid when billing for services. Ancillary charge data is used to determine Alaska Medicaid rates of reimbursement.

## Recipient Cost of Care

Recipients may have a cost-of-care obligation established by the Division of Public Assistance (DPA).

A recipient's cost of care is his or her total monthly income less a personal needs allowance and other allowed disregards. Any cost-of-care amount will be deducted from Alaska Medicaid's reimbursement amount; however, the long-term care facility is responsible for collecting this liability (7 AAC 100.554.).

### Guide to Cost of Care for Medicaid LTC

- Medicaid recipients may be responsible for a portion of their LTC costs in the form of Cost of Care, which is paid directly to the LTC provider
- Medicaid residents are exempt from Cost of Care under the following circumstances:
  - Month of admission to LTC from hospital or home
  - Month of discharge from LTC to home
  - Month of death
- Full Cost of Care is the responsibility of the recipient for
  - Each full month of approved Medicaid LTC stay
  - All bed hold days and patient convenience days
- Cost of Care is prorated when a recipient
  - is transferred to/from another LTC or an assisted living home
  - has a change in payer source (e.g., Medicare to Medicaid, TPL to Medicaid)

## Medicare Coverage Coordination

For recipients who are eligible for both Medicare and Medicaid, and who have been approved for long-term care services, Alaska Medicaid will reimburse an enrolled skilled nursing facility for the Part A coinsurance portion for days 21 through 100. After the recipient's Medicare coverage is exhausted, Alaska Medicaid will pay the established rate for care for day 101 and beyond if Notice of Medicare Non-Coverage (NOMNC) is on file with HCS. Completed and signed NOMNC form must be faxed to HCS Long Term Care Coordinator to (907) 561-1684.

Alaska Medicaid is not obligated to become the sole payer for days Medicare ordinarily reimburses (days 1 through 100) when Medicare refuses to reimburse a skilled nursing facility for services provided during that time. Alaska Medicaid will only make payment to the facility for the level of care authorized by the Division of Senior and Disability Services (DSDS).

Forms are available at <https://www.cms.gov/Medicare/Medicare-General-Information/BN/MAEDNotices.html>

## Change in Level of Care Claim Submission

When a transfer to a different level of care occurs mid-month, bill for each level of care on a separate claim form. The first claim should represent the discharge from the first level of care and the second should represent the admission to the new level of care. Do not bill the claim as a facility discharge.

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# Tribal Targeted Case Management Services

## What is Tribal Targeted Case Management (TTCM)?

Case management services assist eligible individuals in gaining access to needed medical, social, educational, and other services in a culturally appropriate manner. TTCM services are those case management services targeted to eligible clients who are elders needing care, individuals with diabetes, children and adults with health and social service care needs, and pregnant women. TTCM services may be delivered in person, by telephone or electronically. TTCM services are provided by tribal health organizations in Alaska operating under a 638 contract or compact.

Case management is a collaborative, interdisciplinary approach to help medically complex and long term patients receive appropriate medical services in a cost-effective manner. Program activities include:

- Working with the recipient/family, physician, and other medical providers to develop a coordinated care plan.
- Assessing the recipient's personal situation and challenges.
- Providing information, resources, and referrals to support treatment.
- Coordinating services provided by healthcare professionals involved in the recipient's medical treatment.
- Coordinating the services of agencies.
- Pre-admission monitoring.
- Discharge planning.

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## Case Manager Requirements

Each tribal health organization offering TTCM services will develop their requirements for case managers they employ to deliver TTCM services. These requirements may include minimum education and/or experience requirements, an educational curriculum or training course, or other requirements that the organization determines to be adequate to ensure that quality services are rendered.

A tribal case manager must have:

- Demonstrated knowledge and understanding about American Indian and Alaska Native culture, language, spirituality and traditional values and practices.
- Education or experience required by the tribal health organization or completed a case management training curriculum.
- Interviewing skills for gathering data and completing needs assessments to develop case plans and related reports.
- Individual and group communication skills.

- The ability to learn and work with state, federal and tribal rules, laws and guidelines relating to American Indian and Alaska Native child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those services.

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## Enrolling a TTCM Services Provider

To enroll as a provider of TTCM services, a tribal health organization must have at least three years of experience in:

- Working with American Indian and Alaska Native (AI/AN) children, families and elders in providing case management services (assessment, case planning, case plan implementation, case plan coordination, and case plan reassessment).
- Experience in coordinating and linking community medical, social, educational, and other resources as required by the target population.

In addition, the tribal organization must have:

- The administrative capacity to ensure quality of services.
- A sufficient number of case managers meeting the organization's training and experience requirements to ensure access to Tribal Target Case Management services.
- An internal process to identify recipients in need of case management services.

A tribal organization wishing to enroll with Alaska Medical Assistance as a provider of TTCM services should contact the Alaska Department of Health and Social Services Tribal Programs at 907.269.7800 for approval of enrollment. When enrolling, the tribal organization must provide:

- A written program outline describing the target population and the services to be provided.
- An approval letter from the Alaska Department of Health and Social Services Tribal Programs.

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## TTCM Services

Tribal Targeted Case Management services include:

### Assessment

After the need for Tribal Targeted Case Management services has been determined, the tribal case manager shall collect data from a family interview and existing available records to assess the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary decisions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

### Case Planning

The tribal case manager develops a case plan, in conjunction with the client, the family (where applicable), and other team members from the extended family and community to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes determining activities to be completed by the tribal case manager, the family, client and

other team members in support of the client and family. These activities include accessing medical, behavioral health, developmental, social, educational, vocational, transportation and other services to meet the clients' needs.

### **Case Plan Implementation**

The tribal case manager will link the client and family with appropriate agencies and medical, behavioral health, developmental, social, educational, vocational, transportation and other services through calling or visiting these resources. The tribal case manager will facilitate implementation of agreed-upon services through assisting the client, family, and other team members to access them and through ensuring the client and providers fully understand how these services support the agreed-upon case plan.

### **Case Plan Coordination**

After linkages with medical, behavioral health, developmental, social, educational, vocational, transportation and other services have been completed, the tribal case manager will ascertain, on an ongoing basis, whether or not the services have been accessed as agreed, and the level of involvement of the client and family. Coordination activities include establishing and maintaining, with clients and agencies, a referral process that avoids duplication of services to the recipient, planning that identifies needs, goals, objectives, and resources in a coordinated and integrated fashion with the client, family and other involved agencies, and supporting the family to reach the goals of the case plan. Case plan coordination may take place in person, by mail (including email) and through telephone contacts with providers and others identified in the case plan, as well as meetings with the client, family and other team members to ensure that services are being provided and used as agreed.

### **Case Plan Reassessment**

In conjunction with the client, family and other team members, the tribal case manager will determine whether or not the services identified in the case plan continue to meet the client's needs. Reassessment decisions include:

- A determination of whether or not the goals and objectives need to be modified due to changes in the client's circumstances.
- If identified services need to continue, change or terminate.
- If the case plan itself requires revision.

Reassessment activities may take place in person, by mail (including email) and through telephone contacts with providers and other involved parties. Reassessment will occur at least annually, but may be accomplished whenever changes in the client's circumstances necessitate a new assessment to in order to develop a new or revised case plan.

TTCM services may not duplicate case management services that are already reimbursed under another Alaska Medical Assistance provider type, such as mental health or substance abuse rehabilitation, home and community-based waiver services, or children's case management under a Continuing Care Provider Agreement.

Updated 06\04\2013



# Billing for TTCM Services

Bill TTCM services on a CMS-1500 claim form, or, if electronic, in an 837P format. Complete the following fields on the CMS-1500 claim form. This same information is required on the electronic 837P as well as all other fields required for HIPAA compliance.

- Patient's Name
- Patient/Recipient ID Number (10 digit Medicaid ID number)
- From Date of Service
- Thru Date of Service (cannot span more than one month)
- Diagnosis (system will not edit on this; for data tracking purposes)
- Place of Service code
- Procedure Code - Use T2023
- Charges
- Units of Service (1 per month)
- Total Charge
- Amount Due
- Signature of Healthcare Provider
- Date of Signature
- Medicaid Provider ID number
- Provider Name/address/ZIP code/telephone number

Updated 06/04/2013

## How TTCM Services are Paid

TTCM services will be reimbursed at a flat monthly rate for each client with an active case plan regardless of the number of contacts made with the client or on behalf of the client. For payment rates, refer to the rate sheet provided by the [Office of Rate Review](#).

As of October 1, 2011, the monthly payment rate is a flat state-wide rate based on the average cost of TTCM services demonstrated by each of the participating tribal health organizations. Each tribal organization choosing to participate in the TTCM program must submit a copy of a Medicare Cost report as describe below. Alaska Medical Assistance has determined the FFY 2012 Medicaid payment rate by extrapolating prior year costs estimates to the year 2012.

If a new TTCM payment rate cannot be established by October 1<sup>st</sup> of each year due to delays, the prior year's rate will temporarily be paid until a permanent rate can be calculated. If the permanent calculated rate is lower than the prior year's rate, the permanent rate will become effective the day it is established otherwise it will become effective October 1<sup>st</sup> of the appropriate rate year.

A copy of each participating tribal organization's cost report and an audited financial statement for the reporting period must be submitted annually to the department to have the rate determined for the following year. A method E cost report must be submitted March 1<sup>st</sup> one and one half years after the fiscal year represented in the cost report ends (For example, the FFY 10 cost report for the year ending 9/30/10 is due 3/1/12). Organizations not filing a Method E cost report must submit by March 1<sup>st</sup> after the end of the fiscal year represented in the cost report (For example, the FFY 10 cost report for the year ending 9/30/10 is due 3/1/11). The cost report must include a working trial balance that matches audited

financials, a crosswalk of post audit trial balance accounts to the cost report, and statistics showing an unduplicated number of persons served each month during the previous year. Any tribal provider participating in the TTCM program who fails to provide a cost report during the prescribed time frames will be terminated as a TTCM provider the following fiscal year.

TTCM is not payable by any other insurance; Alaska Medical Assistance is the only payer for this service.

Updated 06/08/2018

# Service Authorization

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

Currently, these agencies review and approve SAs:

- Conduent
- Qualis Health
- Magellan Medicaid Administration (MMA)
- The Division of Senior and Disability Services (DSDS)
- Regional Tribal Health Organizations

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 06/08/2018

## Authorization from Conduent

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

### Services Authorized by Conduent

- Behavioral health services (to extend service limits)
  - Mental health physician clinic
  - Community behavioral health clinic
- Certain dental services
- 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/Procedures Review Guidelines](#)

## 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.

## 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.

Updated 06/08/2018

## 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://manuals.medicaidalaska.com/docs/forms.htm>. For additional information, refer to the [Behavioral Health Services Billing Manual](#) and [Mental Health Physician Clinic Billing Manual](#).

Updated 06/08/2018

## Authorization for Certain Maternal/Newborn Admissions

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

Mode of Delivery	Submit Claims as Payable without SA	Administrative SA from Conduent	Medical Necessity Review from Qualis
Vaginal	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 <b>OR</b> discharge is more than two days following date of delivery/birth
Cesarean	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 <b>OR</b> discharge is more than four days following date of delivery/birth

Updated 06/08/2018

## Authorization for Dental Services

These dental services require service authorization (SA):

- Enhanced Adult Dental Services
- Prosthodontics
- Orthodontia
- Certain dental services noted in the [Dental Fee Schedule](#)

Request SA using the Service Authorization Request Form ([AK-SA](#)). For additional information, including specific service authorization requirements, refer to [Section I: Dental Services, Policies and Procedures](#). Adequate medical justification and complete medical rationale must always accompany AK-SA requests for dental services.

### Medical Justification

Written medical justification must accompany SA requests for children's and emergent adult services. Failure to include proper documentation will result in denied SA requests. To determine which procedures require medical justification, refer to the [Dental Fee Schedule](#).

### Service Authorization for Prosthodontics

Submit an authorization request for full or partial dentures on the AK-SA and include complete and accurate justification of medical necessity. Alaska Medicaid allows providers to attach a separate letter with medical justification if needed.

Dentures are covered as an enhanced adult dental benefit, however, if the annual dental reimbursement limit is not adequate to cover reimbursement for denture work, the recipient may use two years' worth of

enhanced adult dental benefits\*, up to a maximum of \$2,300, in order to obtain upper and lower dentures or partials at the same time. If the entire two year limit is exhausted for prosthodontic services, the recipient is not eligible for additional enhanced adult dental benefits during the second year. The recipient still retains access to all emergent dental benefits.

**\* Enhanced adult dental services are subject to an annual reimbursement limit of \$1,150 per state fiscal year, which runs from July 1 to June 30.**

## Service Authorization for Orthodontia

Use the AK-SA to apply for SA. Along with the AK-SA, submit all of the following information to the [Service Authorization Unit](#):

- A description of the condition
- A description of the appliance(s)
- A scored [Handicapping Labiolingual Deviation \(HLD\) Index Report](#) completed and signed by the rendering orthodontist
- A written, comprehensive orthodontic treatment plan
- Panoramic films/intra and extra oral photos, if applicable
- Other pertinent medical or dental information to support the requested treatment, if applicable including
  - Required extractions
  - Orthognathic surgery
  - Study models (must be of diagnostic quality)

Alaska Medicaid cannot approve incomplete SA applications and will not approve SA for treatment rendered before the date on the AK-SA request.

Updated 06/08/2018

## 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://manuals.medicaidalaska.com/docs/forms.htm>.

## 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 [Audiology 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://manuals.medicaidalaska.com/docs/forms.htm>.

Updated 06/08/2018

## 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://manuals.medicaidalaska.com/docs/forms.htm) available at <http://manuals.medicaidalaska.com/docs/forms.htm>. 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 06/08/2018

## Authorization for Home Health Services

Alaska Medicaid covers service-authorized home health services for a maximum of 60 days. Providers must submit a Service Authorization Request Form ([AK-SA](#)) to Conduent within five days of starting home health services. The AK-SA is available at <http://manuals.medicaidalaska.com/docs/forms.htm>.

Any of the following enrolled providers may request SA:

- Home health agency
- Physician
- Advanced nurse practitioner
- Physician assistant
- Rural health clinic
- Hospital
- Skilled nursing facility
- Intermediate care facility

Along with the AK-SA, the requestor must include a written statement from the recipient's attending physician indicating

- Justification for home health care services
- The plan of care

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

Updated 06/08/2018



## Authorization for Non-Emergent Transportation and Accommodation

Tribal providers should submit transportation/accommodation requests to their respective regional tribal travel arrangers. Non-tribal providers and tribal providers outside of a regional Tribal Health Organization transportation service area must submit transportation/accommodation requests to Conduent. Refer to [Appendix K: Tribal Transportation Service Areas](#) to confirm service area.

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](#) available at <http://manuals.medicaidalaska.com/docs/forms.htm> or contact [Provider Inquiry](#).



**Note:** All changes to existing non-emergent travel authorizations must be through the organization that originally approved the travel.

For example, if an authorization was originally approved by YKHC, but the travel dates need to change, the provider must contact YKHC to request the changes.

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 their respective regional tribal health organization or [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 travel representative will guide you through completing other necessary information on the form and provide instructions for separating the form. When the travel representative indicates which services are authorized, complete one copy for each provider and one copy for each taxi ride.

Follow these steps to request a service authorization for transportation or accommodation services.

1. Call the respective regional tribal health organization (refer to [Appendix K](#)) or Conduent Service Authorization Unit at 907.644.6800, option 5, or toll-free in Alaska at 800.770.5650, option 1, 2.
2. Tell the travel representative what kind of transportation and/or accommodation services are needed.
3. Complete fields 8, 10, 19, and 24 of the AK-04 with the information that the travel representative gives you.
4. Complete the remaining fields up to field 16 on the AK-04. Refer to [Transportation Authorization & Invoice Form Guide](#) in this section.



Complete a separate AK-04 for each transportation/accommodation provider who will be billing for services. Complete a separate AK-04 for each taxi ride even if the trips are with the same taxi company.

5. Give the completed AK-04 forms to the recipient.

It is the responsibility of the recipient or the recipient's escort to call their Tribal Travel Arranger or Medicaid Travel Office (MTO) to arrange air or ferry travel. The requesting provider may also set up the recipient's travel through the Tribal Travel Arranger. However, whoever calls must have the service authorization number available.


Providers should contact their regional tribal organization for further guidance on the communities they serve.

**You may reach the MTO at 800.514.7123. MTO phones are staffed 7:00 a.m. – 7:00 p.m. daily, including weekends.**

Transportation Authorization & Invoice Form Guide Page 1


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**Non-Emergency Medical Transportation Authorization & Invoice Form Guide**  
*Provider Instructions for Completing the Travel Authorization and Invoice Form*



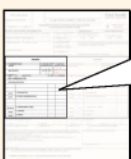
**Transportation Authorization & Invoice Form**

- Healthcare providers can request travel authorizations from the Conduent Service Authorization (SA) unit at 800.770.5650 or 907.644.6800.
- The member or designee must contact the Medicaid Travel Office (MTO) at 800.514.7123 to book airline or ferry travel.
- Use one Travel Authorization and Invoice Form (voucher) per hotel stay and per taxi ride. Taxis must bill for each trip, and may not use the Round Trip Field.
- Create the Lodging and Meals vouchers first. Then, create voucher pages as necessary for each taxi ride required.
- Each form has four pages. Three of the pages are imprint copies. The imprint copies are as valid as the original first page. Vouchers cannot be photocopied.




**Patient (Member) Information Section**

- Write legibly and press hard to imprint all four pages.
- Double check numbers.** Enter the member's ID and SA numbers, names, birthday, travel dates, and other patient information. All entries must be legible and correctly coded to pay invoices promptly.
- Any corrections must be legible and initialed by the provider.
- The member's name must match their Medicaid ID card.
- The healthcare provider requesting the authorization should sign and date the Member Information Section in field 9.



**Patient Section**

- Healthcare providers and health aides shall enter the member's Transportation Origin and Destination information into fields 11 (Transportation) through 19 (Units), as well as the member's dates of travel.
- Members shall book air and ferry travel through the Medicaid Travel Office (MTO). If overnight travel is authorized, the member must make lodging arrangements with an enrolled Medicaid hotel provider.
- The transportation provider that is billing for taxi or hotel services must complete field 20 (Charges) with their billing amount.
- Transportation and hotel charges will be reimbursed for services within the listed Destination City only.

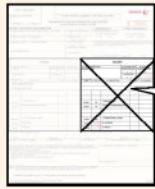


**Escort Section**

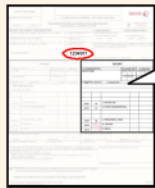
- Complete this section only if the member is using an escort authorized by Service Authorization.
- Include the Escort Name, Dates of Travel, and applicable Units of travel; fields 14 (Transportation) through 24 (Units).
- The transportation provider that is billing for taxi or hotel services must complete the field 25 (Charges) with their billing amount.

Content Effective: 03/10/2015  
Reissued by Conduent: 01/03/2017 Transportation Authorization & Invoice Form Guide

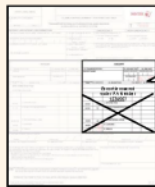
## Transportation Authorization & Invoice Form Guide (Page 1)

**No Escorts used**

- If there is no Escort, the healthcare provider or health aid shall mark a large 'X' through the entire Escort box.
- Press hard to imprint all four voucher pages.

**Escort with Several Children; First Voucher**

- Determine from Service Authorization which child's SA will include the Escort.
- Enter the Escort's name on the indicated child's voucher form.
- Enter the dates of travel and applicable Units of travel into fields 14 (Transportation) through 24 (Units).
- Reference this SA number (circled) in the additional vouchers, as described in the next step 'Escort with Several Children; Additional Vouchers.'
- The transportation provider that is billing for taxi or hotel services for *all* the children must complete field 25 (Charges) with their billing amount.

**Escort with Several Children; Additional Vouchers**

- Use a new voucher form for each additional child. Enter that child's patient information as usual.
- In the Escort box, write "Escort is covered under SA Number xxxxxxxx." Use the SA number assigned in the first voucher (circled in the previous image).
- Put a large 'X' through the remainder of the Escort box.
- The transportation provider that is billing for taxi or hotel services for these additional children must enter their charges in the first voucher only.

**Totals and Signature Section**

- Healthcare providers and health aides need not make entries in this section.
- The transportation or hotel provider enters the dates the services were actually rendered in fields 26 (Actual Patient Service Dates) and 27 (Actual Escort Service Dates), as well as fields 28 (Total Document Charges) to 31 (Ticket Number/Account Number), if they apply.
- The transportation or hotel provider must enter their name and NPI and sign and date the invoice after providing the service.
- The Transportation or Hotel Provider must submit the invoice for payment.

**Questions?** If you have further questions, please contact the Conduent office at 907.644.6800 or 800.770.5650 (toll-free in Alaska).

**Transportation Authorization & Invoice Form Guide (Page 2)**

### Examples of Common Travel Situations

Healthcare providers often encounter situations in which the healthcare needs of an Alaska Medical Assistance patient cannot be met in the patient's home community. These patients must often travel to other communities or states to obtain appropriate health care. The following examples are standard situations in which healthcare providers might authorize travel for these patients, and might authorize escorts for traveling patients.



#### One Parent as Escort for One Child:

In the Patient section of the form, enter the child's Origin and Destination cities and the timeframe in which this trip will occur. Enter the parent's name and their Service Authorization Number in the Escort box.



#### One Parent as Escort for Several Children:

Enter each of the children's names in their own Transportation Authorization form. Enter their Origin and Destination cities and the timeframe in which this trip will occur in the Patient sections of each form.

Enter the parent's name and their Service Authorization Number in the Escort box for the first child. In the subsequent children's forms, strike through the Escort box, and write "Escort is covered under SA# \_\_\_\_". Fill in the blank with the appropriate Service Authorization Number.



#### Pregnant Mother as Escort for One or More Children:

This arrangement would be the same as when one parent escorts one or several children; the mother acts as the escort. Neither pregnancy nor breastfeeding qualifies a mother for an additional escort. If the mother cannot adequately supervise the children, the children must have a different escort.



#### OCS or Foster Caregiver as Escort for One or More Children:

Enter each of the children's names in their own Transportation Authorization form. Enter their Origin and Destination cities and the timeframe in which this trip will occur in the Patient sections of each form.

Enter the OCS or foster caregiver's name and their Service Authorization Number in the Escort box for the first child; in the subsequent children's forms, strike through the Escort box, and write "Escort is covered under SA# \_\_\_\_". Fill in the blank with the appropriate Service Authorization Number.



#### Escort or Travel for Patients in RPTCs

One parent, caseworker or foster caregiver can travel to a Residential Psychiatric Treatment Center (RPTC) for a patient's treatment or discharge. Siblings are not covered for this travel.

A clinician or discharge planner must provide a discharge plan that:

1. Clearly documents what the discharge placement will be, and
2. Contains clinical information regarding what services will be performed while the parent, caregiver, or caseworker is at the facility.

Travel frequency will be based on the discharge/treatment plan, but should generally be no more than four times a year.



#### Foreign Language Translator or Interpreter for the Deaf as Escort

Alaska Medical Assistance will not authorize travel requests for escorts for the purpose of translating foreign languages or interpreting for the deaf. Illiteracy alone does not qualify a recipient for an escort.

## Transportation Authorization & Invoice Form Guide (Page 3)

Updated 06/08/2018

## 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/Procedures Review Guidelines](http://www.qualishealth.org) 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 Conduent 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 06/08/2018

# Authorization from the Division of Senior and Disability Services

The Division of Senior and Disability Services (DSDS) provides service authorizations for the following services:

- Administrative wait and swing bed stays at acute facilities and all long-term care (LTC) facility admissions and continued stays
- Home and Community-Based Waiver Services
- Personal Care Attendant (PCA) services

Updated 06/08/2018

# Authorization from Magellan Medicaid Administration (MMA)

## Authorization for Prescribed Medications

Certain medications require service authorization (SA) before Alaska Medical Assistance covers these medications. The [Prior Authorized Drug List](#) and [Interim Prior Authorized Drug List](#) are available at <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.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 obtain medication SA forms on the Conduent Pharmacy Updates and Forms page at <http://manuals.medicaidalaska.com/docs/pharmacy.htm>, the DHCS Medication Prior Authorization page at <http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx>, or from the Magellan Medicaid Administration Clinical Call Center.

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

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

Updated 06/08/2018

## 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/Procedures Review Guidelines](#)
- 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 [Select Diagnoses/Procedures Review Guidelines](#)

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 06/08/2018

## Authorization for Select Diagnoses and Procedures

Diagnoses and procedures which appear on the [Select Diagnoses/Procedures Review Guidelines](#) always require service authorization regardless of the length of stay. To review the Select Diagnoses/Procedures Review Guidelines, visit <http://www.qualishealth.org/healthcare-professionals/alaska-medicaid-division-health-care-services/provider-resources>.

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

Updated 06/08/2018

## Authorization for Acute Care Inpatient Continued Stays

All acute care inpatient continued stays exceeding three days require pre-certification from Qualis Health. To request a continued stay, be sure to include the following information:

- Recipient demographics
- Physician name and contact information
- Facility name and contact information
- Related diagnoses, procedures performed, and treatment
- Medical justification for continued hospitalization
- Admit/surgery date

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

## Maternal/Newborn Admissions

Certain maternal/newborn admissions may be authorized by Conduent, while Qualis performs medical necessity reviews for maternal/newborn admissions. For additional information, refer to [Authorization for Certain Maternal/Newborn Admissions](#) in this section.

Updated 01/03/2017

## Authorization for Inpatient Psychiatric Stays

Service authorization (SA) is required for all inpatient psychiatric hospital and residential psychiatric treatment center services; submit an authorization request to Qualis Health. To review service authorization requirements, refer to the [Behavioral Health Inpatient Psychiatric Review Provider Manual](#) available at <http://www.qualishealth.org/>. Qualis reviews authorization requests for urgent, non-urgent, and retrospective care.

The requesting facility should use the Alaska State Medicaid Program Acute Care Medical Necessity Criteria to meet all SA requirements; a criteria reference sheet is available in the *Behavioral Health Inpatient Psychiatric Review Provider Manual*.

Updated 06/08/2018

## Authorization for Outpatient Imaging Services

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

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

The [Qualis Select Diagnoses/Procedures Review Guidelines](#) 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 an 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 06/08/2018



# Billing Third-Party Liability

Providers may choose to bill a third-party resource if the service provided is covered by that resource and the payment will exceed the expected Alaska Medicaid reimbursement amount. If chosen, providers must submit the claim to Alaska Medicaid with the primary insurance's explanation of benefits attached.

Updated 06/08/2018

## 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 that 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 06/08/2018

## Non-covered Medicare HCPCS Codes

Codes published in the HCPCS coding manual that Medicare has indicated as non-covered are included in the Alaska Medicaid third-party liability (TPL) avoidance file. Alaska Medicaid verifies the file annually. The claims processing system will not audit for related recipient third-party information (e.g., Medicare in this example) if the reported service is one of the codes listed on the TPL avoidance file because it is recognized as a non-covered code. Providers are not required to bill Medicare in this instance if all of the HCPCS codes on the claim are Medicare non-covered codes. Please note that even though billing Medicare is not required, Alaska Medical Assistance does not guarantee payment for the item or service provided.

Updated 06/08/2018

## 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 Alaska Medical Assistance 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 co-pay 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 you have followed 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 co-pay 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 if billed correctly.

## 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.

All other Alaska Medical Assistance billing requirements still apply to claims submitted with a Medicaid denial letter, including timely filing of claims and 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 health care providers identified by the Veteran, or Alaska Medicaid.

It is the veteran's responsibility to:

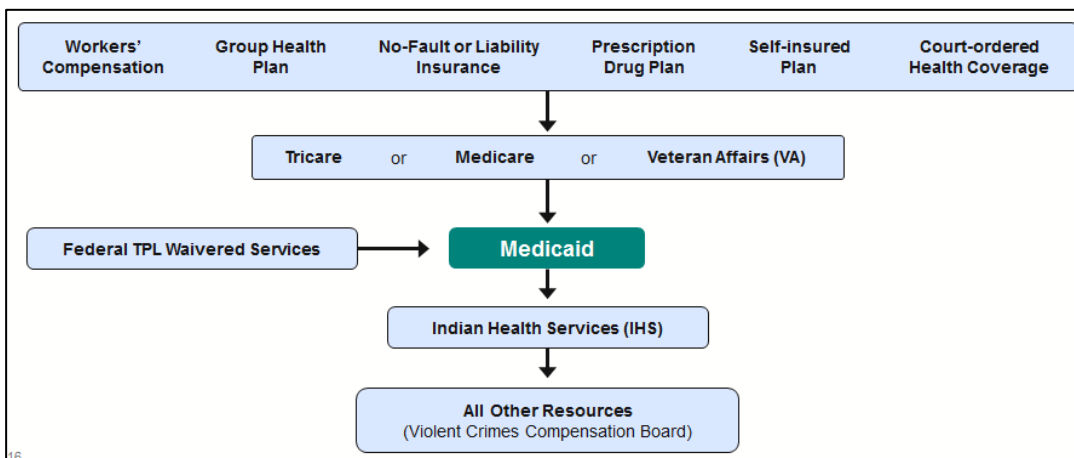


1. Keep annual reviews current with the VA.
2. Provide the healthcare provider with the information about his or her VA coverage at the time of the appointment.
3. Follow all rules for using VA coverage before using Medicare or Alaska Medical Assistance. However, if the VA does not provide coverage for the medical service, the Alaska Medical Assistance member (veteran) is responsible for providing the denial, and must:
  - Get 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 healthcare provider so the provider has an adequate and valid attachment for the provider's claim submission to Alaska Medical Assistance or crossover billing from Medicare.

## TPL Hierarchy

Alaska Medicaid is the payer of last resort, with the exception of IHS and any federal TPL waived services. All claims should be filed using the TPL hierarchy: independent public and private resources, federally funded resources, Alaska Medicaid, Indian Health Services (IHS), and any other resources.

Federal TPL waived services are the only services that have the option to bill TPL before Alaska Medicaid.



Updated 06/08/2018

# Quick Reference

## How to Get Help

If you have any questions or problems, you should contact the Tribal Organization Coordinator. This coordinator is a central point-of-contact for claims issues who will work with you to resolve problems and answer any questions you might have.

**Phone:** 907.644.6805 or 800.770.5650 (toll-free in Alaska)

**Fax:** 907.644.8130

**Address:** P.O. Box 240649, Anchorage, AK 99524-0649



Other phone numbers or addresses that you might need are included in the Directory Assistance section.

When you call the coordinator, please make sure that you have all materials related to the call readily available (for example, the remittance advice, claim forms, recipient's Alaska Medical Assistance identification number, and the Provider Contract ID number you are calling about).

For additional resources, please visit the following websites:

- Tribal Health Services at <http://dhss.alaska.gov/Commissioner/Pages/TribalHealth/default.aspx>.
- Health Care Services at <http://dhss.alaska.gov/dhcs/Pages/default.aspx>.
- Alaska Medicaid Health Enterprise Documentation at <https://medicaidalaska.com/portals/wps/portal/DocumentsandForms>.

Updated 09/19/2019

## Services Not Covered by Alaska Medical Assistance

Alaska Medical Assistance does not cover any service that is not medically necessary.

Alaska Medical Assistance does not cover the services listed below. Some other services may not be covered depending on the type of provider. Refer to provider billing manuals for the specific provider type for this additional information on non-covered services.



**Note:** Refer to the provider billing manual for the specific type of provider (for example, physicians, physical therapists, or advanced nurse practitioners) for additional information about coverage limitations.

## General

Alaska Medical Assistance does not cover:

- Services not covered by the recipient's category of Medical Assistance
- Services not within the scope of the facility's licensure, certification, or accreditation
- Evaluative or periodic checkups, examinations, or immunizations that are in connection with the participation, enrollment, attendance, or accomplishment of a program or activity unrelated to treating the recipient's medical or mental health issues, or rehabilitation (exceptions: Mammograms, EPSDT screenings, and services required by the department for the purpose of determining eligibility)
- Services or inpatient stays for which authorization is required but not obtained or is denied, including but not limited to nonemergency out-of-state services for which authorization was not obtained
- Services and inpatient days of care due to failure to timely request or perform necessary diagnostic studies, procedures, or consultations, or any service that is not properly prescribed or that is determined not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system
- Special or extra charges for services or items normally considered part of routine services and optional or special services not directly related to medical care, including but not limited to private accommodation charges (unless medically necessary) deluxe accommodation charges, and patient convenience items
- Charges for professional fees in addition to those typically charged within specific cost centers, including osteopathic services, except certified registered anesthetist services
- Routine office medical supplies associated with office visits and procedures. These supplies include, but are not limited to, bandages, casts, catheters, dressings, elastic wraps, splints, syringes, tape, and gauze. Non-routine supplies can be billed separately.
- Chiropractic manipulations (unless provided by a physician to recipients under 21)
- Alternative therapies, procedures, items, drugs, supplies, or services including acupuncture, homeopathic and naturopathic remedies, or Ayurvedic medicine
- Experimental or investigational procedures, items, drugs, supplies, and services including those:
  - In Phase I and II clinical trials to determine safety, dosage range, or side effects
  - For which there is inadequate available data to provide a reasonable expectation that the treatment or procedure will be at least as effective as non-investigational therapy
  - For which expert opinion suggests additional information or study is needed
  - For which final approval for the appropriate governmental body has not been granted for the specific indications proposed
  - Not in accordance with customary standards of medical practice
- Educational services and supplies
- Handling and/or conveyance of a specimen for transfer to a laboratory
- Routine venipuncture performed with a surgical or laboratory procedure
- Medical services for a person who is in the care and custody of a federal, state, or local correctional facility, including juveniles in detention facilities
- Hair or wrinkle remover

## Ancillary Services

- Medical testimony
- Provider travel
- Telephone and radio calls for medical management or consultation. A consultation is defined as an opinion, advice, or other appropriate service of a physician or osteopath requested by another physician or osteopath for further evaluation or management of patient. If a consulting

physician/osteopath assumes responsibility for the continuing care of a patient, any subsequent service rendered is no longer considered a consultation. When covered services of a consultant or a specialist are necessary, service authorization is not required from Alaska Medical Assistance.

- Interpreter services

## CAMA Inpatient Hospital Services

In addition to the services listed herein, the Chronic and Acute Medical Assistance (CAMA) program does not cover:

- Inpatient hospital stays for CAMA recipients
- Physician services provided in an inpatient hospital or nursing facility

## Dental Services

- **Children:** the department will not pay for the following dental services for recipients under 21 years of age:
  - Final restorations in resin or amalgam for more than five surfaces
  - Indirect pulp capping
- **Adults:** the department will not pay for the following dental services provided to a recipient 21 years of age or older:
  - Panoramic radiograph more than once in a calendar year
  - Final restorations in amalgam or resin for more than five surfaces
  - Dental sealants
  - Restoration of etched enamel or deep grooves without dentin involvement
  - Inlays, overlays, or three-fourth crowns
  - Endodontic apical surgery or retrograde fillings
  - Periodontal surgery
  - Implant or implant-related dental services
  - Orthodontic services

## Drugs

- A brand-name drug if a therapeutically equivalent generic drug is on the market, unless the brand name drug is included on the Alaska Medical Assistance Preferred Drug List (PDL) or the prescriber writes on the prescription "brand-name medically necessary"
- Antabuse dispensing, methadone dispensing and treatment, and alcohol and drug detoxification and rehabilitation, unless specifically authorized by Alaska Medical Assistance
- Drugs for which the Centers for Medicare and Medicaid Services (CMS) drug rebate is not available
- Drugs that are prohibited from receiving federal Medicaid matching funds (see [42 CFR 441.25](http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr441_02.html) at [http://www.access.gpo.gov/nara/cfr/waisidx\\_02/42cfr441\\_02.html](http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr441_02.html))
- Drugs for which more than a 30-day supply is ordered per prescription, except for birth control drugs and drugs listed on the Alaska Medical Assistance 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
- Immunizations for adult recipients (21 years of age or older)
- Non-prescription drug, vitamin, or dietary or herbal supplements unless otherwise indicated in [7 AAC 120.110\(a\)\(4\)](#)
- Take-home drugs, oxygen, and supplies not otherwise classified, home IV therapy and miscellaneous home dialysis and charges

## Evaluation and Management Services

- Prolonged physician services; procedure codes for prolonged physician services are considered part of the primary service performed at the same time and are therefore not covered. However, Physician Standby Service, Requiring Prolonged Physician Attendance, Each 30 Minutes (e.g., operative standby, standby cesarean/high risk delivery for newborn care) (Code 99360) and Attendance at Delivery (Code 99436) are covered. The physician may not provide services to other patients during this time, and you must submit medical justification with the claim when billing these 2 procedure codes.
- Case management services
- Disability exams (unless requested by Alaska Medical Assistance to determine eligibility)

## Hospital Services

- Personal services not normally associated with hospital care. For example, long distance telephone calls, television rental, guest meals, and personal items are not covered.
- Inpatient services for conditions that do not require hospital care, including but not limited to observation, rest cures, respite care, day care, outpatient special residence charges, inpatient procedures or testing that can be performed on an outpatient basis, recipients who no longer require acute inpatient care, custodial care related to court commitments, and leave of absence, including room and bed hold charges



Hospital stays for patients confined to a hospital under a court commitment for any reason will be covered only for the amount of time that there is a medical reason for the patient to be receiving hospital care.

- Room and board for parents during a child's hospitalization, for a child during a parent's hospitalization, or for any individuals other than the patient, such as a recipient's friend or relative
- Overnight or weekend absences
- Days of care needed because necessary diagnostic studies, medical/surgical procedures, or consultations were not promptly requested or performed
- Charges incurred during an inpatient stay or on a daily basis for certain services, such as admission charges, technical support charges, and late discharges that are medically necessary (for example, revenue codes 220-229). These items are considered part of routine services and are not covered by Alaska Medical Assistance.
- Nursing services, including but not limited to incremental and private duty nursing charges, in addition to room and board (for example, revenue codes 230-239). Payment for room and board includes standard nursing service.
- Flat-rate charges incurred on either a daily basis or total stay basis for ancillary (secondary/subordinate) services only (for example, revenue codes 240-249). You should bill for more specific charges.
- Physician assistants or nurses assisting in an operating room. However, physicians or advanced nurse practitioners (ANPs) acting as surgical assistants are covered for selected procedures. Services of a second surgical assistant will be covered if it is medically necessary.



Physicians or ANPs acting as surgical assistants must submit a separate claim for their services, using a CPT modifier (-80, -81, or -82). If the claim is for a second surgical assistant, you must attach an explanation from the surgeon explaining the need for a second assistant.

- Service charges for accommodations that cannot be included in more specific revenue center codes

## Preventive Services

- Preventive services for adult recipients (21 years of age and older). However, some preventive services are covered, such as mammograms, pap smears, and prostate-specific antigen testing. These services are covered when medically necessary and when screening for a malignant neoplasm, but not when the service is part of a routine physical examination.



Pap smears, if given as part of an EPSDT screening for recipients under age 21, are covered as part of a physical examination.

- Physical examinations for adult recipients (21 years of age and older) except if an examination is requested by Alaska Medical Assistance to determine eligibility based on disability, blindness, or pregnancy
- Separately identifiable preventive care services, clinic services, medical social services, and trauma team response activation charges

## Radiology Services

- Radiologic contrast material except if the low osmolar contrast material is used in intrathecal, intravenous, and intra-arterial injections for a recipient with one of the following conditions:
  - History of previous adverse reaction to contrast material other than sensation of heat, flushing, or a single episode of nausea or vomiting
  - History of asthma or allergy
  - Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, or pulmonary hypertension
  - General severe debilitation
  - Sickle cell disease

## Reproductive System Services

- Pitocin to initiate or augment labor is considered part of a delivery and is not reimbursed separately
- Hysterectomies performed for sterilization purposes only are not covered; however, Alaska Medical Assistance will pay for the hysterectomy if it is performed for medical reasons and if you get service authorization from Qualis Health
- Sterilization for recipients who are under 21 years of age, or who are determined by a court to be incompetent, or who are institutionalized in psychiatric facilities. Sterilization for family planning purposes for all other recipients is covered.
- Infertility services
- Transsexual treatment, therapy, surgery, or other procedures for gender change or reassignment
- Impotence treatment, therapy or services
- Therapeutic abortions; tribal facilities may not be reimbursed for any services related to a therapeutic abortion, including emergency room visits, office visits, etc.

## Surgical Procedures

- Elective surgery
- Cosmetic therapy or plastic or cosmetic surgery; however, coverage is available if required for the following corrective actions if performed within the normal course of treatment or otherwise beginning no later than one year after the event which caused the need for that corrective action:
  - repair of an injury
  - improvement of the functioning of a malformed body member



- correction of a visible disfigurement that would materially affect the recipient's acceptance in society
- Physician assistants or nurses assisting in operating room. However, physicians or advanced nurse practitioners (ANPs) acting as surgical assistants are covered for selected procedures. Services of a second surgical assistant will be covered if it is medically necessary.



**Note:** Physicians or ANPs acting as surgical assistants must submit a separate claim for their services, using a CPT modifier (-80, -81, or -82). If the claim is for a second surgical assistant, you must attach an explanation from the surgeon explaining the need for a second assistant.

- Surgical Trays
- Organ transplants and related services, and dental implants. **Exception:** The department may make payment for organ transplants and requisite related medical care for:
  - Kidney and corneal transplants; service authorization is not required;
  - Skin and bone transplants for which the department has given service authorization; however, dental implants are not covered;
  - Bone marrow transplants for which the department has given service authorization;
  - Liver transplants for which the department has given service authorization, for persons with biliary atresia or other forms of end-stage liver disease;
  - Heart, lung, and heart-lung transplants for which the department has given service authorization

## Therapies

- Swimming therapy
- Maintenance therapy for adults
- Alternative therapies
- Cardiac rehabilitation that exceeds Medicare guidelines, recreational therapy, and medical rehabilitation day programs

## Tribal Clinic Services

In addition to the other services listed herein, the following services cannot be billed by a tribal clinic:

- CHA/P services
- Dental services (except for the following services):
  - Dental fluoride varnish applications
  - Oral evaluations performed by physicians, nurse practitioners and physician assistants who have successfully completed Oral Health or Caries Risk Assessment training
- Mental health clinic services
- Substance abuse clinic services



**Note:** Behavioral health services covered under the scope of practice of a physician, nurse practitioner, or physician assistant, such as individual, group or family therapy are covered tribal clinic services. Refer to the *Alaska Medical Assistance Physician Fee Schedule* for allowed services.

- Registered Nurse services
- Pharmacy services



## Weight Loss/Appearance Services

- Weight loss programs and products
- Services related to treatment of obesity or weight reduction. However, if there is sufficient medical justification, a gastric bypass may be covered if you receive a service authorization.
- Programs to improve overall fitness (for example, membership fees to a gym are not covered)
- Plastic or cosmetic services for enhancement purposes (see *Surgery, Cosmetic therapy or plastic or cosmetic surgery* above for exceptions)

## References

For information regarding services for which Alaska Medical Assistance does not cover for any provider type, refer to:

The Alaska Administrative Code:	7 AAC 105-160, including AAC 105.100
Services that are not reimbursable to hospitals:	7 AAC 105-160, including 7 AAC 140.315
Chronic and Acute Medical Assistance (CAMA) program service limitations:	7 AAC 48.005 - 7 AAC 48.900

Updated 08/18/2016

# How to Get a Service Authorization

Request a service authorization in the following ways, depending on the type of authorization needed. Refer to the [Service Authorization](#) section for specific information on requesting these types of service authorizations.

Type	Contact
Community Behavioral Health Clinic (CBHC) / Mental Health Physician Clinic (MHPC)	Submit your request for service authorization to Conduent in writing using the CBHC/MHPC Service Authorization Request. Requests may be faxed to 866.653.1435.
Dental Services	Submit your request for service authorization to Conduent in writing using the Service Authorization Request form (AK-SA). Requests may be faxed to 907.644.9861.
Outpatient Magnetic Resonance Imaging (MRI)	Contact Qualis Health Provider Portal
Inpatient hospital stays	Contact Qualis Health Provider Portal
Inpatient mental health services	Contact Qualis Health Provider Portal
Oxycodone/Oxycotin® products, Fentanyl patches, and Butorphanol nasal spray	Have the prescribing healthcare provider call Magellan's Medicaid Administration Clinical Call Center (800.884.3238) or fax (888.603.7696).
Transportation and accommodation services	Refer to <a href="#">Authorization for Non-Emergent Transportation and Accommodation</a>
All other services	Submit your request for service authorization to Conduent in writing using the Service Authorization Request form (AK-SA)

Updated 06/08/2018

# Determining the Correct Claim Form to Use



Required fields are minimum required when billing on paper; additional fields may be required to comply with HIPAA EDI requirements.

The claim form that you use depends on which type of provider you are billing.

Provider Type	Transaction Type	Paper Claim Form
Tribal Clinic	837P	CMS-1500 (02/12 Version)
Inpatient Hospital	837I	UB-04
Outpatient Hospital	837I	UB-04
Physician services at an inpatient hospital (or at an outpatient hospital if your facility chose the ASC option; refer to the <a href="#">Tribal Outpatient Hospitals</a> section for additional information)	837P	CMS-1500 (02/12 Version)
Physician billing for CHA/P services	837P	CMS-1500 (02/12 Version)
Dentist billing for DHA services	837D	Dental claim form (J430 Version)
Ambulatory Surgical Center	837I	UB-04
Pharmacy	NCPDP	NCPDP Universal Claim Form (UCF)

You can submit claims electronically or via mail. Refer to [How to Submit a Claim](#) in this section for more information.

Refer to the [Billing Guidelines](#) section for instructions on completing the CMS-1500, UB-04, or Dental claim form.

Updated 10/15/2015

## What to Attach to a Claim

Follow the guidelines below when determining what attachments are needed. You should also review specific attachment requirements for your provider type and for the code you are billing. Samples of these forms are included in the [Forms](#) section.

If you are billing....	You must attach....
A sterilization	<i>Sterilization Consent Form</i>
A hysterectomy	<i>Hysterectomy Consent Form</i> Refer to <a href="#">Completing the Hysterectomy Consent Form</a> in the <a href="#">Forms</a> section for instructions.
An abortion	<i>Certificate to Request Federal (Medicaid) Funds for Abortion</i>

If you are billing....	You must attach....
An unlisted procedure code	Written explanation (or <i>Service Authorization Request</i> form, if you requested an "unlisted code review")
A claim when the patient has other health insurance	Explanation of benefits (EOB) for the other insurance
A claim with modifier 62 (2 surgeons), modifier 66 (surgical team), modifier 22 (unusual services), multiple modifiers, or for a primary care recipient if he/she was seen by a healthcare provider other than their primary care provider	<i>Certificate of Medical Necessity</i> or statement of medical justification
A claim for an assistant surgeon, for a second assistant surgeon, or for multiple modifiers	Operative Report
For a private room	<i>Certificate of Medical Necessity/Private Room Approval</i>
A claim that needs proof of timely filing	Attach one of the following: <ul style="list-style-type: none"> <li>• Copy of the remittance advice (RA) page showing claim denial</li> <li>• Copy of the <i>In-process Claims</i> page of an RA</li> <li>• Electronic claim submission transmission report</li> <li>• Correspondence from Conduent, the Division of Healthcare Services, or the Department of Public Assistance</li> <li>• Court orders or Administrative Hearing documentation</li> </ul>

Updated 01/03/2017



# Administrative Information

## Regulations and Restrictions

### Discriminatory Practices

Federal laws 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 Alaska Medical Assistance services who has a third-party resource. Payments can be made only to providers who comply with federal laws. These federal requirements are stated in Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the 1975 Age Discrimination Act.

Billing for Alaska 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 that the provider is not qualified to participate in Alaska's Medical Assistance programs. [7 AAC 150.410]

Updated 06/04/2013

### Payment Error Rate Measurement (PERM)

Once every three years, the Alaska Department of Health and Social Services takes its turn participating, along with other states, in the Payment Error Rate Measurement (PERM) project instituted by Centers for Medicare and Medicaid Services (CMS). This program audits providers' records to determine the percentage of improper payments made in the Medicaid and Denali KidCare programs. This is a federally-mandated program in which all 50 states must participate on a rotating basis, once every three years.

Providers' participation in this review is crucial to protect Alaska's access to Medicaid funding. The State of Alaska Medical Assistance Program pays over \$1 billion every year to providers. A high error rate calculated through PERM may lead to significant financial consequences to the Alaska Medical Assistance Program.

In January 1, 2011, CMS began its review of Alaska Medical Assistance claims. If your patient records are selected for review, please bear in mind the following:

- Documents requested will be for claims paid by Alaska Medical Assistance from October 1, 2010 through September 30, 2011.
- Requests for medical records will come from A+ Government Solutions, the contractor hired by CMS to conduct the review.
- Sharing patient records with A+ Government Solutions for review is not a breach of patient privacy. In fact, you are required by federal law to provide these records.
- Documentation must be submitted within 75 days of request. The state, however, encourages you to turn in documents within 30 days to allow time to make any corrections before the deadline.
- Past PERM studies (including the one in Alaska) found that the largest sources of payment errors were no response or insufficient documentation. Even legitimate claims count as errors if CMS does not receive the requested medical documentation on time.

Healthcare providers share the risk of potentially driving up the error rate by not responding appropriately and promptly when documents are requested. Alaska Medical Assistance providers have a pivotal role in reducing the PERM by:

- Verifying eligibility of recipients
- Appropriately documenting – if the service is not documented, it will be assumed that it did not occur and will be considered an error
- Maintaining records which support the services for which payment is requested
- Accurate and timely billing
- Effective internal review process for data processing errors
- Promptly responding to request for records

**Note:** Failure to provide complete and accurate documentation within the specified time period will result in an error. Payments for any claims found to be in error will be recovered by the Alaska Medical Assistance Program.

For complete information about PERM, please visit the Centers for Medicare and Medicaid Services' Web site at: <https://www.cms.gov/PERM>.

Updated 06/04/2013

## Medicaid Provider Fraud Control Unit

The Medicaid Provider Fraud Control Unit (MFCU) was established in 1992 by the Alaska Legislature and operates within the State Attorney General's Office. The unit is located in Anchorage and has statewide jurisdiction.

Medicaid Provider Fraud Control Unit  
State of Alaska, Department of Law  
310 K Street, Suite 300  
Anchorage, AK 99501

The MFCU, under federal law 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 Alaska Medical Assistance recipients. Accordingly, the MFCU is an authorized representative of the Department of Health and Social Services (DHSS) for the purpose of investigating and prosecuting Medicaid fraud and the abuse, neglect or financial exploitation of patients in any facility that accepts Medicaid funds.

Pursuant to the Provider Agreement upon enrollment, and on file with the Alaska Department of Health and Social Services, Alaska Medical Assistance providers must comply with the MFCU's requests for records or information about claims submitted to Alaska Medical Assistance and services provided to Alaska Medical Assistance recipients.

The vast majority of healthcare providers are honest and dedicated to providing the highest quality healthcare to their patients. However, nationally, it is estimated that fraud, waste and abuse account for 10 to 20 percent of the payments made by Medicaid. If the national trend holds true for the state of Alaska, these percentages equate to 30 million to 70 million Medicaid dollars annually, resulting in a substantial reduction in monies available to provide necessary medical services to needy Alaskans.

Alaska Medical Assistance recipients may not suspect fraud, as they are seldom made aware of the procedures or dollar amounts billed to Alaska Medical Assistance. An unscrupulous provider can generate a fraudulent payment by:

- Billing for services not rendered
- Billing for higher level of services than actually performed

- Billing for more services than actually performed
- Charging higher rates for services to Alaska Medical Assistance than others
- Coding billings to get more reimbursement
- Providing and billing for unnecessary services
- Misrepresenting an allowable service in an Alaska Medical Assistance billing
- Falsely diagnosing so Alaska Medical Assistance will pay for more services

If you suspect Medicaid healthcare fraud or patient abuse, do your part to protect the integrity of Alaska's Medical Assistance program and the public resources that fund it:

- Contact the Medicaid Fraud Control Hotline at 907.269.6279 and ask to speak to an investigator or simply leave a message.
- Fax your information to 907.269.6202
- Call the Crimestopper's Hotline at 907.561.7867. You need not give your name and you may be eligible for a reward.
- E-mail your information to [medfraud@law.state.ak.us](mailto:medfraud@law.state.ak.us)

Updated 06/04/2013

## Surveillance and Utilization Review Subsystem (SURS)

As fiscal agent for the Alaska Department of Health and Social Services, Conduent monitors and reviews services and claims to detect and prevent fraud, waste, abuse, or misuse of the Alaska Medical Assistance Program by recipients and/or providers and administers the Surveillance and Utilization Review Subsystem (SURS).

Updated 01/03/2017

### Definition

SURS is a federally required component for the Alaska Medical Assistance Program. The goal of SURS 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 Alaska Medical Assistance 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 Alaska Medical Assistance Program by either persons and/or institutions providing services or persons receiving them.

Updated 06/04/2013

## Administration

As fiscal agent for the Alaska Department of Health and Social Services, Conduent monitors and reviews services and claims for:

- Fraud
- Waste
- Abuse
- Misuse of Alaska Medical Assistance funds by recipients and/or providers

Alaska providers should be aware that all claims submitted to Alaska Medical Assistance will be subject to computerized analysis and case review. SURS will identify and report suspected occurrences to the Division of Healthcare Services, including billing irregularities and overuse of services, along with recommendations for potential sanctioning.

Updated 01/03/2017

## Fraud and Abuse Defined

### The Nature of Fraud

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 either the recipient or the provider.

Updated 06/04/2013

### Examples of Fraud by Recipient

Recipient fraud is making false statements to eligibility workers or failing to reveal resources or income to obtain medical assistance.

The key factors in establishing recipient fraud are:

- The fraudulent misrepresentation must be 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.

Updated 06/04/2013

### Examples of Fraud by Provider

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 is not entitled to.

The key factors in establishing provider fraud are:

- The fraudulent misrepresentation must be 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.

Updated 06/04/2013

## **The Nature of Abuse**

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

Updated 06/04/2013

### **Examples of Abuse by Recipient**

Recipient abuse occurs when the recipient uses medical personnel and facilities to meet nonmedical needs, obtains duplicate services, or is uncooperative in accepting treatment plans.

Factors associated with recipient abuse include the following:

- Use of contacts with medical professionals and with persons in the waiting rooms of practitioners and outpatient facilities 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 physicians in general practice, which would more appropriately be provided by specialists or in mental health facilities
- Recipient being inconvenienced or dissatisfied with medical care provided and seeking duplicate care in more congenial and convenient quarters
- Negligence in caring for durable items (glasses, hearing aids, etc.) as well as desiring to keep up with fads of style
- Manipulation of the program to acquire drugs or supplies for ineligible persons or to be sold for personal gain
- Acquisition of drugs to support narcotics abuse
- Gullibility in responding to promotional efforts or suggestions of practitioners that they receive care or supplies for which they previously had no desire and are unlikely to use

Updated 06/04/2013

### **Examples of Abuse by Provider**

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.

Factors associated with provider abuse include the following:

- 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 likely to use improperly (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 (services that are not medically necessary)

- Lack of sufficient medical resources (such as not having appropriate, less expensive alternative for medical care)

Updated 06/04/2013

## Reporting Fraud and Abuse

Recipients and providers should report any suspected fraud and/or abuse to SURS at Conduent's toll-free Fraud Hotline, 800.256.0930. Reports made in writing should be submitted to:

Conduent  
Surveillance and Utilization Review  
P.O. Box 240808  
Anchorage, AK 99524-0808

The aforementioned method of reporting suspected fraud or abuse to Conduent in no way restricts or relieves a citizen of the right and responsibility to report suspected criminal activity to the proper law enforcement authorities.

If you are aware that a patient is receiving treatment for injuries caused negligently or intentionally by another person, business or organization, notify either Conduent or the Division of Healthcare Services. If known, give an example to Conduent or the Alaska Division of Health Care Services that proof of liability exists and then bill the responsible party. If liability is undetermined, notify Conduent or the Alaska Division of Health Care Services of potential liability and bill Alaska Medical Assistance; payment will not be delayed.

Persons knowingly assisting the recipient or the provider in committing fraud are generally considered as aiding in the commission of that act, and may be held responsible.

Updated 01/03/2017

## Measuring Program Integrity

### Activities That May Be Used to Measure Program Integrity

The Department of Health and Social Services (DHSS) or its designee may use the following activities for this purpose:

- Operation of a surveillance, utilization, and review subsystem within the department's system to manage Alaska Medical Assistance information
- Audit activities designed to investigate fraud, abuse, overuse, or Alaska Medical Assistance Program compliance by providers
- Utilization review under 7 AAC 160.140
- Coordination with the Department of Law, the United States Department of Justice, and the United States Office of the Inspector General

The Alaska Department of Health and Social Services or its designee are required to conduct fiscal audits of Alaska Medical Assistance providers, including a desk audit, field audit, or both, to determine the provider's compliance with the requirements of 42 U.S.C. The provider must allow the department or its designee, the federal government, or the Department of Law access to original financial, clinical, and other records documenting care provided to Alaska Medical Assistance recipients.

Updated 06/04/2013

## Statistical Sampling

The Alaska Department of Health and Social Services or its designee may use statistically valid sampling methodologies to select Alaska Medical Assistance claims for review or audit and to calculate overpayment amounts to providers that are subject to a fiscal audit under 7 AAC 160.110 or a quality assurance program review under 7 AAC 160.140.

Updated 06/04/2013

### Audits with 30 Days Advance Notice

Normally the Alaska Department of Health and Social Services or its designee will give a provider 30 days advance notice of an audit to be conducted. The notice will:

- Advise the provider that the department or its designee intends to conduct an audit of the provider's records
- Specify the place where the audit is to be conducted
- Specify the records that the provider must produce for purposes of the audit
- Specify the date by which the provider must produce the records and the address to which the records are to be delivered or at which they are to be inspected
- Advise the provider that the provisions of 7 AAC 105.240 apply to the production of the records requested

Updated 06/04/2013

### Audits without Advance Notice

The Alaska Department of Health and Social Services or its designee may request records and perform an audit of those records without advance notice if it has reason to believe, based on reliable evidence, that the provider is engaging in a course of conduct or performing an act that is in violation of regulatory requirements. In that case, the provider must produce the requested records for an immediate audit at the provider's place of business or other location as specified by the department or its designee.

Following the department's or its designee's audit of a provider's records, the provider will be given the written preliminary findings of the audit. The preliminary findings will not identify any overpayment amounts. The provider has **30 days** after the date of the preliminary findings to submit additional documentation or respond to the preliminary findings.

The department must issue the final audit report to the provider within **30 days** after it has considered any documentation or response submitted and the audit is complete. The final audit report will include audit or review findings and overpayment amounts identified as a result of the audit.

If the department finds that the provider has not complied with the requirements, the department will take one or more of the following actions:

- Recoup any identified overpayment amount from the provider
- Impose sanctions against the provider under 7 AAC 105.400 – 7 AAC 105.490
- Initiate other administrative or other civil actions
- Refer the matter to another state, federal, or local agency

Updated 06/04/2013

## Appealing Audit Findings

A provider may appeal the findings of a final audit and determinations of overpayment amount under the audit. An appeal must:

- Be made in writing and submitted to:  
Commissioner's Office  
Department of Health and Social Services  
P.O. Box 110601  
Juneau, AK 00811-0601
- Be submitted to the commissioner within 30 days after the date of the final audit report
- Contain a description of the finding or determination being appealed, a copy of the determination, and the basis upon which the final audit report is challenged
- Include all information and materials, including any new information that the provider requests the commissioner to consider in resolving the appeal

The commissioner will review the information and materials submitted and consider the following factors in reaching a decision:

- The provider's error rate in the audit
- Whether the provider has a prior history of similar audit findings and whether the previous findings were corrected
- Whether the provider received notice of noncompliance previously and whether the provider received training regarding the noncompliance
- Whether the provider submitted false or fraudulent information or omitted material information on the Alaska Medical Assistance claims to the department
- Whether the findings of the audit indicate that the provider poses a health or safety risk to recipients

The commissioner shall issue a decision within **60 days** of receipt of the appeal. The decision is a final administrative decision. The department will notify providers of their right to appeal the final administrative decisions to the superior court under the Alaska Rules of Appellate Procedure.

Updated 06/04/2013

## Definitions

For regulatory purposes, the following definitions apply:

- **"Audit"** means the process of obtaining competent evidentiary material about a provider through inspection, observation, inquiry, and confirmation sufficient to support a reasonable basis for determining the provider's compliance with the legal requirements of the Alaska Medical Assistance Program;
- **"Desk audit"** means an audit of a provider conducted by the Department of Health and Social Services or its designee based upon an examination of a provider's records without a visit to the provider's place of business or site where the provider maintains business records;
- **"Field audit"** means an audit of a provider conducted by the Department of Health and Social Services or its designee based upon an examination of a provider's records with at least one on-site visit to conduct audit procedures at the provider's place of business or site where the provider maintains business records.

Updated 06/04/2013

## Penalty to Recipient: Restriction

The Alaska Department of Health and Social Services will, at its discretion, restrict a recipient's choice of providers of items and services if the department finds that the recipient has used an item or service paid for under Alaska Medical Assistance or Chronic and Acute Medical Assistance at a frequency or in an amount that is not medically necessary. The department will notify the recipient of such a finding and request that the recipient choose a single provider to be the exclusive provider for the recipient of each item or service that the department designates.

After designating a provider or providers, the department will mark the identification card or medical coupons issued to the recipient with the word "RESTRICTED" and with the name of the designated provider or providers of restricted items or services.

Except in a medical emergency, only a provider designated by the department may provide medical services to a recipient whose identification card or medical coupons are marked "RESTRICTED." In the event of a medical emergency, the recipient may choose a provider without restriction.

A medical emergency exists when a recipient has a severe, life-threatening or potentially disabling condition that requires intervention within minutes or hours.

For further information regarding restriction of a recipient's choice of providers, refer to 7 AAC 105.600.

Updated 06/04/2013

## Penalty to Provider: Sanctions

### Grounds for sanctioning providers

Sanctions may be imposed by the Alaska Division of Healthcare Services (DHCS) for any one or more of the following reasons:

1. Presenting or causing to be presented for payment any false or fraudulent claim for services or supplies
2. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of a rate established by the division or the provider's usual and customary charges
3. Submitting or causing to be submitted false information for the purpose of meeting service authorization requirements
4. Failing to disclose or make available to the division or its authorized agent records of services provided to Alaska Medical Assistance recipients and records of payments made for them
5. Failing to provide and maintain quality services to Alaska Medical Assistance recipients within accepted medical community standards as adjudged by a body of professional peers equivalently licensed to practice in this state
6. Engaging in a course of conduct or performing an act considered improper or abusive of the Alaska Medical Assistance Program or continuing that conduct following notification that it should cease
7. Breaching the terms of the Alaska Medical Assistance provider agreement or failure to comply with the terms of the provider certification on the Alaska Medical Assistance claims form
8. Overusing the Alaska Medical Assistance Program by inducing, or otherwise causing a recipient to receive, services or supplies not required or requested by the recipient
9. Rebating or accepting a fee or portion of a fee or charge for an Alaska Medical Assistance recipient referral

10. Violating any provision of Alaska Statute AS 47.07 or any regulation adopted under it
11. Submitting a false or fraudulent application for provider status
12. Violating any law, regulation, or code of ethics governing the conduct of occupations, professions or regulated industries
13. Being convicted of a criminal offense relating to performance of a provider agreement with the state or to a negligent practice resulting in death or injury to a patient
14. Failing to meet standards required by state or federal law for participation, such as licensure
15. Being excluded from the Medicare program because of fraudulent or abusive practices
16. Following a documented practice of charging recipients for services in an amount above payment made by the Alaska Division of Health Care Services
17. Refusing to execute a new provider agreement when requested to do so
18. Failing to correct deficiencies in provider operations after receiving written notice of these deficiencies from either the Division of Public Assistance, the Division of Public Health, or the Division of Behavioral Health
19. Being formally reprimanded or censured by an association of the provider's peers for unethical practices
20. Being suspended or terminated from participation in another governmental medical program such as worker's compensation, crippled children's program, vocational rehabilitation services, and Medicare
21. Failing to repay or make arrangements for repaying identified overpayments or otherwise erroneous payment
22. Dispensing a lesser quantity of a drug 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
23. Billing for a drug other than the drug dispensed
24. Billing for an amount in excess of the normal charge to the typical walk-in, cash-paying customer
25. Billing for a prescription refill that was not authorized by the prescriber
26. Falsely submitting a bill specifying that a prescriber required a specific brand name drug rather than a less expensive generic equivalent
27. Supplying false information on a dispensing fee or drug cost survey initiated by the Division of Healthcare Services in order to establish or revise drug reimbursement rates
28. Failing to submit business records or other information determined by the Division of Healthcare Services to be necessary for the administration of the Alaska Medical Assistance Program
29. Being convicted of a crime that involves contributing to the delinquency of a minor or of any sex offense as defined in Alaska Statute AS 11 or in the laws of any other jurisdiction or allowing an employee who has been convicted of a crime that involves contributing to the delinquency of a minor or of any sex offense as defined in Alaska Statute AS 11 or in the laws of any other jurisdiction to provide services reimbursed by Alaska Medical Assistance
30. Engaging in, or failing to report, any act of abuse or neglect of a child reportable under AS 47.17.010 - 47.17.022, any harm of an elderly or disabled adult reportable under AS 47.24.010 - 47.24.120, or any other acts reportable under 7 AAC 37.050(b), if the personal care assistant learns of the abuse or neglect in connection with work-related activities
31. Engaging in, or threatening a recipient or a member of recipients' household with, physical, sexual, or mental abuse or coercion
32. Failing to remove an employee from contact with a recipient when there is probable cause to believe that the employee has engaged in an act identified in number 31 above while providing service
33. Exploiting a recipient for financial gain or failing to remove an employee who has exploited a recipient for financial gain

34. Theft of medication, money, property, supplies, equipment, or other assets of a recipient or the division
35. Failing to report a theft as described in number 34 above;
36. Failing to remove from contact with a recipient any employee who is under the influence of alcohol or drugs while providing services to a recipient or whose use of alcohol or drugs interferes with work performance or recipient safety
37. Violating, or knowingly allowing an employee to violate, state or federal laws regulating prescription drugs and controlled substances, including forging prescriptions and unlawfully distributing
38. Failing to report to the division facts known to the provider or a provider's employee regarding the incompetent or illegal practice or conduct of a care provider in connection with personal care services
39. Submitting or causing to be submitted false information under 7 AAC 105.400
40. Failing to investigate and sanction an employee who has knowingly falsified information under 7 AAC 105.400
41. Failing to make available to the division all records of services provided to a recipient and the payments made for those services
42. Performing, or allowing an employee to perform, a service that is beyond that person's professional training
43. Failing to perform the acts that are within a person's scope of competence and training that are necessary to prevent harm or an increase in the risk of harm to a recipient
44. Violating the disclosure of information provisions of 7 AAC 37.010 – 7 AAC 37.130
45. Discriminating, or allowing an employee to discriminate, on the basis of race, religion, color, national origin, ancestry, or gender in the provision of care to a recipient
46. Failing to maintain for each recipient a contemporaneous and accurate record of the services provided
47. A healthcare professional's act or failure to act that would constitute grounds for denial, suspension, or revocation of that individual's occupational license issued under Alaska Statute AS 08.84.120

Updated 06/04/2013

## Types of Sanctions

The following sanctions may be invoked against providers, based on the grounds specified above:

1. Suspension or termination from participation in the Alaska Medical Assistance Program
2. Restriction or withholding of payments to a provider
3. Referral to a utilization and quality control, peer review organization
4. Transfer to a closed-end provider agreement not to exceed twelve months or the shortening of an already existing closed-end provider agreement
5. Attendance at provider education sessions
6. Required service authorization of services
7. 100 percent review of the provider's claims before payment
8. Referral to the state licensing board for investigation
9. Referral for fiscal audit under 7 AAC 160.110 and recoupment of overpayments
10. Public notice of suspension or termination of a provider

Updated 06/04/2013



## Imposition of Sanction

The decision as to the sanction to be imposed will be at the discretion of the director of the Division of Healthcare Services, except as follows:

If a provider has been:

- Convicted of defrauding the Alaska Medical Assistance Program
- Previously suspended due to program or recipient abuse
- Terminated from the Medicare program for abuse, or
- Convicted of a crime that causes the division to consider the provider as posing a health or safety risk to a recipient

Based upon any of the above, the Division of Healthcare Services will institute proceedings to terminate the provider from the Alaska Medical Assistance Program.

The following factors will be considered in determining the sanction to be 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  
(Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)

Updated 06/04/2013

## Scope of Sanction

A sanction may be applied to all known affiliates of a provider. The decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. Violation, failure or inadequacy of performance may be imputed to a person with whom the provider is affiliated where the conduct occurred during the course of the affiliate's official duty or was carried out by her/him with the knowledge or approval of the provider.

A clinic, group, corporation or other association may not submit a payment claim to the division or its fiscal agent for any services or supplies provided by an individual within that organization who has been suspended or terminated from the Alaska Medical Assistance Program. Only services or supplies provided before the suspension or termination can be billed. If this provision is violated, the division may suspend and/or terminate both the organization and the individual within the organization who is responsible for the violation.

(Effective 8/18/79, Reg. 71. Authority: AS 47.05.010, AS 47.07.050)

Updated 06/04/2013

## Notice of Sanction

When the department intends to impose sanctions on a provider, it must send written notice to the provider by certified mail. If the suspension or termination of the provider's participation in the Alaska Medical Assistance Program or the withholding of payment is proposed, the department must notify the



provider of the right to appeal under 7 AAC 105.460. The proposed sanction is effective 30 days after the date on the notice if the provider does not appeal or 30 days after the date of the final administrative appeal decision upholding the proposed sanction.

A proposed immediate suspension issued under 7 AAC 160.140 of a provider's participation in the Alaska Medical Assistance Program is effective 10 days after the date of the notice. The notice must include:

- The nature of the discrepancy or violation
- A description of the proposed sanction to be imposed by the department
- Whether the matter has been referred for fiscal audit under 7 AAC 160.110
- Any action required of the provider
- The provider's right to an appeal under 7 AAC 105.460

When the findings have been made and a sanction has been imposed on a provider, the department will notify:

- The provider's known professional societies
- The Department of Commerce, Community, and Economic Development
- Any other federal or state agency that the department is aware has an interest

If a provider's participation in the Alaska Medical Assistance Program has been suspended or terminated, the department will send written notice of that sanction to each recipient for whom the provider has submitted a claim for any service provided in the twelve months preceding the notice of sanction. The department will send the written notice to the last mailing address of the recipient known to the department. The department will also publish notice of the sanction in a newspaper of general circulation or use another method of posting or publication.

Updated 06/04/2013

## Appealing Sanctions

Within 30 days after receipt of the notice of sanction, the provider may request an appeal and include a request for a formal hearing. The request for appeal must:

- Be in writing,
- Contain a statement and supporting documents that describe the alleged violations or discrepancies,
- Specify the basis upon which the notice is challenged, and
- Explain the reasons that the provider is in compliance.

A provider may request an expedited appeal of a notice of immediate suspension issued under 7 AAC 160.140. A provider requesting an appeal or expedited appeal must submit the request to:

Commissioner's Office  
Department of Health and Social Services  
P.O. Box 110601  
Juneau, AK 00811-0601

Updated 06/04/2013

# Forms

This section contains sample forms which you may need to use when interacting with Alaska Medical Assistance. These forms are included in the manual for your reference and are available for download on the Forms page at <http://manuals.medicaidalaska.com/docs/forms.htm>. You may request original paper claim forms from Conduent by completing the [Healthcare Forms Order Request](#) also available on the Forms page.

- CMS-1500 Claim form
- UB-04 Claim form
- ADA Dental form
- Service Authorization Request form
- Certificate of Medical Necessity
- Certificate to Request Funds for Abortion
- Update Provider Information Request form
- Sterilization Consent Form
- Hysterectomy Consent form
- Electronic Claims Attachment Transmittal form
- Provider Appeals form
- Long Term Care Authorization form
- Healthcare forms Order Request
- Adjustment/Void Request form

Updated 06/08/2018

# CMS-1500 Claim Form



## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> PICA												<input type="checkbox"/> PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare#) (Medicaid#) (ID#DoD#) (Member ID#) (ID#) (ID#)												1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No., Street)			
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)		8. RESERVED FOR NUCC USE			
CITY STATE						CITY STATE		CITY STATE		CITY STATE			
ZIP CODE TELEPHONE (Include Area Code)						ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> # yes, complete items 9, 9a, and 9d.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY		15. OTHER DATE QUAL. MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY		19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.						22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER			
25. FEDERAL TAX ID. NUMBER SBN EIN						26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		28. TOTAL CHARGE \$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION		29. AMOUNT PAID \$		30. Reserved for NUCC Use			
33. BILLING PROVIDER INFO & PH # ( )						34. NPI		35. NPI		36. NPI			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Updated 10/15/2015

# UB-04 Claim Form

1		2		3a PAT. CNTL # b MED. REC. #		4 TYPE OF BILL	
5 FED. TAX NO.				6 STATEMENT COVERS PERIOD FROM		7 THROUGH	
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE				11 SEX		12 DATE	
13 HR		14 TYPE		15 SRC		16 DHR	
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897		898		899			

# ADA Dental Form

## ADA American Dental Association® Dental Claim Form

HEADER INFORMATION															
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT / Title XIX															
2. Predetermination/Preauthorization Number															
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION															
3. Company/Plan Name, Address, City, State, Zip Code															
13. Date of Birth (MM/DD/CCYY)															
14. Gender <input type="checkbox"/> M <input type="checkbox"/> F															
15. Policyholder/Subscriber ID (SSN or ID#)															
16. Plan/Group Number															
17. Employer Name															
OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)															
4. Dental? <input type="checkbox"/> Medical? <input type="checkbox"/> (If both, complete 5-11 for dental only.)															
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)															
6. Date of Birth (MM/DD/CCYY)															
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F															
8. Policyholder/Subscriber ID (SSN or ID#)															
9. Plan/Group Number															
10. Patient's Relationship to Person named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other															
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code															
PATIENT INFORMATION															
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other															
19. Reserved For Future Use															
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code															
21. Date of Birth (MM/DD/CCYY)															
22. Gender <input type="checkbox"/> M <input type="checkbox"/> F															
23. Patient ID/Account # (Assigned by Dentist)															
RECORD OF SERVICES PROVIDED															
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee						
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9															
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33. Missing Teeth Information (Place an "X" on each missing tooth.)															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
34. Diagnosis Code List Qualifier <input type="checkbox"/> (ICD-9 = B; ICD-10 = AB)															
34a. Diagnosis Code(s) A _____ C _____															
(Primary diagnosis in "A") B _____ D _____															
31a. Other Fee(s)															
32. Total Fee															
35. Remarks															
AUTHORIZATIONS															
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.															
X Patient/Guardian Signature _____ Date _____															
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.															
X Subscriber Signature _____ Date _____															
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)															
48. Name, Address, City, State, Zip Code															
49. NPI															
50. License Number															
51. SSN or TIN															
52. Phone Number ( ) -															
52a. Additional Provider ID															
ANCILLARY CLAIM/TREATMENT INFORMATION															
38. Place of Treatment <input type="checkbox"/> (e.g. 11=office; 22=O/P Hospital)															
39. Enclosures (Y or N) <input type="checkbox"/>															
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)															
41. Date Appliance Placed (MM/DD/CCYY)															
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)															
43. Replacement of Prosthesis															
44. Date of Prior Placement (MM/DD/CCYY)															
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident															
46. Date of Accident (MM/DD/CCYY)															
47. Auto Accident State															
TREATING DENTIST AND TREATMENT LOCATION INFORMATION															
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.															
X Signed (Treating Dentist) _____ Date _____															
54. NPI															
55. License Number															
56. Address, City, State, Zip Code															
56a. Provider Specialty Code															
57. Phone Number ( ) -															
58. Additional Provider ID															

© 2012 American Dental Association  
 J430 (Same as ADA Dental Claim Form – J431, J432, J433, J434, J430D)

To reorder call 800.947.4746  
 or go online at adacatalog.org

Updated 10/15/2015

[illegible]

[Return to TOC](#)

# Certificate of Medical Necessity



Certificate of Medical Necessity, Page 1 of 2

MEMBER INFORMATION		PROVIDER INFORMATION	
Member Name: _____ (Last, First, MI)		Ordering Provider's Name: _____	
Alaska Medicaid Member ID: _____		Provider Medicaid ID or NPI: _____	
Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____		Phone Number: _____ Ext. _____	
*Height: _____ (inches) *Weight: _____ (pounds)		Prescription Start Date: _____	
Date of Last Visit: _____		Retrospective Review? <input type="radio"/> Yes <input type="radio"/> No	
<b>SECTION A - CLINICAL INFORMATION</b> (This section <b>MUST</b> be completed by the attending physician, physician assistant, nurse practitioner, or audiologist.)			
	Diagnosis Code	Diagnosis Description	
ICD-10			
Estimated Length of Need (# of Months): _____ (99 = Lifetime)			
<b>SECTION B - CLINICAL ASSESSMENT OF NEED FOR PRESCRIBED SERVICE(S) OR ITEM(S) AND PLAN</b>			
Annotate the medical justification, as it pertains to the member's specific diagnosis, indicating the medical necessity of the requested services or items. Attach any supporting documentation as needed for further justification. (This section may be completed by the attending specialist, including the physician, physician assistant, nurse practitioner, physical therapist, occupational therapist, speech language pathology therapist, registered dietitian, audiologist, or other attending specialist within the scope of his or her specialty.)			
<b>PLAN:</b> The plan should list each service or item specifically needed for the treatment of the member. Additional treatment information may be attached to this form.			
<b>ATTESTATION, SIGNATURE AND DATE OF PHYSICIAN/ PHYSICIAN ASSISTANT/NURSE PRACTITIONER/ AUDIOLOGIST AND SPECIALIST</b> (Note: Specialist = PT, OT, SLP, RD, MD, NP, PhD, LSW, etc.)			
A physician, physician assistant, nurse practitioner, audiologist or specialist who attests to the medical necessity of the prescribed items, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the services or items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.			
This must be signed by the specialist if Section B is completed by someone other than the provider in Section A.			
Signature of Specialist, Title _____		Date _____	
I hereby certify that I am the ordering physician/physician assistant/nurse practitioner/audiologist identified in this form.			
Signature of Physician / Physician Assistant / Nurse Practitioner / Audiologist _____		Date _____	

Rev. 01/03/17

## Certificate of Medical Necessity (pg 2).



Certificate of Medical Necessity, Page 2 of 2

MEMBER INFORMATION					PROVIDER INFORMATION				
Member Name: _____ (Last, First, MI)					Ordering Provider's Name: _____				
Alaska Medicaid Member ID: _____					Provider Medicaid ID or NPI: _____				
Date of Birth (MM/DD/YY): _____ Age: _____ Sex: _____					Phone Number: _____ Ext. _____				
SECTION C - REQUESTED SERVICES OR ITEMS (To Be Completed by DME, P&O, Audiology, or Hearing Aid Providers)					Conduent Use Only				
Provider Name: _____ Address: _____ Provider Medicaid ID: _____ Requester Name: _____ Phone Number: _____ Ext. _____ Fax Number: _____ Ext. _____ Dates of Need – Start Date: _____ End Date: _____									
					Approved: As requested      Modified request Denied: Service Authorization No: _____ Start Date: _____ End Date: _____ Comments: _____ Authorizing Agent Signature/Date: _____				
	Procedure Code	Mod	Description	Qty	Charges	Authorized		Approved Quantity	Approved Amount
						Yes	No		
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SECTION D - SUPPLIER ATTESTATION, SIGNATURE AND DATE									
<i>I certify that those services or items listed in this form are those exact services or items ordered and certified as medically necessary by the ordering physician/physician assistant/nurse practitioner/ audiologist specified in this form, and that these exact services or items listed in this form will be supplied to the specified member. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.</i>									
Signature of Supplier _____						Date _____			

Rev. 01/03/17

Updated 01/03/2017



## Certificate to Request Funds for Abortion

### Certificate to Request Funds for Abortion

The Hyde Amendment allows federal funds to be expended for an abortion only "(1) if the pregnancy is the result of an act of rape or incest; or (2) 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." *Section 508(a) of Public Law 111-8.*

In accordance with a 2001 order of the Supreme Court of the State of Alaska, the Alaska Medicaid program must, under certain circumstances, provide funding for abortions for women who receive Alaska Medicaid but for whom the abortion is not covered by the federal Medicaid program. If the abortion is medically necessary and not elective, the Alaska Medicaid program may pay some or all of the costs. This form will permit the program to determine the proper source of funds for such payment.

\_\_\_\_\_  
(Recipient's Full Name PRINT OR TYPE)

\_\_\_\_\_  
(Recipient's Medicaid Identification Number)

had an abortion procedure performed on \_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year).

☐ I certify based upon all of the information available to me that before performing the abortion procedure on the above patient her pregnancy was the result of an act of rape or incest, or the abortion procedure on the above patient was performed due to physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion was performed.

☐ I certify based upon all of the information available to me that the above does not apply, but the abortion procedure was medically necessary.

This certificate must be signed and dated by the recipient's attending physician and must be submitted to the Division of Health Care Services at the address below. The original is to be kept in the provider's file for the patient with all supporting documentation. No payment will be made for an abortion without a signed certificate on file.

\_\_\_\_\_  
Printed Name of Recipient's Attending Physician M.D. or D.O.

\_\_\_\_\_  
Signature of Recipient's Attending Physician M.D. or D.O.

\_\_\_\_/\_\_\_\_/\_\_\_\_ (month/day/year)  
Date of Physician's Signature

**Submit a copy of the completed and signed certificate by mail or fax to:**

**Alaska Division of Health Care Services  
Attention: Medical Review  
4501 Business Park Blvd., Bldg. I Suite 24  
Anchorage, AK 99503-7167  
Fax: 907.269.8868**

Rev. 11/2012

Updated 10/28/2015

# Update Provider Information Request Form



P.O. Box 240808  
Anchorage, AK 99524-0808  
907.644.6800  
<http://medicaidalaska.com>

## Alaska Medical Assistance Update Provider Information Request

- Do not use this form to update a Tax ID. Please contact the Provider Enrollment Unit at 907.644.6800 for assistance.
  - To change EFT information, please complete the Authorization Agreement for Electronic Funds Transfer (EFT) form.
  - To change Billing Agent Information, please complete the Provider Information Submissions Agreement (PISA) form.
- Additional forms can be found at <https://medicaidalaska.com/portals/wps/portal/DocumentsandForms>.

<b>Section A: Information on File</b> Complete this section for all requests.	1. Provider Name _____ <i>(as currently on file)</i> 2. Alaska Medical Assistance ID _____ <i>(Are other Medicaid IDs affected by this change? Complete and sign a separate form for each ID.)</i> 3. Effective Date of Change _____
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<b>Section B: Update Information</b> Complete only the information that needs to be updated.	1. Provider Name _____ <i>(attach legal documentation for a name change)</i> 2. Doing Business As (DBA) Name _____ 3. Service Location Address _____ <i>(Street address, NO PO Boxes for servicing location)</i> Also Applies to: Mailing <input type="checkbox"/> Publication/Distribution <input type="checkbox"/> 4. Phone Number (____) _____ Applies to: Contact <input type="checkbox"/> Fax <input type="checkbox"/> 5. Billing Address _____ <i>(The president, owner, CEO, CFO, shareholder of at least five percent, or other authorized representative must sign a group application to update this address.)</i> Also Applies to: Mailing <input type="checkbox"/> Publication/Distribution <input type="checkbox"/> 6. Taxonomy Code: add <input type="checkbox"/> end <input type="checkbox"/> _____ 7a. Identifier _____ Choose identifier type: NPI <input type="checkbox"/> DEA <input type="checkbox"/> CLIA <input type="checkbox"/> NCPDP <input type="checkbox"/> <i>(Attach documentation for identifier being added.)</i> 7b. Identifier _____ Choose identifier type: NPI <input type="checkbox"/> DEA <input type="checkbox"/> CLIA <input type="checkbox"/> NCPDP <input type="checkbox"/> <i>(Attach documentation for identifier being added.)</i>
--	---

Section C: Change Affiliation(s)	ADD Affiliations	Discontinue Affiliations
Add or discontinue by filling out all information in the numbered field.	1. Effective Date _____ Alaska Medical Assistance ID _____	1. Effective End Date _____ Alaska Medical Assistance ID _____
	2. Effective Date _____ Alaska Medical Assistance ID _____	2. Effective End Date _____ Alaska Medical Assistance ID _____
	3. Effective Date _____ Alaska Medical Assistance ID _____	3. Effective End Date _____ Alaska Medical Assistance ID _____

Other: \_\_\_\_\_

### Original Signature Required

**Important Notice:** Individual providers must sign this change form. Groups or entities require the signature of an authorized representative.

Signature _____	Date _____
Signer's Printed Name _____	Signer's Title _____

Rev.01/03/2017

Updated 01/03/2017

# Sterilization Consent Form

Form Approved: OMB No. 0937-0166  
Expiration date: 12/31/2018

## CONSENT FOR STERILIZATION

**NOTICE:** YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

### ■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from \_\_\_\_\_ . When I first asked \_\_\_\_\_  
*Doctor or Clinic*  
for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.  
I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a \_\_\_\_\_ . The discomforts, risks

*Specify Type of Operation*  
and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: \_\_\_\_\_

I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_

*Doctor or Clinic*  
by a method called \_\_\_\_\_ . My  
*Specify Type of Operation*

consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services, or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

\_\_\_\_\_  
*Signature* \_\_\_\_\_ *Date*

You are requested to supply the following information, but it is not required: (Ethnicity and Race Designation) (please check)

*Ethnicity:* \_\_\_\_\_ *Race (mark one or more):*

- |   |  |
|---|--|
| <input type="checkbox"/> Hispanic or Latino     | <input type="checkbox"/> American Indian or Alaska Native          |
| <input type="checkbox"/> Not Hispanic or Latino | <input type="checkbox"/> Asian                                     |
|   | <input type="checkbox"/> Black or African American                 |
|   | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
|   | <input type="checkbox"/> White                                     |

### ■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:  
I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in

language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

\_\_\_\_\_  
*Interpreter's Signature* \_\_\_\_\_ *Date*

HHS-687 (10/12)

### ■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before \_\_\_\_\_ signed the  
*Name of Individual*  
consent form, I explained to him/her the nature of sterilization operation \_\_\_\_\_ , the fact that it is

*Specify Type of Operation*  
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

\_\_\_\_\_  
*Signature of Person Obtaining Consent* \_\_\_\_\_ *Date*

\_\_\_\_\_  
*Facility*

\_\_\_\_\_  
*Address*

### ■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon

\_\_\_\_\_ on \_\_\_\_\_  
*Name of Individual* *Date of Sterilization*  
I explained to him/her the nature of the sterilization operation \_\_\_\_\_ , the fact that it is

*Specify Type of Operation*  
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery  
Individual's expected date of delivery: \_\_\_\_\_  
☐ Emergency abdominal surgery (describe circumstances): \_\_\_\_\_

\_\_\_\_\_  
*Physician's Signature* \_\_\_\_\_ *Date*

Updated 03/10/2016

## Hysterectomy Consent Form

### HYSTERECTOMY CONSENT FORM

#### **PART I**

This hysterectomy ☐ (is not being) ☐ (was not) performed solely for the purpose of rendering \_\_\_\_\_ permanently incapable of reproducing, and  
(patient's name)

this hysterectomy ☐ (would be) ☐ (would have been) performed even without the purpose of rendering \_\_\_\_\_ permanently incapable of reproducing  
(patient's name)

because of: \_\_\_\_\_.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

A hysterectomy consent form was not obtained because:

1. The patient \_\_\_\_\_ was sterile before this procedure because of:  
(patient's name)

2. It was a life-threatening emergency and prior acknowledgement could not be obtained.

The emergency was: \_\_\_\_\_.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

#### **PART II**

I told \_\_\_\_\_ and her representative \_\_\_\_\_ both  
(patient's name) (if one is present)  
orally and in writing, that a hysterectomy will render her permanently incapable of reproducing.

Signature: \_\_\_\_\_

\_\_\_\_\_  
Person Obtaining Surgical Consent

\_\_\_\_\_  
Date

#### **PART III**

I have received and understood both oral and written information explaining that a woman undergoing a hysterectomy will be permanently incapable of having children after the operation.  
I was informed of this before my surgery was performed.

Signature: \_\_\_\_\_

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

## Hysterectomy Consent Form (pg 2)

Hysterectomy Consent Forms	
<b>If You Complete This Section</b>	<b>PART I</b> This hysterectomy (is not being) (was not) performed solely for the purpose of rendering _____ (patient's name) permanently incapable of reproducing, and this hysterectomy (would be) (would have been) performed even without the purpose of rendering _____ (patient's name) permanently incapable of reproducing because of: _____  _____ Physician's Signature  _____ Date
	A hysterectomy consent form was not obtained because: 1. The patient _____ (patient's name) was sterile before this procedure because of: _____ 2. It was a life-threatening emergency and prior acknowledgement could not be obtained. The emergency was: _____  _____ Physician's Signature  _____ Date
	<b>PART II</b> I told _____ (patient's name) and her representative _____ (if one is present) both orally and in writing, that a hysterectomy will render her permanently incapable of reproducing.  Signature: _____ Person Obtaining Surgical Consent  _____ Date
<b>Do Not Complete These Sections</b>	<b>PART III</b> I have received and understood both oral and written information explaining that a woman undergoing a hysterectomy will be permanently incapable of having children after the operation. I was informed of this before my surgery was performed.  Signature: _____ Patient  _____ Date
	<b>The second paragraph of this form, (in Part 1) is mutually exclusive of Part II and Part III and it is incorrect to complete both parts of this consent form.</b>

Updated 06/04/2013

## Completing the Hysterectomy Consent Form

Before performing the hysterectomy, you must

1. Tell the recipient, in writing and orally, that the procedure will cause sterility (will make the individual permanently incapable of reproducing).
2. Have the recipient sign the *Hysterectomy Consent Form* (refer to the *Forms Section* for a copy of the *Hysterectomy Consent Form*).
3. Sign the *Hysterectomy Consent Form* stating that the recipient was informed orally and in writing that the surgery will cause sterility (the person signing the form must be the person who informed the recipient)



The *Hysterectomy Consent Form* does not need to be signed before the surgery if the physician performing the surgery states, in writing, that the individual was sterile before the procedure and also states the cause of sterility

or

that the hysterectomy was performed because of a life-threatening emergency in which prior acknowledgement was not possible. The physician must include a description of the emergency.

When completing the remainder of the *Hysterectomy Consent Form*, the physician must include the medical justification for the procedure. The signed *Hysterectomy Consent Form* must be submitted with the claim for the hysterectomy.

Updated 06/04/2013

## Electronic Claims Attachment Transmittal Form



### ATTACHMENT FAX COVER SHEET

**Conduent**  
**P.O. Box 240808 • Anchorage, Alaska 99524-0808**  
**Telephone: 907.644.6800 or 800.770.5650**  
**Fax: 907.644.8122 or 907.644.8123**

From: \_\_\_\_\_ Fax # \_\_\_\_\_

Number of Pages: \_\_\_\_\_ Attachment Control # \_\_\_\_\_

A new fax cover sheet must be completed for each TCN that you are submitting attachments for.  
Please complete the following fields:

TCN (17-digit Transaction Control Number) \_\_\_\_\_

Member Medicaid ID \_\_\_\_\_

Provider Medicaid ID \_\_\_\_\_

Date(s) of Service \_\_\_\_\_ to \_\_\_\_\_

### CONFIDENTIALITY NOTICE

This message, including any attachments, is intended solely for the use of the named recipient(s) and may contain confidential and/or privileged information. Any unauthorized review, use, disclosure, or distribution of this communication is expressly prohibited. If you are not the intended recipient, please notify the sender at the sender's fax number above and destroy any and all copies of the original message. Thank you.

*Rev. 01/03/2017*

Updated 01/03/2017

# Provider Appeals Form



## Conduent Provider First-Level Appeal Request

To appeal the denial or reduction of a claim or service, complete the following form and mail to Conduent along with supporting documentation. Instructions for this form are on the second page. Faxed or emailed forms will not be accepted. All fields are required. Conflicting or missing information may result in delay or denial of your appeal request.

Mail completed form to: **Conduent State Healthcare**  
Attn: First-Level Appeals  
P.O. Box 240808  
Anchorage, AK 99524-0808

### PROVIDER INFORMATION

1. Provider Group Name: \_\_\_\_\_
2. Alaska Medical Assistance ID: \_\_\_\_\_
3. Contact Name: \_\_\_\_\_
4. Phone Number: \_\_\_\_\_
5. Email Address: \_\_\_\_\_

### MEMBER AND CLAIM INFORMATION

**NOTE:** Only a single date of service may be appealed unless services exceed 24 hours (e.g., inpatient hospital stay).

6. Member Name: \_\_\_\_\_
7. Alaska Medical Assistance Member ID: \_\_\_\_\_
8. Date of Service Related to this Appeal: \_\_\_\_\_
9. Service(s) or Procedure(s) Related to this Appeal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PROVIDER CHECKLIST

Please attach all of the following documents. Only single sided documents will be accepted.

- |   |   |
|---|---|
| 10. Original Claim (Red/White) <input type="checkbox"/>   | 12. Remittance Advice that includes appealed claim <input type="checkbox"/>                           |
| 11. Supporting Medical Documentation (e.g., physician and/or progress notes, referrals, prescriptions, run sheets) <input type="checkbox"/> | 13. Third Party Liability Explanation of Benefits (EOB, EOMB), if applicable <input type="checkbox"/> |

### 14. REASON FOR REQUEST AND ADDITIONAL INFORMATION:

<div></div>
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Rev. 01/03/2017

Updated 01/03/2017



# Long Term Care Facility Authorization Forms

State of Alaska • Department of Health and Social Services • Senior and Disabilities Services



## Long Term Care (LTC) Facility Authorization Request

*This form may be completed by hospital discharge staff or a person with knowledge of the applicant for initial admission, or by LTC facility staff if individual is already a resident. The information provided must be accurate and complete. Senior and Disabilities Services (SDS) cannot process incomplete forms. SDS uses the information on this form to comply with LTC placement and payment determinations. All information requested on this form is required.*

*Submit complete form, with all required signatures and attachments, by direct secure messaging (DSM) to: **DSDS.LTCAuthorizations@direct.dhss.akhie.com***

### Section 1: Identifying Information

<b>Name of Individual</b> (Last, First, MI)

<b>DOB</b>	<b>Medicaid #</b>	<b>Address (Street, City, Zip)</b>	<b>Telephone Number</b>

<b>Applicant</b>	<b>Resident</b>
<input type="checkbox"/> New Admission <input type="checkbox"/> Inter-facility Transfer (from one facility to another) <input type="checkbox"/> Retroactive Medicaid (was initially admitted under alternative payment source and now has Medicaid) Date of discharge or DOD (if applicable):	<input type="checkbox"/> Continued Placement <input type="checkbox"/> Significant Change (Resident Review) <input type="checkbox"/> Condition improvement- LOC from SNF to ICF <input type="checkbox"/> Condition decline- LOC from ICF to SNF <input type="checkbox"/> New diagnosis

<b>Current Location</b>	<b>Placement Category</b>	<b>Payment Source</b>	<b>Recommended Level of Care</b>
<input type="checkbox"/> Hospital/acute care facility <input type="checkbox"/> Home/residence <input type="checkbox"/> LTC Facility & Medicaid Provider ID #: <input type="checkbox"/> Other (specify):	<input type="checkbox"/> LTC <input type="checkbox"/> Swing Bed <input type="checkbox"/> AWD (Administrative Wait Days)	<input type="checkbox"/> Medicaid <input type="checkbox"/> Other (specify):	<input type="checkbox"/> ICF <input type="checkbox"/> SNF

<b>Proposed/Actual Admission</b>	<b>Requested Period of Coverage</b>	<b>Travel Authorization Request</b>
Date:	From:	Traveling from:
	To:	Traveling to:
		Dates:

LTC-01 (Revised 11/03/2016)

1

Name of Individual:	Admitting Facility ID #:
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Name of Proposed/ Admitting LTC Facility and ID#	Address (Street, City, Zip)	Telephone Number	Email	Contact Name/Title

☐ If new admission, LTC facility contacted and agrees to consider individual for admission. If multiple facilities are being considered, please identify these here (*Facility ID # and Name*):

Name of Individual's Representative	Address (Street, City, Zip)	Telephone Number	Type of Representative (POA, Guardian, Surrogate Decision Maker)

**Only for LTC Placements that Involve Travel**

*I certify that I am the authorized representative of the facility utilization review committee and that the committee reviewed this request for:*

- ☐ Authorization to admit the applicant  
☐ Reauthorization  
☐ Change in level of care

*And determined the facility has personnel with the qualifications necessary to provide the direct care needed by the applicant. As required, I attached the following for SDS to review:*

- ☐ Current history and physical      ☐ Therapy notes and orders  
☐ Medication record and orders      ☐ Plan of care established by the attending physician

*Facility utilization review committee authorization representative:*

Signature of the admitting long term care facility representative: \_\_\_\_\_

Date: \_\_\_\_\_

Print name:

Title:

**Section 2: Discharge Planning**

<b>Supports Needed for Community Placement:</b>
<b>Reasons Why Alternative Placement is not Feasible or Appropriate:</b>
<b>Plan for Discharge:</b>

Name of Individual:	Admitting Facility ID #:
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**Section 3: Physician Certifications**

Name of Physician	License #	Name of Person Completing on the Physician's Behalf/Title	Telephone Number	Email

Provide Both Diagnosis and Code	Primary Diagnosis and Code (ICD-10)	Secondary Diagnosis and Code (ICD-10)	Additional Diagnoses and Codes (ICD-10)
Admitting Diagnosis			
Discharge Diagnosis			

Medical Reason for Admission (for an applicant) or Continued Stay (for a resident):	
Level Of Care Recommendation:	<input type="checkbox"/> SNF <input type="checkbox"/> ICF
Certification of Intended Length of Stay:	<input type="checkbox"/> Less than 30 days <input type="checkbox"/> Convalescent Care (less than 90 days) <input type="checkbox"/> Long Term Placement (more than 90 days)

Signature: To be completed by the individual's attending physician or delegated authority (physician only)	Telephone Number:	Email:
Signature:	Date:	
<input type="checkbox"/> Physician's signature on file (reauthorization / continued placement only)		

**Section 4: Individual Needs**

Prescribed Medications	Dosage/Frequency	Route	Purpose

Name of Individual:	Admitting Facility ID #:
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Capacity for Independent Living and Self-Care	Self-Performance Score	Support Score	Capacity for Independent Living and Self-Care	Self-Performance Score	Support Score
Medication management			Toilet use		
Bed mobility			Personal hygiene		
Transfers			Bathing		
Locomotion			Eating		
Dressing					

Self-performance score (Score 1 – 8 for activities, not including set-up, occurring during the last 7 days, or last 24 to 48 hours if individual in hospital.)  
**0** = Independent: no help or oversight, or help/oversight provided only 1 or 2 times  
**1** = Supervision: oversight, encouragement, or cueing provided 3 times, or supervision plus non-weight bearing physical assistance provided 1 or 2 times  
**2** = Limited assistance: individual highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3+ times, or limited assistance plus weight-bearing 1 or 2 times  
**3** = Extensive assistance: weight-bearing support, or full staff/caregiver performance 3+ times  
**4** = Total dependence: full staff/caregiver performance every day of period  
**5** = Cueing: spoken instruction or physical guidance to perform activity  
**8** = Activity did not occur  
 (No score of 6 or 7)

Support score (Score 1 – 8 for the most support provided for each activity during last 7 days, or last 24 to 48 hours if individual in hospital.)  
**0** = no setup or physical help from staff/caregiver  
**1** = setup help only  
**2** = one-person physical assist  
**3** = two or more person physical assist  
 (No score of 4)  
**5** = Cueing support every day.  
 (No score of 6 or 7)  
**8** = Activity did not occur

Cognition		
Short-Term Memory	<input type="checkbox"/> OK	<input type="checkbox"/> Problem:
Long-Term Memory	<input type="checkbox"/> OK	<input type="checkbox"/> Problem:
Orientation	<input type="checkbox"/> OK	<input type="checkbox"/> Problem:
Cognitive Abilities	<input type="checkbox"/> OK	<input type="checkbox"/> Problem:
Decision Making	<input type="checkbox"/> OK	<input type="checkbox"/> Problem:

Therapy Services (Check all that apply and specific frequency)			
<input type="checkbox"/> Physical Therapy	# of Days per Week:	<input type="checkbox"/> Speech-Language Therapy	# of Days per Week:
<input type="checkbox"/> Occupational Therapy	# of Days per Week:	<input type="checkbox"/> Other:	# of Days per Week:

<b>Check all that are attached</b>	<input type="checkbox"/> H&P (required for all new admissions) <input type="checkbox"/> Plan of Care <input type="checkbox"/> Current psychological evaluation (if applicable) <input type="checkbox"/> Other (specify):
------------------------------------	---

Name of Individual:	Admitting Facility ID #:
---------------------	--------------------------

**Section 5: Signatures and Contact Information**

Name and Title of Person Completing this Application	Date	Telephone Number	Email
Signature:			

Name of Individual:	Admitting Facility ID #:
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*State of Alaska use only*

Long Term Care Authorization and PASRR (Preadmission Screening and Resident Review) Determination

Segment Control Number:	
Date Received:	Date Reviewed:
Date of Determination:	
Level of care determination <input type="checkbox"/> SNF <input type="checkbox"/> ICF	
Admission determination <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved as modified <input type="checkbox"/> Denied	
Placement category <input type="checkbox"/> ICF <input type="checkbox"/> SNF <input type="checkbox"/> Swing bed <input type="checkbox"/> AWD	
Placement duration of care From: To:	
Travel authorization <input type="checkbox"/> Approved as requested <input type="checkbox"/> Approved as modified <input type="checkbox"/> Denied	
Name of SDS Reviewer:	Contact Information:
Applicable Category	<i>Based on the information reviewed by SDS, the following determination is made. If admission or continued placement for this individual is approved, all services as identified by the PASRR Level II evaluation must be provided, by collaborative effort with the state, to meet the individual's nursing and disability-specific needs. A copy of the PASRR evaluation report will be provided for inclusion in the medical record; the recommendations made in that report must be incorporated into the plan of care. A notice has been provided to the individual and/or his/her representative of the need for a Level II evaluation if applicable, and a summary of the PASRR Level II evaluation report.</i>
Negative Screen	<input type="checkbox"/> PASRR Level I screening does not indicate need for Level II PASRR evaluation. Applicant may be admitted to the LTC facility.
Exempted Hospital Discharge	<input type="checkbox"/> Placement in facility for 30 days or less, as certified by physician. If the individual stays beyond the 30 days, an individualized PASRR Level II evaluation must be completed by the state on or before the 40 <sup>th</sup> day. The facility shall notify SDS on day 25 that it anticipates the resident will need services more than 30 days. Day 25 is:
Primary Dementia/Mental Illness	<input type="checkbox"/> Primary dementia in combination with mental illness. May be admitted to the LTC facility.
PASRR Categorical Determinations (certain circumstances that are time-limited that require an abbreviated PASRR Level II evaluation report)	<input type="checkbox"/> Convalescent care for a period of 90 days or less, as certified by the physician. If the individual stays beyond the 90 days, an individualized PASRR Level II evaluation must be completed. The facility shall notify SDS on day 85 that it anticipates the resident will need services more than 90 days. Day 85 is:
	<input type="checkbox"/> Primary dementia in combination with a diagnosis of intellectual disability or related condition applies. A Level II evaluation may be required, if there is a substantial change in condition.
	<input type="checkbox"/> Terminal illness, as certified by attending physician. A Level II evaluation may be required, if there is a substantial change in condition.
	<input type="checkbox"/> Severe physical illness. A Level II evaluation may be required, if there is a substantial change in condition.
Resident Review	<input type="checkbox"/> May be considered appropriate for continued placement in the LTC facility, without specialized services for disability-specific needs.
	<input type="checkbox"/> May not continue to reside in LTC facility. Alternative placement and services are developed by the state in cooperation with the facility. Payment continues until transfer completed.
Level II PASRR Evaluation needed	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Related condition
	Date referred for Level II evaluation:  Date Level II report received:



**Pre-Admission Screening and Resident Review (PASRR) Level I**

To ensure an individual is placed in a long term care facility appropriately and receives needed services, federal regulations, 42 CFR 483.100 - 483.138 require a Pre-Admission Screening and Resident Review (PASRR) Level I screening for individuals who have or may have a diagnosis of mental illness, intellectual disabilities, and/or related conditions. The PASRR Level I Screening is required for all applicants to long term care Medicaid certified facilities, regardless of the individual's payment source, and for long term care Medicaid certified facility residents who have had a significant change in condition or diagnosis (resident review). All information requested on this form is required.

Submit complete form, with all required signatures and attachments, by direct secure messaging (DSM) to: **DSDS.LTCAuthorizations@direct.dhss.akie.com**

<b>Name of Individual</b> (Last, First, MI)

<b>DOB</b>	<b>Medicaid #</b> (if applicable)	<b>Address</b> (Street, City, Zip)	<b>Telephone Number</b>

<b>Name of Representative</b>	<b>Address</b> (Street, City, Zip)	<b>Telephone Number</b>	<b>Type of Representative</b>

<b>Current Location</b>	<b>Admitting Facility &amp; ID #</b>	<b>Address</b> (Street, City, Zip)	<b>Telephone Number</b>	<b>Email</b>	<b>Contact Name/Title</b>

If multiple facilities are being considered, please identify these here (*Facility ID # and Name*):

<b>Applicant</b>	<b>Resident</b>
<input type="checkbox"/> New Admission. Proposed/Actual Date: _____	<input type="checkbox"/> Significant Change (Resident Review)
<input type="checkbox"/> Inter-facility Transfer (from one facility to another)	<input type="checkbox"/> Condition improvement- LOC from SNF to ICF
	<input type="checkbox"/> Condition decline- LOC from ICF to SNF
	<input type="checkbox"/> New diagnosis

<b>Exempted Hospital Discharge</b> (does not require PASRR Level II evaluation)	<input type="checkbox"/> Individual being admitted to LTC facility for less than 30 days, as certified by physician
<b>Primary Dementia/Mental Illness</b> (does not require PASRR Level II evaluation)	<input type="checkbox"/> Primary dementia in combination with mental illness as certified by physician

Name of Individual:	Admitting Facility ID#:
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<b>PASRR Categorical Determinations</b> (certain circumstances that are time-limited that only require an abbreviated PASRR Level II evaluation report)	<input type="checkbox"/> Individual has a primary diagnosis of dementia, Alzheimer's disease or related disorder in combination with diagnosis of intellectual disability or related condition. (Further evaluation may be required for validation of diagnosis)
	<input type="checkbox"/> Individual admitted directly to LTC facility from hospital for convalescent care for an acute physical illness and is likely to require less than 90 days of NF services
	<input type="checkbox"/> Terminal illness, as certified by physician (life expectancy of less than six months)
	<input type="checkbox"/> Severe physical illness resulting in level of impairment so severe that individual needs LTC services but cannot be expected to benefit from specialized services.

Identify primary/secondary diagnosis, applicable code, and age of onset	Primary Diagnosis and Code (ICD-10)	Secondary Diagnosis and Code (ICD-10)	Date of Onset
Mental Illness			
Intellectual Disability			
Related Condition			
The individual has been referred for or has received services/treatment for mental illness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
The individual has been referred for or has received services/treatment for intellectual disability or related condition		<input type="checkbox"/> Yes	<input type="checkbox"/> No
The individual has a history or other indication of substance abuse disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any known or suspected diagnosis of mental illness, intellectual disability, substance abuse disorder, or related condition		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician's Name:		Date:	
Physician's Signature:			

Functional and Adaptive Needs (Check all that apply)		
Communication/Language	<input type="checkbox"/> unable to communicate basic needs	<input type="checkbox"/> does not participate in conversation
	<input type="checkbox"/> does not understand directions	<input type="checkbox"/> incoherent/bizarre speech content
Challenges with Practical Skills	<input type="checkbox"/> occupation skills	<input type="checkbox"/> use of money
	<input type="checkbox"/> safety	<input type="checkbox"/> healthcare and self-care
	<input type="checkbox"/> schedule/routines	<input type="checkbox"/> use of telephone
	<input type="checkbox"/> mobility/ travel/transportation	
Challenges with Conceptual Skills	<input type="checkbox"/> language and literacy	<input type="checkbox"/> time & number concepts
	<input type="checkbox"/> limitations in reasoning	<input type="checkbox"/> self- direction
	<input type="checkbox"/> learning, problem-solving	
Completion of Tasks/Activities	<input type="checkbox"/> difficulty completing	<input type="checkbox"/> slow pace to completion
	<input type="checkbox"/> makes mistakes/errors with tasks	<input type="checkbox"/> lacks persistence
	<input type="checkbox"/> needs assistance to complete	<input type="checkbox"/> difficulty concentrating
Harmful to Self or Others	<input type="checkbox"/> head bangs	<input type="checkbox"/> causes physical pain to others
	<input type="checkbox"/> hits, bites, or scratches self	<input type="checkbox"/> threatens physical violence
	<input type="checkbox"/> threatens physical violence	<input type="checkbox"/> suicidal ideation/attempt
Unusual Activities	<input type="checkbox"/> talks to self	<input type="checkbox"/> stares at objects or into space
	<input type="checkbox"/> makes faces or odd noises	<input type="checkbox"/> hallucinations or delusions

LTC-2 (Revised 09/28/2016)

2



Name of Individual:	Admitting Facility ID#:
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<b>Disruptive Behavior</b>	<input type="checkbox"/> challenging/combative <input type="checkbox"/> interferes with others <input type="checkbox"/> excessive irritability	<input type="checkbox"/> yells or screams <input type="checkbox"/> uncooperative <input type="checkbox"/> overly demanding
<b>Socially Inappropriate Behaviors</b>	<input type="checkbox"/> spits at others <input type="checkbox"/> verbally abusive <input type="checkbox"/> inability to follow rules <input type="checkbox"/> history of altercation	<input type="checkbox"/> social isolation <input type="checkbox"/> challenges with independent living <input type="checkbox"/> inappropriately touches self or others
<b>Withdrawn Behavior</b>	<input type="checkbox"/> difficulty interacting with others <input type="checkbox"/> sad or worried	<input type="checkbox"/> uninterested in activities <input type="checkbox"/> anxious or fearful
<b>Destructive to Property</b>	<input type="checkbox"/> defaces or breaks objects <input type="checkbox"/> tears or cuts materials	<input type="checkbox"/> attempts to burn objects
<b>Has Experienced Restrictive Interventions</b>	<input type="checkbox"/> interpersonal skills <input type="checkbox"/> restraints	<input type="checkbox"/> medication to control behavior
<b>Challenges with Social Skills</b>	<input type="checkbox"/> seclusion <input type="checkbox"/> social responsibility <input type="checkbox"/> self-esteem	<input type="checkbox"/> social problem-solving <input type="checkbox"/> vulnerable to manipulation by others
<b>Check all that were reviewed during PASRR Level I Screening</b>	<input type="checkbox"/> H&P (required) <input type="checkbox"/> Plan of Care <input type="checkbox"/> Current psychological evaluation (if applicable) <input type="checkbox"/> Other (specify):	

#### Signatures and Contact Information

*The State is responsible for the final determination regarding PASRR. If review of the Level I PASRR Screening indicates a need for a PASRR Level II evaluation, the State may require additional documentation, will complete the evaluation and make a determination regarding appropriate placement within 7-9 business days, and will notify all parties of the outcome.*

Name of person Completing this PASRR Level I Screening	Date	Telephone Number	Email
<b>Signature:</b>			

Name of Individual:	Admitting Facility ID#:
---------------------	-------------------------

**State of Alaska use only - Preadmission Screening and Resident Review Determination**

<b>Date Received:</b>		<b>Date Reviewed:</b>		<b>Date of Determination:</b>	
<b>Date of Admission:</b>					
<b>Name of SDS Reviewer:</b>				<b>Contact Information:</b>	
<b>Applicable Category</b>	<i>Based on the information reviewed by SDS, the following determination is made. If admission or continued placement for this individual is approved, all services as identified by the PASRR Level II evaluation must be provided, by collaborative effort with the state, to meet the individual's nursing and disability-specific needs. A copy of the PASRR evaluation report will be provided for inclusion in the medical record; the recommendations made in that report must be incorporated into the plan of care. A notice has been provided to the individual and/or his/her representative of the need for a Level II evaluation if applicable, and a summary of the PASRR Level II evaluation report.</i>				
<b>Negative Screen</b>	<input type="checkbox"/> PASRR Level I screening does <b>not</b> indicate need for Level II PASRR evaluation. Applicant may be admitted to the LTC facility.				
<b>Exempted Hospital Discharge</b>	<input type="checkbox"/> Placement in facility for 30 days or less, as certified by physician. If the individual stays beyond the 30 days, an individualized PASRR Level II evaluation must be completed by the state on or before the 40 <sup>th</sup> day. The facility shall notify SDS on day 25 that it anticipates the resident will need services more than 30 days. <b>Day 25 is:</b>				
<b>Primary Dementia/Mental Illness</b>	<input type="checkbox"/> Primary dementia in combination with mental illness. May be admitted to the LTC facility.				
<b>PASRR Categorical Determinations</b> (certain circumstances that are time-limited that require an abbreviated PASRR Level II evaluation report)	<input type="checkbox"/> Convalescent care for a period of 90 days or less, as certified by the physician. If the individual stays beyond the 90 days, an individualized PASRR Level II evaluation must be completed. The facility shall notify SDS on day 85 that it anticipates the resident will need services more than 90 days. <b>Day 85 is:</b>				
	<input type="checkbox"/> Primary dementia in combination with a diagnosis of intellectual disability or related condition applies. A Level II evaluation may be required, if there is a substantial change in condition.				
	<input type="checkbox"/> Terminal illness, as certified by attending physician. A Level II evaluation may be required, if there is a substantial change in condition.				
	<input type="checkbox"/> Severe physical illness. A Level II evaluation may be required, if there is a substantial change in condition.				
<b>Resident Review</b>	<input type="checkbox"/> May be considered appropriate for continued placement in the LTC facility, without specialized services for disability-specific needs. <input type="checkbox"/> May not continue to reside in LTC facility. Alternative placement and services are developed by the state in cooperation with the facility. Payment continues until transfer completed.				
<b>Level II PASRR Evaluation needed</b>	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Related condition		Date referred for Level II evaluation:  Date Level II report received:		

# Healthcare forms Order Request



P.O. Box 240808  
Anchorage, AK 99524-0808  
(907) 644-6800  
<http://medicaidalaska.com>

## HEALTHCARE FORMS ORDER REQUEST

Please order a 2-month supply.

Mail to: Conduent  
P.O. Box 240808  
Anchorage, AK 99524-0808

Allow approximately 4 weeks for delivery.

Ship to: \_\_\_\_\_

Attention: \_\_\_\_\_

Phone Number: \_\_\_\_\_

AK Medicaid Provider ID: \_\_\_\_\_

Number	Form Requested Description	Quantity				
		25	50	100	300	Other
UB-04	Institutional Claim Form (e.g., Inpatient/Outpatient Hospital, Home Health, Long Term Care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AK-04	Transportation/Accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AK-05	Adjustment/Void	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
J430	Dental Claim Form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AK-10	Child Health Screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AK-11	Claim Inquiry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AK-PA	Prior Authorization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CMS-1500	Non-Institutional Claim Form (e.g., Physician, Therapists, Nurse Practitioner)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Provider Billing Manual	Title of Manual or Provider Type (see reverse):					

\_\_\_\_\_  
*Signature of Provider or Authorized Person*

\_\_\_\_\_  
*Date of Request*

### For Conduent Use Only

Comments: \_\_\_\_\_

Date Shipped: \_\_\_\_\_ Shipped By: \_\_\_\_\_

Rev. 01/03/2017

Updated 01/03/2017

## 206

## Forms

# Glossary of Terms

## A

### **Adjudicated Claim**

A claim that has reached final disposition, being either paid or denied.

### **Adjustment/Void Request Form**

A form that a provider submits to the division to: a) change a paid claim line that was billed or processed incorrectly, b) void a paid claim line, or c) repay an overpayment to the division.

### **ABC Codes**

Alternative Billing Codes (ABC) consisting of five-character, alphabetic strings that identify services, remedies, and/or supplies. Codes are followed by two-character modifiers which identify the practitioner type that delivered the care.

### **AK-SA**

The Service Authorization Request form used to authorize medical services in advance, when required.

### **Alaska Medical Assistance Waiver**

Services to keep individuals with disabilities in their home communities and out of institutions, hospitals and nursing facilities. Alaska has three Home and Community-Based Waivers: waivers for children with complex medical conditions, waivers for children and adults with developmental disabilities, and waivers for adults with developmental disabilities who also have physical disabilities.

### **Alaska Medical Assistance Provider ID Number**

A unique identifier assigned upon enrollment with Alaska Medical Assistance. It is used for processing and tracking claims for a particular provider. The ID is usually between 6 and 8 characters in length. The first 2 characters are letters which indicate the provider type.

### **Alaska MMIS**

Alaska Medicaid Management Information System; claims processing.

### **Appeal**

An action taken by a provider who disagrees with a claim denial or reduced payment, non-certification of hospital admission or length of stay, denied or reduced SA request, non-certification of a service that requires certification by a quality improvement organization, denied enrollment, disenrollment, or disputed recoupment of an overpayment.

**AVRS (Automated Voice Recognition System)**

An automated telephone system maintained by Conduent to help providers determine the Alaska Medical Assistance eligibility of their patients.

**B****Beneficiary (more commonly called "Recipient")**

An individual eligible to receive medical services under Alaska Statutes.

**C****CAMA (Chronic and Acute Medical Assistance)**

See "Chronic and Acute Medical Assistance."

**CCN (Claim Control Number)**

An identification number assigned to each Alaska Medical Assistance claim submitted for processing, based upon the Julian calendar. Also referred to as "Internal Control Number" (ICN).

**Chronic and Acute Medical Assistance (CAMA)**

CAMA is a state-funded program designed to help needy Alaskans who have specific illnesses get the medical care they need to manage those illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Alaska Medical Assistance benefits, have very little income, and have inadequate or no health insurance.

**Claim Line**

A line item of a claim form identifying the services and/or charges for service for a single recipient from a single provider. A UB-04 claim (formerly UB-92), which is processed as one claim line, is an exception.

**CMS (Centers for Medicare and Medicaid Services)**

Formerly Healthcare Financing Administration (HCFA), CMS is the Centers for Medicare and Medicaid Services. CMS is the federal agency responsible for administering the Medicare, Medicaid, State Children's Health Insurance (SCHIP), Health Insurance Portability and Accountability Act (HIPAA), Clinical Laboratory Improvement Amendments (CLIA), and several other health-related programs.

**CMS-1500**

Formerly HCFA-1500. The Centers for Medicare and Medicaid Services' Claim form used to bill Alaska Medical Assistance for professional healthcare services.

**Conduent**

See "fiscal agent"

## **Cost Sharing**

Copayment. An established amount that is collected from some recipients by providers for some of Alaska Medical Assistance services. Payment to the provider is reduced by the cost sharing amount.

## **CPT® (Current Procedural Terminology)**

A listing of descriptive terms and identifying codes for reporting services and procedures performed by physicians. CPT is revised and published annually by the American Medical Association.

## **Crossover Claim**

A claim for services rendered to a recipient eligible for benefits under both Alaska Medical Assistance and Medicare programs. Medicare benefits must be processed prior to Alaska Medical Assistance benefits.

## **D**

### **Denali KidCare**

An Alaska Department of Health and Social Services Medical Assistance program to ensure that children and teenagers of both working and non-working families can have the health insurance they need. Denali KidCare provides excellent health insurance coverage for children and teenagers through age 18, and for pregnant women who meet income guidelines.

### **Denied Claim**

A claim for which no payment is made to the provider.

### **Department of Health and Human Services (DHHS)**

The department of the federal government that administers Medicare and Medicaid programs.

### **Department of Health and Social Services (DHSS)**

The department of Alaska State government responsible for State administration of assistance programs.

### **Division of Behavioral Health (DBH)**

The division within the Alaska Department of Health and Social Services responsible for administering outpatient mental health programs, inpatient psychiatric care, residential psychiatric treatment centers, program grants, and certifying substance abuse rehabilitation programs.

### **Division of Healthcare Services (DHCS)**

The division within the Alaska Department of Health and Social Services responsible for administering Alaska Medical Assistance and other Medical Assistance programs, including CAMA and Denali KidCare.

### **Division of Public Assistance (DPA)**

The division within the Alaska Department of Health and Social Services responsible for determining eligibility for the Alaska Medical Assistance Program.

**Division of Senior and Disabilities Services (DSDS)**

The division within the Alaska Department of Health and Social Services responsible for administering the Personal Care Assistant and Home and Community-Based Waiver programs as well as providing service authorization for long term care facilities.

**E****EDI (Electronic Data Interchange)**

The electronic submission of Medicaid claims for processing.

**Edit**

Verification of appropriateness of claim data.

**Effective Date (of Payments)**

The date on which a new or modified prospective payment rate is determined by the Department of Health and Social Services to be effective. [7 AAC 150.990]

**Eligibility Code**

A category of eligibility assigned to a recipient by the Alaska Division of Public Assistance, determining the type of medical services the recipient is eligible to receive.

**Eligible Recipient**

See "Recipient."

**EOB (Explanation of Benefits)**

A notice issued by an insurance company to the recipient or provider of Alaska Medical Assistance-covered services that explains the payment or non-payment of a specific claim processed.

**EOB Code**

An explanation code appearing on the Alaska Medical Assistance remittance advice for those claim charges denied or returned for correction.

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

A federally mandated program to prevent, or to identify early, and treat potentially disabling diseases and conditions in individuals less than 21 years of age as a more cost-effective way to provide medical aid to eligible recipients. The program includes an outreach component to identify eligible individuals, match them with providers, and enroll them in the program.

**Explanation of Benefits**

See "EOB."



## F

### Facility

An acute care hospital, specialty hospital, nursing facility, intermediate care facility for individuals with intellectual and developmental disabilities, psychiatric hospital, rural health clinic, or outpatient surgical clinic. [7 AAC 150.990]

### Family Planning (FP) Services

Those services and materials provided with the purpose of postponing, avoiding, or terminating pregnancy, including the dispensing of birth control drugs and devices for males and females, and the performance of vasectomies, sterilizations, and abortions for the purpose of avoiding or terminating pregnancy, except as limited under 7 AAC 120.140 (f) (2). [7 AAC 160.990]

### Federally Qualified Health Center (FQHC)

A facility that has filed an agreement with the Alaska Department of Health and Social Services to provide federally qualified health center services under Alaska Medical Assistance. [7 AAC 160.990]

### Federally Qualified Health Center (FQHC) Visit

The aggregate of face-to-face encounters, occurring on the same calendar day and at a single location, between a federally qualified health center patient and one or more federally qualified health center professionals. "Aggregate of face-to-face encounters" does **not** include:

- Multiple face-to-face encounters in which, after the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment;
- A face-to-face encounter for dental or mental health diagnosis or treatment that occurs on the same calendar day and single location as one or more face-to-face encounters for medical diagnosis or treatment; **or**
- Charity care as defined in 7 AAC 145.700.

### Fiscal Agent

A Fiscal Agent is an organization that reviews, processes and pays provider claims on behalf of the Alaska Department of Health and Social Services for Alaska Medical Assistance. Alaska's Fiscal Agent for Alaska Medical Assistance is Conduent.

### FP (Family Planning)

See "family planning services."

## H

### HCPCS

Healthcare Common Procedure Coding System. HCPCS is a set of healthcare procedure codes based on the American Medical Association's Current Procedural Terminology (CPT®). HCPCS includes three levels of codes:

- **Level I** consists of CPT codes. See "CPT® (Current Procedural Terminology)"
- **Level II** codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices.

- **Level III** codes, also called local codes, were eliminated.

## **Hospital**

A facility licensed by the Alaska Department of Health and Social Services to provide inpatient and outpatient hospital services. [7 AAC 160.990]

### **Hospital Inpatient/Outpatient Claim**

The UB-04 (formerly UB-92) used to bill inpatient hospital services.

## **I**

### **ICD (International Classification of Diseases)**

A classification and coding structure of diseases, published by the World Health Organization and used by the healthcare community to describe a patient's condition and illness and to facilitate the collection of statistical and historical data.

#### **ICD-10-CM (ICD-9-CM)**

ICD-10-CM (ICD-9-CM) is the coding classification system used to describe diseases and operations. It serves an important function for physician reimbursement, hospital payments, quality review, and benchmarking measurement.

#### **ICF (Intermediate Care Facility)**

A licensed facility certified to deliver intermediate care services. These services are the:

- Observation, assessment, and treatment of a recipient with a long-term illness or disability, whose condition is relatively stable and where the emphasis is on maintenance rather than rehabilitation, or
- Care for a recipient nearing recovery and discharge, whose condition is relatively stable but who continues to require professional medical or nursing supervision. [7 AAC 140.510]

#### **Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IDD)**

A facility certified as an intermediate care facility for individuals with intellectual and developmental disabilities or individuals with related conditions. [7 AAC 160.990]

#### **Indian Health Service (IHS)**

An agency within the Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. As the principal federal healthcare provider and health advocate, the goal of the IHS is to raise the health status of Indian and Native peoples to the highest possible level.

#### **Institutional Claim**

The UB-04 (formerly UB-92) claim form used by institutional providers for inpatient and outpatient billing.

#### **Interdisciplinary Team**

A group of caregivers from different specialties who work together to achieve a team-defined, favorable patient outcome. While representation of some disciplines is mandated by regulation or necessity, others

may participate if resources permit. For instance, a hospice team must include a physician, a registered nurse, a social worker, and a spiritual counselor. However, a physical therapist and home health representative might be welcome – although optional – additions. Ideally, the patient or patient's representative serves as a team member as well.

Each member of the interdisciplinary team must be qualified in terms of applicable education and training. If the individual's profession requires licensing or certification, that license or certification must be current. [7 AAC 12.327; 7 AAC 43.470; 7 AAC 160.990]

## **J**

### **Julian Date**

The consecutively numbered day of the calendar year. It is used to assign a claim control number to each claim submitted for Alaska Medical Assistance processing.

## **L**

### **Long Term Care Facility**

An intermediate care facility for individuals with a developmental disability, or a nursing facility.

### **LTC (Long Term Care)**

Medical care services performed in nursing homes. Refer to "Long Term Care Facility."

## **M**

### **Medicaid**

A joint federal and state assistance program created by Title XIX of the Social Security Act designed to pay for necessary, covered medical care for individuals who meet the program's eligibility requirements.

### **Medical Assistance Authorization**

A medical assistance card or coupon issued by the Alaska Division of Public Assistance, that identifies a recipient as being eligible for Alaska Medical Assistance, CAMA or Denali KidCare coverage during a specific time period.

### **Medicare Remittance Notice**

See "MRN."

### **MMIS (Medicaid Management Information System)**

See "Alaska MMIS."

### **MRN (Medicare Remittance Notice)**

Same as EOB, except notice is issued by Medicare.

## **N**

### **NDC**

National Drug Code. Each drug product listed is assigned an NDC code, a unique 11-digit, 3-segment number which identifies the labeler, product, and trade package size.

The **first** segment, the labeler code, is assigned by the FDA. A labeler is any firm (including a repacker or relabeler), that manufactures or distributes the drug under its own name.

The **second** segment, the product code, identifies a specific strength, dosage form, and formulation for a particular firm.

The **third** segment, the package code, identifies package size and type. Both the product and package codes are assigned by the firm.

## **O**

### **Outpatient Care**

Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.

### **Outpatient Surgical Clinic**

An ambulatory surgical center which operates as a distinct entity exclusively for the purpose of providing surgical services to patients not requiring hospitalization. [7 AAC 150.990]

## **P**

### **PA (Prior Authorization)**

Now called "Service Authorization" (see). [7 AAC 160.990]

### **Paid Claim**

A claim that has been processed through the system, approved for payment, and paid.

### **Patient Day**

A calendar day of inpatient care, including the day of admission and not the day of discharge. [7 AAC 150.990]

### **Pended Claim**

A claim that has failed to pass the system edits and requires manual intervention by state or fiscal agent personnel before continuing in the processing cycle.

### **Physician Collaborator**

- An advanced nurse practitioner, physician assistant, physical therapist, occupational therapist, or audiologist who is licensed or registered under AS 08 and who practices within the scope of that license or registration

- A speech pathologist who meets the requirements of 7 AAC 43.926(a) (1)(A)
- A nurse anesthetist who is licensed under AS 08 and certified to select and administer anesthetic and give anesthetic care, and who practices within the scope of that license and certification. [7 AAC 160.990]

### **Pricing Methodology**

The method for determining the allowable amount Alaska Medical Assistance will reimburse a provider for a specific service rendered to an eligible recipient.

### **Prior Authorization**

Now called “Service Authorization” (see). [7 AAC 160.990]

### **Prior Resource**

An alternative resource available to provide or pay for a service, which must be fully utilized before payment will be made on behalf of an eligible recipient by Alaska Medical Assistance.

### **Procedure Code**

A specific code (e.g., CPT, HCPCS, or ABC) given to each individual service or procedure, which is entered on a Alaska Medical Assistance claim by the provider to identify the services rendered to an eligible recipient.

### **Provider**

An individual, firm, corporation, association, or institution that provides or has been approved to provide medical assistance to a recipient under Alaska Medical Assistance. [7 AAC 160.990]

### **Provider Relations**

Communications between providers and the State (or State fiscal agent) involving provider training, provider recruitment, problem resolution, and other provider inquiries.

### **Psychiatric Facility**

A licensed hospital facility or part of a licensed hospital facility that is primarily for the diagnosis and treatment of mental, emotional, or behavioral disorders. [7 AAC 160.990]

## **R**

### **RA (Remittance Advice)**

The statement mailed to a provider detailing the charges pending, paid, denied, or returned. Explanation codes are included for those denied or returned for correction.

### **Recipient**

An individual eligible for Alaska Medical Assistance in accordance with State Statutes and certified as such by the State.

## **Remittance Advice**

See "RA."

## **Resource Code**

Medical insurance coverage other than Alaska Medical Assistance, identified on the recipient's Alaska Medical Assistance authorization card or coupon.

## **Rolling Year**

The twelve-month period commencing with the date of the initial examination, visit or treatment.

## **Rural Health Clinic**

A facility that has filed an agreement with the Alaska Department of Health and Social Services to provide rural health clinic services under Alaska Medical Assistance. [7 AAC 160.990]

## **Rural Health Clinic Visit**

The aggregate of face-to-face encounters, occurring on the same calendar day and at a single location, between a rural health clinic patient and one or more rural health clinic professionals. "Aggregate of face-to-face encounters" does **not** include:

- Multiple face-to-face encounters in which, after the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment
- A face-to-face encounter for dental or mental health diagnosis or treatment that occurs on the same calendar day and single location as one or more face-to-face encounters for medical diagnosis or treatment
- Charity care as defined in 7 AAC 145.700 [7 AAC 160.990]

## **S**

### **SA (Service Authorization)**

Service Authorization. Was previously called "Prior Authorization." [7 AAC 160.990]

### **Sanction**

A disciplinary action imposed by the State on providers or recipients as a result of having committed an offense against the program as outlined in the Alaska Administrative Code.

### **Service Authorization**

Approval by the department of a certain type and number of units of Alaska Medical Assistance-covered services before those services are provided. Was previously called "Prior Authorization." [7 AAC 160.990]

### **SNF (Skilled Nursing Facility)**

A licensed facility certified to deliver skilled nursing care services to medical care recipients under 7 AAC 140.515. These services are the observation, assessment, and treatment of a recipient's unstable condition requiring the care of licensed nursing personnel to identify and evaluate the recipient's need for

possible modification of treatment, the initiation of ordered medical procedures, or both until the condition improves to the point of stabilization. [7 AAC 140.515]

### **State Medicaid Plan**

The comprehensive written commitment by an Alaska Medical Assistance agency, submitted under Section 1903(a) of the Social Security Act, to administer or supervise the administration of an Alaska Medical Assistance Program in accordance with federal and state requirements.

### **SUR (Surveillance and Utilization Review)**

Review that builds a statistical base for healthcare delivery and utilization pattern profiles for both providers and recipients and generates a listing of potential abuses for review by State personnel.

## **T**

### **TEFRA**

Tax Equity and Fiscal Responsibility Act. This is an Alaska Medical Assistance Program for children under the age of 19 who meet certain medical and disability guidelines. Only the child's income and resources are considered in applying for TEFRA. The child's income may be no more than 300 percent of the federal poverty standard and her/his resources must be less than \$2,000.

### **Third-Party Liability (TPL)**

See "TPL."

### **Timely Filing**

All claims must be filed within twelve months of the date services were provided 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.

## **Title XIX**

Title Nineteen of the Social Security Act of 1965, which established Medicaid to provide medical assistance to certain low income needy individuals and families.

### **TPL (Third-Party Liability)**

Health insurance resources other than Alaska Medical Assistance which may or may not be responsible for at least partial payment of a claim.

## **U**

### **UB-04**

The Uniform Bill (claim form) used by institutional providers for institutional billing.

### **Unlisted Procedure Code**

A specific code (e.g., CPT, HCPCS, or ABC) designated for reporting an unlisted procedure. The use of an unlisted code on a claim form requires a written description by the provider of the service or procedure

rendered to an eligible recipient and the reason no other procedure code was appropriate for the service or procedure rendered. This information is to be attached to the claim when submitted.

## **V**

### **Verification**

The process of checking the accuracy and correctness of data.

Updated 03/09/2017



# Appendices

The following appendices are included in this manual:

- [Appendix A: Alaska Medical Assistance Acronyms and Abbreviations](#)
- [Appendix B: Directory Assistance](#)
- [Appendix C: Web site Navigation](#)
- [Appendix D: Julian Calendar](#)
- [Appendix E: Care Management](#)
- [Appendix F: Hospital Revenue Codes](#)
- [Appendix G: BHA CPT and HCPCS Codes](#)
- [Appendix H: CHA/P CPT, CDT, and HCPCS Codes](#)
- [Appendix I: Service Authorization Table for Prescription Drugs](#)
- [Appendix K: Tribal Transportation Service Areas](#)

# Appendix A

## Alaska Medicaid Abbreviations

The following list contains abbreviations commonly used with Alaska Medicaid. This list is not a legal document. Other commonly used abbreviations can be accessed at <http://cms.gov/apps/acronyms>.

AAC	Alaska Administrative Code
AK-PA	Alaska Prior Authorization form
ANP/NM	Advanced Nurse Practitioner/Nurse Midwife
AS	Alaska Statutes
AVRS	Automated Voice Response System
BAISA	Billing Agent Information Submission Agreement
CAMA	Chronic and Acute Medical Assistance
CCN	Claim Control Number
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendments
CMP	Care Management Program
CMS	Centers for Medicare and Medicaid Services
CMS-1500	Professional claim form (formerly HCFA-1500)
COBA	Coordination of Benefits Agreement
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPT-4	Current Procedural Terminology, Fourth Edition
DBH	Division of Behavioral Health
DEA	Drug Enforcement Agency
DEM	Direct Entry Midwife
DHCS	Division of Health Care Services
DHHS	Department of Health and Human Services

DHSS	Department of Health and Social Services
DKC	Denali KidCare
DME	Durable Medical Equipment
DOB	Date of Birth
DOH	Department of Health
DPA	Division of Public Assistance
DRA	Deficit Reduction Act
DRG	Diagnosis-Related Group
DSDS	Division of Senior and Disabilities Services
Dx	Diagnosis
E/M	Evaluation and Management (Codes)
EC	Eligibility Code
ECCS	Electronic Commerce Customer Support
EDI	Electronic Data Information/Interchange
EIN	Employer Identification Number
EMC	Electronic Media Claim
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits/Explanation of Medical Benefits
EPS	Enhanced Provider Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ESRD	End-Stage Renal Disease
FDA	Food and Drug Administration
FHSC	First Health Services Corporation (First Health)
FP	Family Planning Services
GAO	Government Accountability Office
HCFA	Health Care Financing Administration
HCP	Health Care Provider

HCPCS	Healthcare Common Procedure Coding System
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIPDB	Healthcare Integrity & Protection Database
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
ICF	Intermediate Care Facility
ICF-MR	Intermediate Care Facility for the Mentally Retarded
ICN	Internal Control Number
LOC	Level of Care
LOS	Length of Stay
LTC	Long-Term Care
MCI	Medicaid Contract ID
MFCU	Medicaid Fraud Control Unit
MIP	Medicare Integrity Program/Medicaid Integrity Program
MMIS	Medicaid Management Information System
MRN	Medicare Remittance Notice
NCPDP	National Council for Prescription Drug Program
NDC	National Drug Code
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OIG	Office of Inspector General
OTC	Over-The-Counter
PA	Prior Authorization
PCP	Primary Care Physician
PDL	Preferred Drug List
PERM	Payment Error Rate Measurement

PISA	Provider Information Submission Agreement
POC	Plan of Care
PPO	Preferred Provider Organization
PT	Provider Type
QC	Quality Control
QMB	Qualified Medicare Beneficiary
RA	Remittance Advice
RPTC	Residential Psychiatric Treatment Center
RTD	Resubmission Turnaround Document
SCHIP	State Children's Health Insurance Program (also known as Denali KidCare)
SI	Severity of Illness
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income
SUR	Surveillance and Utilization Review
TEFRA	Tax Equity and Fiscal Responsibility Act
TOS	Type of Service
TPL	Third Party Liability
UB-04	Institutional claim form (replaced UB-92)
UCF	Universal Claim Form

# Appendix B

## Directory Assistance for the State of Alaska

### Medicaid Provider Fraud Control Unit, Department of Law

To report fraud and abuse of the Medicaid program by providers:

Medicaid Provider Fraud Control Unit  
State of Alaska, Department of Law  
Criminal Division  
310 K Street, Suite 300  
Anchorage, AK 99501-2043                      Anchorage                      907.269.6279

### Fraud Control Unit, Division of Public Assistance, Department of Health and Social Services

To report fraud and abuse of Medicaid and other public assistance programs by recipients

Fraud Control Unit	Toll Free	800.478.6406
State of Alaska, DHSS	Anchorage	907.269.1060
Division of Public Assistance	Wasilla	907.352.2534
3601 C Street, Suite 200	Kenai	907.283.2947
Anchorage, AK 99503-2043	Fairbanks	907.451.2802

Updated 01/12

### Office of the Commissioner/Department of Health and Social Services

350 Main Street, Room 404  
P.O. Box 110601  
Juneau, AK 99811-0601                      907.465.3030

Updated 07/08

### Office of Children's Services/Department of Health and Social Services

3025 Clinton Drive, 1<sup>st</sup> floor  
P.O. Box 110630  
Juneau, AK 99811-0630                      907.465.1650

Infant Learning Program  
323 E. 4<sup>th</sup> Ave  
Anchorage, AK 99501                      907.269.8442

WIC-Family Nutrition  
130 Seward Street, 5th Floor  
P.O. Box 110612  
Juneau, AK 99811-0630                      907.465.3100

Updated 01/12

**Division of Behavioral Health (Substance Abuse and Mental Health Services)**

P.O. Box 110620  
Juneau, AK 99811-0620 907.465.3370

Updated 07/08

**Division of Health Care Services**

4501 Business Park Boulevard, Suite 24  
Anchorage, AK 99503-7167 907.334.2400

Medicaid  
4501 Business Park Boulevard, Suite 24  
Anchorage, AK 99503-7167 907.334.2400

Denali KidCare  
P.O. Box 240047  
Anchorage, AK 99524-0047 907.269.6529

Health Facilities Licensing and Certification  
4501 Business Park Boulevard, Suite 24  
Anchorage, AK 99503-7167 907.334.2483

Chronic and Acute Medical Assistance (CAMA)  
800.780.9972

Breast and Cervical Cancer Screening  
907.269.8069

Infant Screening and Testing Programs  
907.269.3400

Genetic and Specialty Clinics, Family Planning  
907.269.3499

Medical Care Advisory Committee  
4431 North Franklin, Suite 200 907.451.2014  
Juneau, AK 99801 Fax 907.465.4410  
[mcacwebsites@alaska.gov](mailto:mcacwebsites@alaska.gov)

Nutrition Services Office  
907.465.3100

Early Screening Travel Program  
4501 Business Park Boulevard, Suite 24  
Anchorage, AK 99503-7167 907.269.4575

Updated 01/12

**Division of Public Assistance (DPA) District Offices**

Anchorage District Office		907.269.6599
400 Gambell Street	Toll Free	888.876.2477
Anchorage, AK 99501	Fax	907.269.6520
Bethel District Office		907.543.2686
P. O. Box 365	Toll Free	800.478.2686
Bethel, AK 99559-0365	Fax	907.543.2650
Eagle River Job Center		
11723 Old Glenn Hwy., Space B-4		907.694.7006
Eagle River, AK 99577	Fax	907.694.1490
Fairbanks District Office		907.451.2850
675 7th Avenue, Station D	Toll Free	800.478.2850
Fairbanks, AK 99701-4592	Fax	907.451.2923
Homer District Office		907.266.3040
3670 Lake Street, Suite 200	Toll Free	877.235.2421
Homer, AK 99603-7559	Fax	907.235.6176
Kenai Peninsula Job Center		907.283.2900
11312 Kenai Spur Highway, Suite 2	Toll Free	800.478.9032
Kenai, AK 99611-9106	Fax	907.283.6619
Ketchikan District Office		907.225.2135
2030 Sea Level Drive, Suite 301	Toll Free	800.478.2135
Ketchikan, AK 99901-6073	Fax	907.247.2135
Kodiak District Office		907.486.3783
307 Center Street	Toll Free	888.480.3783
Kodiak, AK 99615-6315	Fax	907.486.3116
Kotzebue District Office		907.442.3451
P.O. Box 1210	Toll Free	800.478.3451
Kotzebue, AK 99752-1210	Fax	907.442.2151
Mat-Su District Office		907.376.3903
855 W. Commercial Drive	Toll Free	800.478.7778
Wasilla, AK 99654	Fax	907.373.1136
Muldoon Job Center		
1251 Muldoon Rd., Suite 111-B	Toll Free	907.269.0001
Anchorage, AK 99504-2095	Fax	907.269.0070



Nome District Office		907.443.2237
P.O. Box 2110	Toll Free	800.478.2236
Nome, AK 99762-2110	Fax	907.443.2307
 Sitka District Office		 907.747.8234
201 Katlian Street, Suite 107	Toll Free	800.478.8234
Sitka, AK 99835-7511	Fax	907.747.8224

Updated 01/12

#### **Division of Public Assistance (DPA) Regional Offices**

Central Office		
P.O. Box 110640		
Juneau, AK 99811-0640		907.465.3347
 Juneau Field Office		 
SE APA & Specialized Med		907.465.3537
10002 Glacier Highway, Suite 201	Toll Free	800.478.3537
Juneau, AK 99801-1149	Fax	907.465.4657

Updated 06/08/2018

#### **Division of Public Health (DPH)**

350 Main Street, Room 508		
P.O. Box 110610		907.465.3090
Juneau, AK 99811-0610	Fax	907.465.1733
 Injury Prevention & EMS		 907.465.3027
 Epidemiology		 907.269.8000
	Toll-Free/After Hrs	800.478.0084
	Fax	907.562.7802
 Laboratories		 907.334.2109
 Public Health Nursing		 907.465.3150
	Toll Free	800.499.2964
	Fax	907.465.3913
 State Medical Examiner		 907.334.2200
 Vital Statistics		 
	Juneau	907.465.3391
	Fax	907.465.3618

Anchorage	907.269.0991
Fax	907.269.0994
Fairbanks	907.452.4863
Fax	907.452.4872

Updated 07/08

## Division of Senior and Disabilities Services

3601 C Street, Suite 310	907.269.3665
Anchorage, AK 99503-5984	907.269.3680

Toll-Free	800.478.9996
Fax	907.269.3688

Developmental Disabilities	Juneau	907.465.3135
	Toll Free	866.465.3165
	Fax	907.465.2677
	Anchorage	907.269.3666
	Toll Free	800.478.9996
	Fax	907.269.3689
	Fairbanks	907.451.5045
	Toll-Free	800.770.1672
Fax	907.451.5046	

## Governor's Council on Disabilities and Special Education

	907.269.8990
Toll Free	888.269.8990
Fax	907.269.8995

Home and Community-Based Services	907.465.3250
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Personal Care Assistant Program		907.269.3666
	Toll-Free	800.478.9996
	Fax	907.269.8164

Assisted Living Licensing	907.269.3640
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Alaska Medicare		907.269.3680
	Toll-Free	800.478.6065
	Fax	907.269.4973

Adult Protective Services		907.269.3666
	Toll-Free	800.478.9996
	Fax	907.269.3648

Updated 01/12

**American Medical Association**

Order Department

P.O. Box 10950

Chicago, IL 60610-0950

Toll-Free

800.621.8335

Updated 07/08

**American Society of Anesthesiologists Publications**

520 Northwest Highway

Park Ridge, IL 60068-2573

Fax

847.825.5586

847.825.1692

Updated 07/08

**American Speech-Language-Hearing Association**

2200 Research Blvd.

Rockville, MD 20850-3289

Members

800.498.2071

Non-Members

800.638.8255

Fax

301.296.8580

Updated 07/08

**Municipality of Anchorage Health and Human Services Commission**

P.O. Box 196650

Anchorage, AK 99519-6650

907.343.4619

Updated 07/08

**CCH (formerly Commerce Clearing House, Inc.)**

4025 W. Peterson Avenue

Chicago, IL 60646-6085

Toll-Free

888.224.7377

Fax

800.224.8299

Updated 07/08

# Appendix C

## Web Addresses

### **Adult Protective Services**

<http://www.hss.state.ak.us/dsds/aps.htm>

### **Alaska Administrative Code (AAC)**

<http://www.legis.state.ak.us/cgi-bin/folioisa.dll/aac>

### **Alaska Statutes (AS)**

<http://www.legis.state.ak.us/folhome.htm> or email [library@courts.state.ak.us](mailto:library@courts.state.ak.us) (for official, printed versions of current and superseded Alaska Statutes (AS), regulations (AAC), and court rules)

### **Alternate Billing Codes (ABC)**

[http://www.alternativelink.com/ali/abc\\_codes/code\\_struct.asp](http://www.alternativelink.com/ali/abc_codes/code_struct.asp)

### **American Medical Association (AMA)**

<http://www.ama-assn.org>

### **American Society of Anesthesiologists (ASA) Publications**

<http://www2.asahq.org/publications>

### **American Speech-Language-Hearing Association (ASHA)**

<http://www.asha.org/default.htm>

### **Anchorage Health and Human Services**

<http://www.muni.org/health1/index.cfm>

### **Breast and Cervical Health Check (BCHC)**

<http://www.hss.state.ak.us/dph/wcfh/BCHC/provider/default.htm>

### **Case Management Services**

[http://hss.state.ak.us/dhcs/Medicaid\\_Medicare/caseman\\_medicaid\\_qualis.htm](http://hss.state.ak.us/dhcs/Medicaid_Medicare/caseman_medicaid_qualis.htm)

### **Center for Medicare and Medicaid Services (CMS)**

<http://www.cms.hhs.gov/>

**Certification and Licensing**

<http://www.hss.state.ak.us/dph/CL/default.htm>

**Chronic and Acute Medical Assistance (CAMA)**

<http://hss.state.ak.us/dhcs/CAMA/default.htm>

**Code of Federal Regulations (CFR)**

<http://www.gpoaccess.gov/cfr/index.html>

**Commerce Clearing House, Inc. (CCH)**

<http://health.cch.com/>

**Current Procedural Terminology (CPT)**

<http://www.ama-assn.org/ama/pub/category/3113.html>

**Denali KidCare (DKC)**

[http://www.hss.state.ak.us/dhcs/denalikidcare/contact\\_dkc.htm](http://www.hss.state.ak.us/dhcs/denalikidcare/contact_dkc.htm)

**Department of Health and Social Services (DHSS)**

<http://www.hss.state.ak.us>

**Division of Behavioral Health (DBH)**

<http://www.hss.state.ak.us/dbh>

**Division of Health Care Services (DHCS)**

<http://www.hss.state.ak.us/dhcs>

**Division of Public Assistance (DPA)**

<http://www.hss.state.ak.us/dpa>

**Division of Public Health (DPH)**

<http://www.hss.state.ak.us/dph/>

**Division of Senior and Disabilities Services (DSDS)**

<http://www.hss.state.ak.us/dsds>

**Early Periodic Screening Diagnosis Treatment (EPSDT)**

[http://dhss.alaska.gov/dhcs/Pages/epsdt\\_hcs.aspx](http://dhss.alaska.gov/dhcs/Pages/epsdt_hcs.aspx)

**Epidemiology**

<http://www.epi.hss.state.ak.us/default.jsp>

**Family Planning**

<http://www.hss.state.ak.us/dph/wcfh/familyplan.htm>

**First Health Services Corporation**

<http://alaska.fhsc.com>

**Governor's Council on Disabilities and Special Education**

<http://www.hss.state.ak.us/gcdse>

**Healthcare Common Procedure Coding System (HCPCS)**

<http://www.ama-assn.org/ama/pub/category/9525.html>

**Help and Resources Beyond Medicaid and CAMA**

[http://hss.state.ak.us/dhcs/medicaid\\_medicare/helpbeyond\\_hcs.htm](http://hss.state.ak.us/dhcs/medicaid_medicare/helpbeyond_hcs.htm)

**Indian Health Service (IHS)**

<http://www.ihs.gov>

**Infant Screening and Testing**

[http://www.hss.state.ak.us/dph/wcfh/screening\\_testing.htm](http://www.hss.state.ak.us/dph/wcfh/screening_testing.htm)

**International Classification of Diseases (ICD)**

<http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/>

**Medicaid**

[http://www.hss.state.ak.us/dhcs/Medicaid\\_Medicare/](http://www.hss.state.ak.us/dhcs/Medicaid_Medicare/)

**Nutrition Services**

<http://www.hss.state.ak.us/dpa/programs/nutri/default.htm>

**Office of Children's Services (OCS)**

<http://www.hss.state.ak.us/ocs>

**Payment Error Rate Measurement (PERM)**

<http://hss.state.ak.us/perm/default.htm>

**Personal Care Assistant (PCA) Program**

<http://www.hss.state.ak.us/dsds/pca/default.htm>

**Preferred Drug List (PDL)**

<http://dhss.alaska.gov/dhcs/Pages/pdl/default.aspx>

**Public Health Nursing**

<http://www.hss.state.ak.us/dph/nursing>

**Qualis Health**

<http://www.qualishealth.org>

**Regulation Changes**

<http://www.hss.state.ak.us/apps/publicnotice/>

**Transportation**

[http://hss.state.ak.us/dhcs/medicaid\\_medicare/transportation\\_medaid.htm](http://hss.state.ak.us/dhcs/medicaid_medicare/transportation_medaid.htm)

**Women, Infants and Children (WIC)**

<http://www.hss.state.ak.us/dpa/programs/nutri/WIC/default.htm>

**Women's, Children's, and Family Health Programs**

<http://www.hss.state.ak.us/dph/wcfh/programs.htm>

# Appendix D

## Julian Calendar

The Julian Date Calendar is useful in determining what day your claim was received by Conduent for processing.

Each claim receives a Transaction Control Number (TCN) with a portion of the TCN corresponding to the Julian date on which the claim was received for processing. The format of this number is YYJJxxxxxxxxxxx. The first two digits are the last two digits of the year and the Julian date the claim was submitted. For example, the TCN 16123456789012340 was submitted on day number 123 of the year 2016.

For a Leap Year, one day must be added to the Julian date number after February 28. The fifth through the seventeenth digits of the TCN are assigned by Conduent to identify the during the adjudication process.

JULIAN DATE CALENDAR PERPETUAL													
Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

For a leap year, one day must be added to the Julian date number after February 28. The fifth through the seventeenth digits of the TCN are assigned by Conduent to identify the claim during the adjudication process.



JULIAN DATE CALENDAR LEAP YEARS													
Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31

Updated 06/08/2018

# Appendix E

## Care Management Program

### Purpose

The purpose of the Care Management Program (CMP) is to assist recipients of Alaska Medical Assistance in obtaining uncompromised healthcare. This program helps to ensure continuity and coordination of care for the recipient and promotes communication between physicians and pharmacies on behalf of those selected for the program. The Alaska Administrative Code (7 AAC 43.027) provides the Division of Health Care Services the authority to restrict selected recipients to one primary physician and one pharmacy.

Updated 03/06

### Background

The Care Management Program was previously known to providers and recipients as the Lock In Program. Although many components of the program remain the same, the name change reflects the mission of this revised program. A recipient's medical usage is monitored through the Division of Health Care Services Surveillance and Utilization Review Subsystem (SURS). SURS is a management subsystem of our Medical Management Information System (MMIS) that uses Medical Assistance health care data and statistics to establish norms of care within peer groups in order to detect excessive, improper or unusual utilization of services.

Updated 03/06

### Selection of Care Management Program Participants

SURS will be used to select recipients that are potential candidates for the Care Management Program. Providers may contact the program when they have a patient that they think may benefit from the program as well. A utilization review will be completed to check the recipient's pattern of use to determine if the criteria have been met for placement. The review also includes a review of medical records from providers and pharmacies that encompass the most recent 15 months in question. After the above steps are completed, a determination will be made by the Care Management Program regarding placement of the recipient into the program.

Updated 03/06

### Notification to Care Management Program Providers

The Care Management Program coordinators will personally contact each selected primary care provider regarding placement of recipients. If the provider agrees to accept a recipient and become their primary care provider, that provider will receive a letter detailing the placement start date and the reason the recipient was placed in the Care Management Program.

Updated 03/06

## Notification to Selected Recipients

The Care Management Program coordinators will notify each recipient prior to their placement in the program. This notice will include a copy of the reviews that were done which define what areas were over-utilized and why they have been selected for placement. This notification will also include their Fair Hearing Rights if the recipient disagrees with the determination.

Updated 03/06

## Duration

Recipients will remain in the Care Management Program for twelve months. Prior to the completion of twelve months, the Care Management Program will once again review the patterns of utilization for each recipient. At that time, the provider will be sent a questionnaire form asking if (1) their patient has benefited from the placement into the Care Management Program and (2) if the provider feels that the recipient would continue to benefit from the program. If continued placement is warranted due to utilization and provider recommendation, the recipient could continue in the program.

The recipient's utilization will continue to be monitored after the recipient is released from the Care Management Program after a six month period.

Updated 03/06

## Coupons for Care Management Program Recipients

After a provider agrees to accept a specific Care Management recipient, they will become the only provider that recipient may see without a referral. A special coupon will be printed and sent to the recipient each month. These easily recognizable coupons are printed on pink paper and identify the recipient's assigned primary care physician and pharmacy. The Eligibility Verification System (EVS) also lists the selected primary care providers for each recipient. Checking the recipient's status on EVS, as well as recognizing the distinctive appearance of the Care Management Medical Assistance coupons will alert new providers that the patient is restricted. If the restricted patient goes to another provider for non-emergency care without a referral from their primary care provider, the recipient will be responsible for payment of fees incurred with that visit.

Updated 03/06

## Care Management Provider Exceptions

### Referrals to Other Providers

If necessary, the primary care provider may refer the recipient to another provider. The provider must give a copy of the referral letter or note to present to the referred provider as well as a copy for the recipient to present to the pharmacy.

If you are the provider that is seeing a Care Management recipient as a referral, you must enter the name of the referring provider and Medicaid ID number in Field 17a on the claim form. The receiving provider must attach a copy of the referral letter for the date of service on their claim form.

Updated 03/06

## Prescriptions from Referred Providers

The pharmacy must acquire an override to fill any prescription from a referred provider. The pharmacy must contact the Pharmacy Technical Help Desk at (800) 884-7387 to inform them that they have received a prescription from a referred provider and require an override.

After the Help desk has given the pharmacy the override to fill the prescription, the pharmacy will place a copy of the referral in the recipient's file. Refer to the [Pharmacy Billing Manual](#) for details regarding billing for Care Management recipient prescriptions.

Updated 03/06

## Emergency Room Visits

A recipient may receive medical care from an emergency room if they have a life-threatening emergency<sup>1</sup>. The emergency services provider must attach a copy of the recipient's emergency room records for the date of service on their claim form.

Updated 03/06

## Coordination and Contact

Providers can write, call, fax, or speak with an ACS CMP coordinator to refer recipients to the Care Management Program. When making a referral to the Care Management Program, providers should identify the individual by name and Medical Assistance identification number.

**Phone:** (907) 644-6842 or (800) 770-5650

**Fax:** (907) 644-8128

**Write:** Affiliated Computer Services, Inc.  
Alaska Medicaid Care Management Program  
P.O. Box 240808  
Anchorage, AK 99524-9985

**Email:** [SUR-AK@acs-inc.com](mailto:SUR-AK@acs-inc.com)

If you have further questions about the Care Management Program or wish to discuss a specific case, please contact Affiliated Computer Services, Inc..

Updated 02/09

<sup>1</sup> "Emergency" means the sudden and unexpected onset of an illness or accidental injury, requiring medical attention immediately 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.

NIMI		MEDICAL INSURANCE MANUAL ISSUANCE		052705 11:19	
RECIPIENT		D.O.B.		ELIG	PGM/ RE
I.D.	RECIPIENT NAME	MM DD YY SEX		CODE	MEDSB SRCE(S)
060000000X	Doe, Johnna	05 17 58 F		20 ME	AP A2

PO BOX		*****			
WASILLA	AK99629	*THIS AUTHORIZATION GOOD FOR*		VILL:	J21
		* BENEFIT MONTH 0605 ONLY: *		DIST:	077
		*****			

SPECIAL INFORMATION (OPTIONAL)		RESTRICTED TO THE FOLLOWING PRIMARY CARE:			
		PHYSICIAN: DR. SOANSO MD0000			
		PHARMACY: FILL-MEDS-HERE INC. PH0000			

AUTHORIZATION SIGNATURE: JG8		DOCUMENT#	M8177495
*** STATE OF ALASKA ***		ISSUANCE INDICATOR:	F

RESTRICTED

## Care Management Program Coupon

# Appendix F

## Hospital Revenue Codes

Code Range	Description																				
01	Total Charge																				
10X	<b>Room and Board: All Inclusive and Ancillary Charges</b> (Flat fee charge based on either daily or total stay for services rendered. Charge may cover room and board plus ancillary services or room and board only.)																				
	<table><tr><th>Subcategory ("X" =)</th><th>Standard Abbreviation</th></tr><tr><td>0 = All-inclusive Room and Board + Ancillary</td><td>"ALL INCL R&amp;B/ANC"</td></tr><tr><td>1 = All-inclusive Room and Board</td><td>"ALL INCLUDE R&amp;B"</td></tr></table>	Subcategory ("X" =)	Standard Abbreviation	0 = All-inclusive Room and Board + Ancillary	"ALL INCL R&B/ANC"	1 = All-inclusive Room and Board	"ALL INCLUDE R&B"														
Subcategory ("X" =)	Standard Abbreviation																				
0 = All-inclusive Room and Board + Ancillary	"ALL INCL R&B/ANC"																				
1 = All-inclusive Room and Board	"ALL INCLUDE R&B"																				
11X	<b>Room and Board: Private, Medical or General</b> (Routine service charges for single-bed room; use of this revenue code requires medical justification)																				
	<table><tr><th>Subcategory ("X" =)</th><th>Standard Abbreviation</th></tr><tr><td>0 = General Classification</td><td>"ROOM-BOARD/PVT"</td></tr><tr><td>1 = Medical/Surgical/Gyn</td><td>"MED-SUR-GY/PVT"</td></tr><tr><td>2 = Obstetric</td><td>"OB/PVT"</td></tr><tr><td>3 = Pediatric</td><td>"PEDS/PVT"</td></tr><tr><td>4 = Psychiatric</td><td>"PSYCH/PVT"</td></tr><tr><td>5 = Hospice</td><td>"HOSPICE/PVT"</td></tr><tr><td>6 = Detoxification</td><td>"DETOX/PVT"</td></tr><tr><td>7 = Oncology</td><td>"ONCOLOGY/PVT"</td></tr><tr><td>9 = Other</td><td>"OTHER/PVT"</td></tr></table>	Subcategory ("X" =)	Standard Abbreviation	0 = General Classification	"ROOM-BOARD/PVT"	1 = Medical/Surgical/Gyn	"MED-SUR-GY/PVT"	2 = Obstetric	"OB/PVT"	3 = Pediatric	"PEDS/PVT"	4 = Psychiatric	"PSYCH/PVT"	5 = Hospice	"HOSPICE/PVT"	6 = Detoxification	"DETOX/PVT"	7 = Oncology	"ONCOLOGY/PVT"	9 = Other	"OTHER/PVT"
Subcategory ("X" =)	Standard Abbreviation																				
0 = General Classification	"ROOM-BOARD/PVT"																				
1 = Medical/Surgical/Gyn	"MED-SUR-GY/PVT"																				
2 = Obstetric	"OB/PVT"																				
3 = Pediatric	"PEDS/PVT"																				
4 = Psychiatric	"PSYCH/PVT"																				
5 = Hospice	"HOSPICE/PVT"																				
6 = Detoxification	"DETOX/PVT"																				
7 = Oncology	"ONCOLOGY/PVT"																				
9 = Other	"OTHER/PVT"																				
12X	<b>Room and Board: Semi-private (Two Bed), Medical or General</b> (Routine service charges for two-bed room)																				
	<table><tr><th>Subcategory ("X" =)</th><th>Standard Abbreviation</th></tr><tr><td>0 = General Classification</td><td>"ROOM-BOARD/SEMI"</td></tr><tr><td>1 = Medical/Surgical/Gyn</td><td>"MED-SUR-GY/2BED"</td></tr><tr><td>2 = Obstetric</td><td>"OB/2BED"</td></tr></table>	Subcategory ("X" =)	Standard Abbreviation	0 = General Classification	"ROOM-BOARD/SEMI"	1 = Medical/Surgical/Gyn	"MED-SUR-GY/2BED"	2 = Obstetric	"OB/2BED"												
Subcategory ("X" =)	Standard Abbreviation																				
0 = General Classification	"ROOM-BOARD/SEMI"																				
1 = Medical/Surgical/Gyn	"MED-SUR-GY/2BED"																				
2 = Obstetric	"OB/2BED"																				

3 = Pediatric	"PEDS/2BED"
4 = Psychiatric	"PSYCH/2BED"
5 = Hospice	"HOSPICE/2BED"
6 = Detoxification	"DETOX/2BED"
7 = Oncology	"ONCOLOGY/2BED"
8 = Rehabilitation	"REHAB/2 BED"
9 = Other	"OTHER/2BED"

**13X Room and Board: Three and Four Bed**  
(Routine service charges for three-bed or four-bed room)

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"ROOM-BOARD/3&4BED"
1 = Medical/Surgical/Gyn	"MED-SUR-GY/3&4"
2 = Obstetric	"OB/3&4BED"
3 = Pediatric	"PEDS/3&4BED"
4 = Psychiatric	"PSYCH/3&4BED"
5 = Hospice	"HOSPICE/3&4BED"
6 = Detoxification	"DETOX/3&4BED"
7 = Oncology	"ONCOLOGY/3&4BED"
9 = Other	"OTHER/3&4BED"

**15X Room and Board: Ward, Medical or General**  
(Routine service charges for room with five or more beds)

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"ROOM-BOARD/WARD"
1 = Medical/Surgical/Gyn	"MED-SUR-GY/WARD"
2 = Obstetric	"OB/WARD"
3 = Pediatric	"PEDS/WARD"
4 = Psychiatric	"PSYCH/WARD"
5 = Hospice	"HOSPICE/WARD"
6 = Detoxification	"DETOX/WARD"
7 = Oncology	"ONCOLOGY/WARD"
9 = Other	"OTHER/WARD"

**16X Other Room and Board**  
(Routine service charges for accommodations that cannot be included in the more

specific revenue codes; \* sterile environment is to be used by hospitals that are currently separating this charge for billing.)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"R&B"
4 = Sterile Environment *	"R&B/STERILE"
7 = Self Care	"R&B/SELF"
9 = Other	"R&B/OTHER"

## 17X

### Nursery

(Charges for nursing care to newborn and premature infants in nurseries)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"NURSERY"
1 = Newborn	"NURSERY/NEWBORN"
2 = Premature	"NURSERY/PREMIE"
3 = Newborn - Level III	"NURSERY/LEVEL III"
4 = Newborn - Level IV	"NURSERY/LEVEL IV"
5 = Neonatal ICU	"NURSERY/ICU"
9 = Other	"NURSERY/OTHER"

## 20X

### Intensive Care

(Routine service charges for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"INTENSIVE CARE" or "ICU"
1 = Surgical	"ICU/SURGICAL"
2 = Medical	"ICU/MEDICAL"
3 = Pediatric	"ICU/PEDS"
4 = Psychiatric	"ICU/PSYCH"
6 = Post ICU	"POST ICU"
7 = Burn Care	"ICU/BURN CARE"
8 = Trauma	"ICU/TRAUMA"
9 = Other Intensive Care	"ICU/OTHER"

## 21X

### Coronary Care

(Routine service charges for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit)

Subcategory ("X" =)	Standard Abbreviation
---------------------	-----------------------



0 = General Classification	"CORONARY CARE" or "CCU"
1 = Myocardial Infarction	"CCU/MYO INFARC"
2 = Pulmonary Care	"CCU/PULMONARY"
3 = Heart Transplant	"CCU/TRANSPLANT"
4 = Post CCU	"POST CCU"
9 = Other Coronary Care	"CCU/OTHER"

**25X**
**Pharmacy**

(Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed, and distributed under the direction of licensed pharmacist)

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"PHARMACY"
1 = Generic Drugs	"DRUGS/GENERIC"
2 = Non-generic Drugs	"DRUGS/NONGENERIC"
4 = Drugs Incident to Other Diagnostic Services	"DRUGS/INCIDENT OTHER DX"
5 = Drugs Incident to Radiology	"DRUGS/INCIDENT RAD"
7 = Non-prescription	"DRUGS/NONPSCRIPT"
8 = Intravenous Solutions	"IV SOLUTIONS"

**26X**
**IV Therapy**

(Charges for equipment or administration of intravenous solution by specially trained personnel to individuals requiring such treatment; used only when a discrete service unit exists.)

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"IV THERAPY"
1 = Infusion Pump	"IV THER/INFSN PUMP"
2 = IV Therapy/Pharmacy Svcs	"IV THER/PHARM/SVC"
3 = IV Therapy/Drug/Supply Delivery	"IV THER/DRUG/SUPPLY DELV"
4 = IV Therapy/Supplies	"IV THER/SUPPLIES"
9 = Other IV Therapy	"IV THERAPY/OTHER"

**27X**
**Medical/Surgical Supplies and Devices**

(Charges for supply items required for patient care)

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"MED-SUR SUPPLIES"

1 = Non-sterile Supply	"NON-STER SUPPLY"
2 = Sterile Supplies	"STERILE SUPPLY"
4 = Prosthetic/Orthotic Devices	"PROSTHE/ORTH DEV"
5 = Pacemaker	"PACE MAKER"
6 = Intraocular Lens	"INTRA OC LENS"
7 = Oxygen, Take Home	"O2/TAKEHOME"
8 = Other/Implants	"SUPPLY/IMPLANTS"
9 = Other Supplies/Devices	"SUPPLY/OTHER"

<b>28X</b>	<b>Oncology</b> (Charges for the treatment of tumors and related diseases)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"ONCOLOGY"
	9 = Other	"ONCOLOGY/OTHER"

<b>29X</b>	<b>Durable Medical Equipment - Other than Renal</b> (Charges for medical equipment that can withstand repeated use; excluding renal equipment)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"MED EQUIP/DURAB"
	1 = Rental	"MED EQUIP/RENT"
	2 = Purchase	"MED EQUIP/PURCH"
	9 = Other Equipment	"MED EQUIP/OTHER"

<b>30X</b>	<b>Laboratory</b> Charges for performance of diagnostic and routine clinical laboratory tests)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"LABORATORY" or "LAB"
	1 = Chemistry	"LAB/CHEMISTRY"
	2 = Immunology	"LAB/IMMUNOLOGY"
	3 = Renal Patient (Home)	"LAB/RENAL HOME"
	4 = Non-routine Dialysis	"LAB/NR DIALYSIS"
	5 = Hematology	"LAB/HEMATOLOGY"
	6 = Bacteriology & Microbiology	"LAB/BACT-MICRO"
	7 = Urology	"LAB/UROLOGY"
	9 = Other Laboratory	"LAB/OTHER"

<b>31X</b>	<b>Laboratory, Pathological</b> (Charges for diagnostic and routine laboratory tests on tissues and culture)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"PATHOLOGY LAB" or "PATH LAB"
	1 = Cytology	"PATHOL/CYTOLOGY"
	2 = Histology	"PATHOL/HYSTOL"
	4 = Biopsy	"PATHOL/BIOPSY"
	9 = Other	"PATHOL/OTHER"
<b>32X</b>	<b>Radiology - Diagnostic</b> (Charges for diagnostic radiology services provided for patient examination and care; includes taking, processing, examining, and interpreting radiographs and fluorographs)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"DX X-RAY"
	1 = Angiocardiology	"DX X-RAY/ANGIO"
	2 = Arthrography	"DX X-RAY/ARTH"
	3 = Arteriography	"DX X-RAY/ARTER"
	4 = Chest X-ray	"DX X-RAY/CHEST"
	9 = Other	"DX X-RAY/OTHER"
<b>33X</b>	<b>Radiology - Therapeutic</b> (Charges for therapeutic radiology services and chemotherapy required for patient care and treatment; includes therapy by injection or ingestion of radioactive substances)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"RX X-RAY"
	1 = Chemotherapy - Injected	"CHEMOTHER/INJ"
	2 = Chemotherapy - Oral	"CHEMOTHER/ORAL "
	3 = Radiation Therapy	"RADIATION RX"
	5 = Chemotherapy - IV	"CHEMOTHERP-IV"
	9 = Other	"RX X-RAY/OTHER"
<b>34X</b>	<b>Nuclear Medicine</b> (Charges for procedures and tests performed by a radioisotope laboratory using radioactive materials required for diagnosis and treatment of patients)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"NUCLEAR MEDICINE" or "NUC MED"

1 = Diagnostic	"NUC MED/DX"
2 = Therapeutic	"NUC MED/RX"
9 = Other	"NUC MED/OTHER"

**35X Computed Tomographic (CT) Scan**  
(Charges for CT scans of the head and other parts of the body)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"CT SCAN"
1 = Head Scan	"CT SCAN/HEAD"
2 = Body Scan	"CT SCAN/BODY"
9 = Other CT Scan	"CT SCAN/OTHER"

**36X Operating Room Services**  
(Charges for services provided by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"OR SERVICES"
1 = Minor Surgery	"OR/MINOR"
2 = Organ Transplant, Other Than Kidney	"OR/ORGAN TRANS"
7 = Kidney Transplant	"OR/KIDNEY TRANS"
9 = Other Operating Room Services	"OR/OTHER"

**37X Anesthesia**  
(Charges for anesthesia services in the hospital)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"ANESTHESIA"
1 = Anesthesia Incident to Radiology	"ANESTHE/INCIDENT RAD"
2 = Anesthesia Incident to Other Diagnostic Services	"ANESTHE/INCDNT OTHER DX"
4 = Acupuncture	"ANESTHE/ACUPUNC"
9 = Other Anesthesia	"ANESTHE/OTHER"

**38X Blood**



Use of these revenue codes requires completion of Field 39 of the UB-04 claim form.

Subcategory ("X" =)	Standard Abbreviation
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0 = General Classification	"BLOOD"
1 = Packed Red Cells	"BLOOD/PKD RED"
2 = Whole Blood	"BLOOD/WHOLE"
3 = Plasma	"BLOOD/PLASMA"
4 = Platelets	"BLOOD/PLATELETS"
5 = Leucocytes	"BLOOD/LEUCOCYTES"
6 = Other Components	"BLOOD/COMPONENTS"
7 = Other Derivatives (Cryoprecipitates)	"BLOOD/DERIVATIVES"
9 = Other Blood	"BLOOD/OTHER"

### 39X

#### Blood Storage and Processing



Use of these revenue codes requires completion of Field 39 of the UB-04 claim form.

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"BLOOD/STOR-PROC"
1 = Blood Administration	"BLOOD/ADMIN"
9 = Other Blood Storage and Processing	"BLOOD/OTHER STOR"

### 40X

#### Other Imaging Services

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"IMAGE SERVICE"
1 = Diagnostic Mammography	"DIAG MAMMOGRAPHY"
2 = Ultrasound	"ULTRASOUND"
3 = Screening Mammography	"SCRN MAMMOGRAPHY"
4 = Positron Emission Tomography	"PET SCAN"
9 = Other Imaging Service	"OTHER IMAG SVC"

### 41X

#### Respiratory Services

(Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy, through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"RESPIRATORY SVC"
2 = Inhalation Service	"INHALATION SVC"
3 = Hyperbaric Oxygen Therapy	"HYPERBARIC O2"

42X

Physical Therapy  
(Charges for therapeutic exercises, massage, and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic, and other disabilities)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"PHYSICAL THERP"
1 = Visit Charge	"PHYS THERP/VISIT"
2 = Hourly Charge	"PHYS THERP/HOUR"
3 = Group Rate	"PHYS THERP/GROUP"
4 = Evaluation or Re-evaluation	"PHYS THERP/EVAL"
9 = Other Physical Therapy	"OTHER PHYS THERP"

43X

<b>Occupational Therapy</b> (Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity)	
Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"OCCUPATION THER"
1 = Visit Charge	"OCCUP THERP/VISIT"
2 = Hourly Charge	"OCCUP THERP/HOUR"
3 = Group Rate	"OCCUP THERP/GROUP"
4 = Evaluation or Re-evaluation	"OCCUP THERP/EVAL"
9 = Other Occupational Therapy	"OTHER OCCUP THER"

44X	<b>Speech-Language Pathology</b> (Charges for services provided to persons with impaired functional communications skills)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"SPEECH PATHOL"
	1 = Visit Charge	"SPEECH PATH/VISIT"
	2 = Hourly Charge	"SPEECH PATH/HOUR"
	3 = Group Rate	"SPEECH PATH/GROUP"
	4 = Evaluation or Re-evaluation	"SPEECH PATH/EVAL "
	9 = Other Speech-Language Pathology	"OTHER SPEECH PAT"

<b>45X</b>	<b>Emergency Room</b>
	(Charges for emergency treatment to those ill and injured persons who require

	immediate unscheduled medical or surgical care)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"EMERG ROOM"
	9 = Other Emergency Room	"OTHER EMER ROOM"
<b>46X</b>	<b>Pulmonary Function</b> (Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"PULMONARY FUNC"
	9 = Other Pulmonary Function	"OTHER PULMON FUNC"
<b>47X</b>	<b>Audiology</b> (Charges for the detection and management of hearing communication handicaps)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"AUDIOLOGY"
	1 = Diagnostic	"AUDIOLOGY/DX"
	2 = Treatment	"AUDIOLOGY/RX"
	9 = Other Audiology	"OTHER AUDIOL"
<b>48X</b>	<b>Cardiology</b> (Charges for cardiac procedures rendered in a separate unit of the hospital; include, but are not limited to, heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"CARDIOLOGY"
	1 = Cardiac Cath Lab	"CARDIAC CATH LAB"
	2 = Stress Test	"STRESS TEST"
	9 = Other Cardiology	"OTHER CARDIOL"
<b>49X</b>	<b>Ambulatory Surgical Care</b>	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"AMBUL SURG"
	9 = Other Ambulatory Surgical Care	"OTHER AMBL SURG"
<b>50X</b>	<b>Outpatient Services</b> (Outpatient charges for services rendered to an outpatient who is admitted as an inpatient before midnight on the day following the date of service)	

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"OUTPATIENT SVS"
9 = Other Outpatient Services	"OUTPATIENT/OTHER"

<b>51X</b>	<b>Clinic Services</b> (Charges for diagnostic, preventive, curative, and rehabilitative services on a non-emergency/scheduled outpatient visit to ambulatory patients)												
	<table> <tr> <th><b>Subcategory ("X" =)</b></th><th><b>Standard Abbreviation</b></th></tr> <tr> <td>0 = General Classification</td><td>"CLINIC"</td></tr> <tr> <td>1 = Chronic Pain Clinic</td><td>"CHRONIC PAIN CL"</td></tr> <tr> <td>4 = Ob-Gyn Clinic</td><td>"OB-GYN CLINIC"</td></tr> <tr> <td>5 = Pediatric Clinic</td><td>"PED CLINIC"</td></tr> <tr> <td>9 = Other Clinic</td><td>"OTHER/CLINIC"</td></tr> </table>	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>	0 = General Classification	"CLINIC"	1 = Chronic Pain Clinic	"CHRONIC PAIN CL"	4 = Ob-Gyn Clinic	"OB-GYN CLINIC"	5 = Pediatric Clinic	"PED CLINIC"	9 = Other Clinic	"OTHER/CLINIC"
<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>												
0 = General Classification	"CLINIC"												
1 = Chronic Pain Clinic	"CHRONIC PAIN CL"												
4 = Ob-Gyn Clinic	"OB-GYN CLINIC"												
5 = Pediatric Clinic	"PED CLINIC"												
9 = Other Clinic	"OTHER/CLINIC"												

<b>53X</b>	<b>Osteopathic Services</b> (Charges for structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy)								
	<table> <tr> <th><b>Subcategory ("X" =)</b></th><th><b>Standard Abbreviation</b></th></tr> <tr> <td>0 = General Classification</td><td>"OSTEOPATH SVS"</td></tr> <tr> <td>1 = Osteopathic Therapy</td><td>"OSTEOPATH RX"</td></tr> <tr> <td>9 = Other Osteopathic Services</td><td>"OTHER/OSTEOPATH"</td></tr> </table>	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>	0 = General Classification	"OSTEOPATH SVS"	1 = Osteopathic Therapy	"OSTEOPATH RX"	9 = Other Osteopathic Services	"OTHER/OSTEOPATH"
<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>								
0 = General Classification	"OSTEOPATH SVS"								
1 = Osteopathic Therapy	"OSTEOPATH RX"								
9 = Other Osteopathic Services	"OTHER/OSTEOPATH"								

<b>55X</b>	<b>Skilled Nursing Services</b> (Charges for nursing services under the direct supervision of a licensed nurse to assure the safety of the patient)										
	<table> <tr> <th><b>Subcategory ("X" =)</b></th><th><b>Standard Abbreviation</b></th></tr> <tr> <td>0 = General Classification</td><td>"SKILLED NURSING"</td></tr> <tr> <td>1 = Visit Charge</td><td>"SKILLED NURS/VISIT"</td></tr> <tr> <td>2 = Hourly Charge</td><td>"SKILLED NURS/HOUR"</td></tr> <tr> <td>9 = Other Skilled Nursing</td><td>"SKILLED NURS/OTHER"</td></tr> </table>	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>	0 = General Classification	"SKILLED NURSING"	1 = Visit Charge	"SKILLED NURS/VISIT"	2 = Hourly Charge	"SKILLED NURS/HOUR"	9 = Other Skilled Nursing	"SKILLED NURS/OTHER"
<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>										
0 = General Classification	"SKILLED NURSING"										
1 = Visit Charge	"SKILLED NURS/VISIT"										
2 = Hourly Charge	"SKILLED NURS/HOUR"										
9 = Other Skilled Nursing	"SKILLED NURS/OTHER"										

<b>56X</b>	<b>Medical Social Services</b> (Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis)								
	<table> <tr> <th><b>Subcategory ("X" =)</b></th><th><b>Standard Abbreviation</b></th></tr> <tr> <td>0 = General Classification</td><td>"MED SOCIAL SVS"</td></tr> <tr> <td>1 = Visit Charge</td><td>"MED SOC SERS/VISIT"</td></tr> <tr> <td>2 = Hourly Charge</td><td>"MED SOC SERV/HOUR"</td></tr> </table>	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>	0 = General Classification	"MED SOCIAL SVS"	1 = Visit Charge	"MED SOC SERS/VISIT"	2 = Hourly Charge	"MED SOC SERV/HOUR"
<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>								
0 = General Classification	"MED SOCIAL SVS"								
1 = Visit Charge	"MED SOC SERS/VISIT"								
2 = Hourly Charge	"MED SOC SERV/HOUR"								



9 = Other Med. Social Service

"MED SOC  
SERV/OTHER"

61X	<b>MRI</b> (Charges for Magnetic Resonance Imaging of the brain and other parts of the body)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"MRI"
	1 = Brain (including Brain stem)	"MRI - BRAIN"
	2 = Spinal Cord (including Spine)	"MRI - SPINE"
	9 = Other MRI	"MRI - OTHER"
62X	<b>Medical/Surgical Supplies - Extension of 27X</b> (Charges for supply items required for patient care. The category is an extension of 27X for reporting additional breakdown where needed. Subcode "1" is for providers that cannot bill supplies used for radiology procedures under radiology. Subcode "2" is for providers that cannot bill supplies used for other diagnostic procedures.)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	1 = Supplies Incident to Radiology	"MED-SUR SUPP/INCDNT RAD"
	2 = Supplies Incident to Other Diagnostic Services	"MED-SUR SUP/INCDNT ODX"
63X	<b>Drugs Requiring Specific Identification</b> (Charges for drugs and biologicals requiring specific identification as required by the payer.)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"DRUGS"
	1 = Single Source Drug	"DRUG/SNGLE"
	2 = Multiple Source Drug	"DRUG/MULT"
70X	<b>Cast Room</b> (Charges for services related to the application, maintenance, and removal of casts)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"CAST ROOM"
	9 = Other Cast Room	"OTHER CAST ROOM"
71X	<b>Recovery Room</b>	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"RECOVERY ROOM"

**72X****Labor Room/Delivery**

(Charges for labor and delivery room services provided by specially trained nursing personnel to patients; include prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"DELIVEROOM/LABOR"
1 = Labor	"LABOR"
2 = Delivery	"DELIVERY ROOM"
3 = Circumcision	"CIRCUMCISION"
4 = Birthing Center	"BIRTHING CENTER"
9 = Other Labor Room/Delivery	"OTHER/DELIV-LABOR"

**73X****EKG/ECG [Electrocardiogram]**

(Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"EKG/ECG"
1 = Holter Monitor	"HOLTER MONT"
2 = Telemetry	"TELEMETRY"
9 = Other EKG/ECG	"OTHER EKG-ECG"

**74X****EEG [Electroencephalogram]**

(Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"EEG"
9 = Other EEG	"OTHER EEG"

**75X****Gastrointestinal Services**

(Procedure room charges for endoscopic procedures not performed in the operating room)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"GASTR-INTS SVS"
9 = Other Gastrointestinal	"OTHER GASTRO-INTS"

<b>76X</b>	<b>Treatment/Observation Room</b> (Charges associated with outpatient services only)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"TREATMENT/OBSERVATION RM"
	1 = Treatment Room	"TREATMENT RM"
	2 = Observation Room	"OBSERVATION RM"
	9 = Other	"OTHER TREAT/OBSERV RM"
<b>79X</b>	<b>Lithotripsy</b> (Charges for the use of lithotripsy in the treatment of kidney stones)	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"LITHOTRIPSY"
	9 = Other Lithotripsy	"LITHOTRIPSY/OTHER"
<b>80X</b>	<b>Inpatient Renal Dialysis</b> (Charges associated with the use of an artificial kidney in an inpatient setting to remove waste directly from the blood [hemodialysis] or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue [peritoneal dialysis])	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"RENAL DIALYSIS"
	1 = Inpatient Hemodialysis	"DIALY/INPT"
	2 = Inpatient Peritoneal (Non-CAPD)	"DIALY/INPT/PER"
	3 = Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	"DIALY/INPT/CAPD"
	4 = Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	"DIALY/INPT/CCPD"
	9 = Other Inpatient Dialysis	"DIALY/INPT/OTHER"
<b>81X</b>	<b>Organ Acquisition</b> (Charges associated with the acquisition of a kidney, liver, or heart for use in transplantation; also see "89X")	
	<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
	0 = General Classification	"ORGAN ACQUISIT"
	1 = Living Donor - Kidney	"KIDNEY/LIVE"
	2 = Cadaver Donor - Kidney	"KIDNEY/CADAVER"
	3 = Unknown Donor - Kidney	"KIDNEY/UNKNOWN"
	4 = Other Kidney Acquisition	"KIDNEY/OTHER"
	5 = Cadaver Donor - Heart	"HEART/CADAVER"

6 = Other Heart Acquisition	"HEART/OTHER"
7 = Donor - Liver	"LIVER ACQUISIT"
9 = Other Organ Acquisition	"ORGAN/OTHER"

**82X Hemodialysis - Outpatient or Home**  
(Charges associated with the use of an artificial kidney in an outpatient or home setting to remove waste directly from the blood [hemodialysis])

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"HEMO/OP OR HOME"
1 = Hemodialysis/Composite Rate	"HEMO/COMPOSITE"
2 = Home Supplies	"HEMO/HOME/SUPPL"
3 = Home Equipment	"HEMO/HOME/EQUIP"
4 = Maintenance/100%	"HEMO/HOME/100%"
5 = Support Services	"HEMO/HOME/SUPSERV"
9 = Other Outpatient Hemodialysis	"HEMO/HOME/OTHER"

**83X Peritoneal Dialysis - Outpatient or Home**  
(Charges associated with the use of an artificial kidney in an outpatient or home setting to remove waste indirectly by flushing a special solution between the abdominal covering and the tissue)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"PERITONEAL/OP OR HOME"
1 = Peritoneal/Composite Rate	"PERTNL/COMPOSITE"
2 = Home Supplies	"PERTNL/HOME/SUPPL"
3 = Home Equipment	"PERTNL/HOME/EQUIP"
4 = Maintenance/100%	"PERTNL/HOME/100%"
5 = Support Services	"PERTNL/HOME/SUPSERV"
9 = Other Outpatient Peritoneal Dialysis	"PERTNL/HOME/OTHER"

**84X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home**  
(Charges associated with a continuous dialysis process performed in an outpatient or home setting, in which the patient peritoneal membrane is used as a dialyzer)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"CAPD/OP OR HOME"
1 = CAPD/Composite Rate	"CAPD/COMPOSITE"
2 = Home Supplies	"CAPD/HOME/SUPPL"
3 = Home Equipment	"CAPD/HOME/EQUIP"

4 = Maintenance/100%	"CAPD/HOME/100%"
5 = Support Services	"CAPD/HOME/SUPSERV"
9 = Other Outpatient CAPD	"CAPD/HOME/OTHER"

**85X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home**  
(Charges associated with a continuous dialysis process performed in an outpatient or home setting, in which a machine is used to make automatic exchanges at night)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"CCCD/OP OR HOME"
1 = CCPD/Composite Rate	"CCPD/COMPOSITE"
2 = Home Supplies	"CCPD/HOME/SUPPL"
3 = Home Equipment	"CCPD/HOME/EQUIP"
4 = Maintenance/100%	"CCPD/HOME/100%"
5 = Support Services	"CCPD/HOME/SUPSERV"
9 = Other Outpatient CCPD	"CCPD/HOME/OTHER"

**88X Miscellaneous Dialysis**  
(Charges for dialysis not identified elsewhere)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"DIALY/MISC"
1 = Ultrafiltration	"DIALY/ULTRAFILT"
9 = Misc. Dialysis Other	"DIALY/MISC/OTHER"

**89X Other Donor Bank**  
(Charges for the acquisition, storage, and preservation of all human organs [excluding kidneys])

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"DONOR BANK"
1 = Bone	"DONOR BANK/BONE"
2 = Organ (Other Than Kidney)	"DONOR BANK/ORGN"
3 = Skin	"DONOR BANK/SKIN"
9 = Other Donor Bank	"OTHER DONOR BANK"

**90X Psychiatric/Psychological Treatments**  
(Charges associated with inpatient services only)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"PSYCH TREATMENT"

1 = Electroshock Treatment	"ELECTRO SHOCK"
2 = Milieu Therapy	"MILIEU THERAPY"
3 = Play Therapy	"PLAY THERAPY"
9 = Other	"OTHER PSYCH RX"

**91X Psychiatric/Psychological Services**  
(Charges for providing nursing and professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment; associated with inpatient services only)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"PSYCH SERVICES"
1 = Rehabilitation	"PSYCH/REHAB"
4 = Individual Therapy	"PSYCH/INDIV RX"
5 = Group Therapy	"PSYCH/GROUP RX"
6 = Family Therapy	"PSYCH/FAMILY RX"
8 = Testing	"PSYCH/TESTING"
9 = Other	"PSYCH/OTHER"

**92X Other Diagnostic Services**  
(Charges for other diagnostic services not otherwise categorized)

Subcategory ("X" =)	Standard Abbreviation
0 = General Classification	"OTHER DX SVS"
1 = Peripheral Vascular Lab	"PERI VASCUL LAB"
2 = Electromyogram	"EMG"
3 = Pap Smear	"PAP SMEAR"
4 = Allergy Test	"ALLERGY TEST"
5 = Pregnancy Test	"PREG TEST"
9 = Other Diagnostic Service	"ADDITIONAL DX SVS"

**94X Other Therapeutic Services**  
(Charges for therapeutic services not otherwise categorized)

Subcategory ("X" =)	Standard Abbreviation
3 = Cardiac Rehabilitation	"CARDIAC REHAB"

**96X Professional Fees**  
(Charges for medical professionals that hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.)

<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
0 = General Classification	"PRO FEE"
1 = Psychiatric	"PRO FEE/PSTAY"
2 = Ophthalmology	"PRO FEE/EYE"
3 = Anesthesiologist (MD)	"PRO FEE/ANES MED"
4 = Anesthetist (CRNA)	"PRO FEE/ANES CRNA"
9 = Other Professional Fees	"OTHER PRO FEE"

<b>97X</b>	<b>Professional Fees [extension of "96X"]</b>
<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
1 = Laboratory	"PRO FEE/LAB"
2 = Radiology - Diagnostic	"PRO FEE/RAD/DX"
3 = Radiology - Therapeutic	"PRO FEE/RAD/RX"
4 = Radiology - Nuclear Medicine	"PRO FEE/NUC MED"
5 = Operating Room	"PRO FEE/OR"
6 = Respiratory Therapy	"PRO FEE/RESPIR"
7 = Physical Therapy	"PRO FEE/PHYSI"
8 = Occupational Therapy	"PRO FEE/OCCUPA"
9 = Speech Pathology	"PRO FEE/SPEECH"

<b>98X</b>	<b>Professional Fees [extension of "96X" and "97X"]</b>
<b>Subcategory ("X" =)</b>	<b>Standard Abbreviation</b>
1 = Emergency Room	"PRO FEE/ER"
2 = Outpatient Services	"PRO FEE/OUTPT"
3 = Clinic	"PRO FEE/CLINIC"
4 = Medical Social Services	"PRO FEE/SOC SVC"
5 = EKG	"PRO FEE/EKG"
6 = EEG	"PRO FEE/EEG"

Updated 02.2009

# Appendix G

## BHA CPT and HCPCS Codes

The following behavioral health services may be reimbursed when rendered by a Behavioral Health Aide through a **Health Professional Group or Community Behavioral Health Clinic**.

CODE	DESCRIPTION	BHA I	BHA II	BHA III	BHP
99408	SBIRT 15-30 MIN	x	x	x	x

The following behavioral health services may only be reimbursed when rendered by a Behavioral Health Aide through a **Health Professional Group**.

CODE	DESCRIPTION	BHA I	BHA II	BHA III	BHP
90791	PSYCH DIAGNOSTIC EVALUATION			x	x
90832	PSYTX W PT 30 MINUTES			x	x
90834	PSYTX W PT 45 MINUTES			x	x
90837	PSYTX W PT 60 MINUTES			x	x
90839	PSYTX CRISIS INITIAL 60 MIN			x	x
90840	PSYTX CRISIS INITIAL ADDITIONAL 30 MIN			x	x
90846	FAMILY PSYTX W/O PATIENT			x	x
90847	FAMILY PSYTX W/PATIENT			x	x
90849	MULTIPLE FAMILY GROUP PSYTX			x	x
90853	GROUP PSYCHOTHERAPY				x
96127	ASSESSMENT TOOL	x	x	x	x
96150	ASSESS HLTH/BEHAVE INIT			x	x
96151	ASSESS HLTH/BEHAVE SUBSEQ			x	x
96152	INTERVENE HLTH/BEHAVE INDIV	x	x	x	x
96153	INTERVENE HLTH/BEHAVE GROUP	x	x	x	x
96154	INTERV HLTH/BEHAV FAM W/PT	x	x	x	x
99406	BEHAV CHNG SMOKING 3-10 MIN		x	x	x



99407	BEHAV CHNG SMOKING > 10 MIN		x	x	x
99409	SBIRT OVER 30 MIN	x	x	x	x

The following behavioral health services may only be reimbursed when rendered by a Behavioral Health Aide through a **Community Behavioral Health Clinic**.

CODE	DESCRIPTION	BHA I	BHA II	BHA III	BHP
H0001	ALCOHOL AND/OR DRUG ASSESS		x	x	x
H0031	MH HEALTH ASSESS BY NON-MD				x
H0031-HH	INTERGRATED MH HEALTH ASSESS BY NON-MD				x
H0038	SELF-HELP/PEER SVC PER 15 MIN	x	x	x	x
H0038-HR	SELF-HELP/PEER SVC PER 15 MIN	x	x	x	x
H0038-HS	SELF-HELP/PEER SVC PER 15 MIN	x	x	x	x
H0046	MENTAL HEALTH SERVICE, NOS	x	x	x	x
H0047	ALCOHOL/DRUG ABUSE SVC NOS	x	x	x	x
H2011	CRISIS INTERVEN SVC, 15 MIN	x	x	x	x
H2015	COMP COMM SUPP SVC, 15 MIN – INDIVIDUAL	x	x	x	x
H2015-HQ	COMP COMM SUPP SVC, 15 MIN – GROUP	x	x	x	x
H2019	THER BEHAV SVC, PER 15 MIN – INDIVIDUAL	x	x	x	x
H2019-HQ	THER BEHAV SVC, PER 15 MIN – GROUP	x	x	x	x
H2019-HR	THER BEHAV SVC, PER 15 MIN – FAMILY W/PATIENT	x	x	x	x
H2019-HS	THER BEHAV SVC, PER 15 MIN – FAMILY W/O PATIENT	x	x	x	x
S9484	CRISIS INTERVENTION PER HOUR	x	x	x	x
T1007	TREATMENT PLAN DEVELOPMENT	x	x	x	x
T1016	CASE MANAGEMENT	x	x	x	x
T1023	PROGRAM INTAKE ASSESSMENT	x	x	x	x

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# Appendix H

## CHA/P CPT, CDT, and HCPCS Codes

CODE	DESCRIPTION	CHA I	CHA II	CHA III	CHA IV	CHP
10060	Drainage of skin abscess		X	X	X	X
10061	Drainage of skin abscess		X	X	X	X
10120	Remove foreign body		X	X	X	X
10140	Drainage of hematoma/fluid		X	X	X	X
10160	Puncture drainage of lesion		X	X	X	X
11400	Exc tr-ext b9+marg 0.5 < cm			X	X	X
11401	Exc tr-ext b9+marg 0.6-1 cm			X	X	X
11402	Exc tr-ext b9+marg 1.1-2 cm			X	X	X
11403	Exc tr-ext b9+marg 2.1-3 cm			X	X	X
11404	Exc tr-ext b9+marg 3.1-4 cm			X	X	X
11406	Exc tr-ext b9+marg > 4.0 cm			X	X	X
11420	Exc h-f-nk-sp b9+marg 0.5 <			X	X	X
11421	Exc h-f-nk-sp b9+marg 0.6-1			X	X	X
11422	Exc h-f-nk-sp b9+marg 1.1-2			X	X	X
11423	Exc h-f-nk-sp b9+marg 2.1-3			X	X	X
11424	Exc h-f-nk-sp b9+marg 3.1-4			X	X	X
11426	Exc h-f-nk-sp b9+marg > 4 cm			X	X	X
11440	Exc face-mm b9+marg 0.5 < cm			X	X	X
11441	Exc face-mm b9+marg 0.6-1 cm			X	X	X
11442	Exc face-mm b9+marg 0.6-1 cm			X	X	X
11443	Exc face-mm b9+marg 0.6-1 cm			X	X	X
11444	Exc face-mm b9+marg 3.1-4 cm			X	X	X
11446	Exc face-mm b9+marg > 4 cm			X	X	X
11720	Debride nail 1-5			X	X	X
11721	Debride nail 6 or more			X	X	X

11730	Removal of nail plate			X	X	X
11765	Excision of nail fold toe			X	X	X
12001	Repair superficial wound(s)		X	X	X	X
12002	Repair superficial wound(s)		X	X	X	X
12004	Repair superficial wound(s)		X	X	X	X
12021	Closure of split wound		X	X	X	X
16000	Initial treatment of burn(s)	X	X	X	X	X
16020	Dress/debrid p-thick burn s	X	X	X	X	X
16025	Dress/debrid p-thick burn m	X	X	X	X	X
16030	Dress/debrid p-thick burn l	X	X	X	X	X
20520	Removal of foreign body		X	X	X	X
21310	Treatment of nose fracture	X	X	X	X	X
21450	Treat lower jaw fracture	X	X	X	X	X
23500	Treat clavicle fracture		X	X	X	X
23620	Treat humerus fracture		X	X	X	X
23650	Treat shoulder dislocation		X	X	X	X
24500	Treat humerus fracture		X	X	X	X
25500	Treat fracture of radius		X	X	X	X
26600	Treat metacarpal fracture		X	X	X	X
27197	Closed treatment of fracture &/or dislocation of pelvis &/or sacrum		X	X	X	X
27500	Treatment of thigh fracture		X	X	X	X
27508	Treatment of thigh fracture		X	X	X	X
27510	Treatment of thigh fracture		X	X	X	X
27750	Treatment of tibia fracture		X	X	X	X
28400	Treatment of heel fracture		X	X	X	X
29105	Apply long arm splint	X	X	X	X	X
29125	Apply forearm splint	X	X	X	X	X
29130	Application of finger splint	X	X	X	X	X
29200	Strapping of chest	X	X	X	X	X
29240	Strapping of shoulder	X	X	X	X	X
29260	Strapping of elbow or wrist	X	X	X	X	X

29280	Strapping of hand or finger	X	X	X	X	X
29505	Application long leg splint	X	X	X	X	X
29515	Application lower leg splint	X	X	X	X	X
29530	Strapping of knee	X	X	X	X	X
29550	Strapping of toes	X	X	X	X	X
30300	Remove nasal foreign body			X	X	X
30901	Control of nosebleed	X	X	X	X	X
30903	Control of nosebleed			X	X	X
30905	Control of nosebleed			X	X	X
30906	Repeat control of nosebleed			X	X	X
36680	Insert needle bone cavity			X	X	X
51701	Insert bladder catheter			X	X	X
51702	Insert temp bladder cath			X	X	X
59414	Deliver placenta			X	X	X
65205	Remove foreign body from eye	X	X	X	X	X
65210	Remove foreign body from eye			X	X	X
69200	Clear outer ear canal	X	X	X	X	X
69210	Remove impacted ear wax			X	X	X
81000	Urinalysis nonauto w/scope	X	X	X	X	X
81001	Urinalysis auto w/scope			X	X	X
81002	Urinalysis nonauto w/o scope			X	X	X
81003	Urinalysis auto w/o scope			X	X	X
81025	Urine pregnancy test	X	X	X	X	X
82270	Occult blood feces		X	X	X	X
82948	Reagent strip/blood glucose	X	X	X	X	X
82962	Glucose blood test	X	X	X	X	X
83013	H pylori (c-13) breath			X	X	X
83014	H pylori drug admin			X	X	X
83026	Hemoglobin copper sulfate	X	X	X	X	X
83036*	Glycosylated hemoglobin test	X	X	X	X	X
85018*	Hemoglobin	X	X	X	X	X

85610*	Prothrombin time	X	X	X	X	X
86580	TB intradermal test		X	X	X	X
87081	Culture screen only	X	X	X	X	X
87210*	Smear wet mount saline/ink	X	X	X	X	X
87320	Chylmd trach ag eia			X	X	X
87804*	Influenza assay w/optic	X	X	X	X	X
87880*	Strep a assay w/optic	X	X	X	X	X
90371	Hep b ig im			X	X	X
90460	Imadm any route 1st vac/tox	X	X	X	X	X
90461	Inadm any route addl vac/tox	X	X	X	X	X
90471	Immunization admin	X	X	X	X	X
90472	Immunization admin each	X	X	X	X	X
90473	Immune admin oral/nasal	X	X	X	X	X
90474	Immune admin oral/nasal	X	X	X	X	X
90585	Vaccine for tuberculosis injection into skin	X	X	X	X	X
90630	Vaccine for influenza for injection into skin	X	X	X	X	X
90632	Hep a vaccine adult im	X	X	X	X	X
90636	Hep a/hep b vacc adult im	X	X	X	X	X
90649	Hpv vaccine 4 valent im	X	X	X	X	X
90650	Hpv vaccine 2 valent im	X	X	X	X	X
90651	Hpv vaccine 3 dose im	X	X	X	X	X
90653	Vaccine for influenza for injection into muscle	X	X	X	X	X
90654	Vaccine for influenza injection into skin	X	X	X	X	X
90656	Flu vaccine no preserv 3 & >	X	X	X	X	X
90658	Flu vaccine 3 yrs & > im	X	X	X	X	X
90660	Flu vaccine nasal	X	X	X	X	X
90661	Vaccine for influenza for administration into muscle, 0.5 ml dosage	X	X	X	X	X
90662	Vaccine for influenza for injection into muscle	X	X	X	X	X
90664	Vaccine for influenza for nasal administration, pandemic formulation	X	X	X	X	X
90674	Vaccine for influenza for administration into muscle, 0.5 ml dosage	X	X	X	X	X

90682	Vaccine for influenza for administration into muscle	X	X	X	X	X
90685	Vaccine for influenza for administration into muscle, 0.25 ml dosage	X	X	X	X	X
90686	Vaccine for influenza for administration into muscle, 0.5 ml dosage	X	X	X	X	X
90688	Vaccine for influenza for administration into muscle, 0.5 ml dosage	X	X	X	X	X
90707	Mmr vaccine sc	X	X	X	X	X
90714	Vaccine for tetanus & diphtheria toxoids injection into muscle, patient 7 years or older	X	X	X	X	X
90715	Tdap vaccine >7 im	X	X	X	X	X
90716	Chicken pox vaccine sc	X	X	X	X	X
90732	Pneumococcal vaccine	X	X	X	X	X
90733	Vaccine for meningococcus for injection beneath skin	X	X	X	X	X
90734	Meningococcal vaccine im	X	X	X	X	X
90736	Zoster vacc sc	X	X	X	X	X
90740	Vaccine for Hepatitis B (3 dose schedule) for injection into muscle, dialysis or immunosuppressed patient	X	X	X	X	X
90746	Hep b vaccine adult im	X	X	X	X	X
90750	Vaccine for shingles for injection into muscle	X	X	X	X	X
90756	Vaccine for influenza for injection into muscle	X	X	X	X	X
92551	Pure tone hearing test air			X	X	X
92552	Pure tone audiometry air			X	X	X
92567	Tympanometry			X	X	X
92950	Heart/lung resuscitation cpr	X	X	X	X	X
93005	Electrocardiogram tracing			X	X	X
94640	Airway inhalation treatment	X	X	X	X	X
94760	Measure blood oxygen level	X	X	X	X	X
94761	Measure blood oxygen level	X	X	X	X	X
96110	Developmental screening			X	X	X
96111	Developmental testing, (includes assessment of motor, language, social)			X	X	X
96360	Hydration iv infusion init		X	X	X	X

96361	Hydrate iv infusion add-on		X	X	X	X
96365	Ther/proph/diag iv inf init			X	X	X
96366	Ther/proph/diag iv inf addon			X	X	X
96372	Ther/proph/diag inj sc/im			X	X	X
96374	Ther/proph/diag inj iv push			X	X	X
96375	Tx/pro/dx inj new drug addon			X	X	X
99050	Medical services after hrs	X	X	X	X	X
99173	Visual acuity screen	X	X	X	X	X
99201	Office/outpatient visit new	X	X	X	X	X
99202	Office/outpatient visit new			X	X	X
99203	Office/outpatient visit new			X	X	X
99204	Office/outpatient visit new			X	X	X
99205	Office/outpatient visit new			X	X	X
99211	Office/outpatient visit est	X	X	X	X	X
99212	Office/outpatient visit est			X	X	X
99213	Office/outpatient visit est			X	X	X
99214	Office/outpatient visit est			X	X	X
99215	Office/outpatient visit est			X	X	X
99341	Home visit new patient			X	X	X
99342	Home visit new patient			X	X	X
99343	Home visit new patient			X	X	X
99347	Home visit est patient			X	X	X
99348	Home visit est patient			X	X	X
99349	Home visit est patient			X	X	X
99381	Init pm e/m new pat infant			X	X	X
99382	Init pm e/m new pat 1-4 yrs			X	X	X
99383	Init pm e/m new pat 5-11 yrs			X	X	X
99384	Init pm e/m new pat 12-17 yrs			X	X	X
99385 #	Prev visit new age 18-39			X	X	X
99391	Per pm reeval est pat inf	X	X	X	X	X
99392	Prev visit est age 1-4	X	X	X	X	X

99393	Prev visit est age 5-11	X	X	X	X	X
99394	Prev visit est age 12-17	X	X	X	X	X
99395 #	Prev visit est age 18-39	X	X	X	X	X
99406	Behav chng smoking 3-10 min			X	X	X
99407	Behav chng smoking > 10 min			X	X	X
99408	Audit/dast 15-30 min			X	X	X
99409	Audit/dast over 30 min			X	X	X
99461	Init nb em per day non-fac			X	X	X
99465	Nb resuscitation	X	X	X	X	X
D0145	Oral evaluation, PT < 3 yrs			X	X	X
D1206 <sup>1</sup>	Topical fluoride varnish			X	X	X
D1208 <sup>1</sup>	Topical application fluoride – exclude varnish	X	X	X	X	X
J0561	Injection, penicillin G benzathine, 100,000 units	X	X	X	X	X
J0696	Injection, ceftriaxone sodium, per 250 mg	X	X	X	X	X
J0885	Injection, epoetin alfa, 1000 units	X	X	X	X	X
J1050	Injection, Medroxyprogesterone Acetate, 1 Mg	X	X	X	X	X
J1438	Injection, etanercept, 25 mg	X	X	X	X	X
J1885	Injection, ketorolac tromethamine, per 15 mg	X	X	X	X	X
J2550	Injection, promethazine HCl, up to 50 mg	X	X	X	X	X
J3420	Injection, vitamin B-12, up to 1,000 mcg	X	X	X	X	X
J7030	Infusion, normal saline solution, 1,000 cc		X	X	X	X
J7040	Infusion, normal saline solution, 500 cc		X	X	X	X
J7120	Ringer's lactate infusion, up to 1,000 cc		X	X	X	X
J7613	Albuterol unit dose, 1 mg	X	X	X	X	X

The CPT code descriptions herein have been shortened to 28 characters or less to comply with copyright restrictions. Please refer to the current CPT for complete descriptions.

\* Indicates QW Modifier Required

# Coverage limited to EPSDT services

<sup>1</sup> For **adults**, Alaska Medicaid covers fluoride treatments applied topically (D1206 and D1208) **up to four times per fiscal year**. Any combination of topical fluoride applications, varnish or non-varnish, may not exceed four applications per fiscal year.

For **children under 21 years of age**, Alaska Medicaid covers fluoride treatments applied topically (D1206 and D1208) **up to four times per calendar year**. Any combination of topical fluoride applications, varnish or non-varnish, may not exceed four applications per calendar year.

Updated 01/02/2019



# Appendix I

## Prior Authorization Table for Prescription Drugs

### Alaska Medicaid Prior-authorized Medications

Medication Name	PA Requester		Clinical Call Center (MAP Desk)	Electronic Step-edits
	Prescriber PA Requester	Pharmacist PA Requester		
Actiq®	X		X	
Adcirca® (≥1/1/2011)	X		X	
Botox®	X		X	
Butorphanol Nasal Spray	X		X	
Byetta® √	X		X	X
Carisprodol	X		X	
Cyclobenzaprine Long Acting √	X		X	X
Cyclobenzaprine 7.5mg√	X		X	X
Ergocalciferol Oral Drops		X	X	
Fentanyl patches	X		X	
Fentora® (≥1/1/2011)	X		X	
Hydromorphone Products, Oral	X		X	
Growth Hormones†	X		X	
Long Acting Beta Agonists √	X		X	X
Lupron Depot® and Eligard®		X	X	
Magnesium Oxide		X	X	
Methadone Products	X		X	
Long Acting Morphine products, Oral	X		X	
Neutra-Phos®		X	X	
New Products (new to market ≥1/1/2011)	X		X	
Nicotine Nasal Spray	X		X	

Onsolis™ (≥1/1/2011)	X		X	
OTC Calcium Product		X	X	
Oxycodone (IR and ER) Products	X		X	
Oxymorphone ER products	X		X	
Proton Pump Inhibitors√ (≥1/1/2011)	X		X	X
Panretin®		X	X	
Quinine Sulfate	X		X	
Quinine Sulfate Powder	X		X	
Revatio®	X		X	
Scopolamine Hydrobromide (Patch)	X		X	
Serostim®(≥1/1/2011)	X		X	
Suboxone®† and Subutex®† (≥1/1/2011)	X		X	
Statins √ (≥1/1/2011)	X			X
Symlin® √	X		X	X
Synagis®†	X		X	
Tekturna® and Tekturna HCT® √			X	X
Vitamin E Oral Liquid	X		X	
Vitamin B Complex √	X		X	X
Vivitrol® (≥1/1/2011)	X		X	
† Medications requiring special forms				
√ Shows medication where Step Edit is required				
Magellan Clinical Call Center	Phone 1-800-331-4475			

# Appendix K

## Tribal Transportation Service Areas

### ANTHC Prior Authorization

**Service Area includes region codes AN, BA, BB, MA, NS, and SE.**

**Hours:** 7 days a week, 8:00 a.m. – 5:00 p.m. AKT

**Contact:** [tmomedicaid@anthc.org](mailto:tmomedicaid@anthc.org) or 833.318.6184

**Call Center:** 866.824.8140 or 907.729.7720, Option 1

**When to Call:**

- New Prior Authorizations for referral to ANMC
- New Prior Authorizations for referral outside of ANMC referred by ANMC
- New Prior Authorizations for Anchorage Service Unit village to hub travel

### TCC Prior Authorization

**Service Area includes region code TC.**

**Hours:** Monday - Saturday, 8:00 a.m. – 5:30 p.m. AKT

**Call Center:** 907.451.6682

**When to Call:**

- New Prior Authorizations for referral to TCC
- New Prior Authorizations for referral outside of TCC referred by TCC
- New Prior Authorizations for Tanana Chiefs Conference Service Area village to hub travel
- New Prior Authorizations for Anchorage Service Unit village to hub travel

### YKHC Prior Authorization

**Service Area includes region code YK.**

**Hours:** 7 days a week, 8:00 a.m. – 5:00 p.m. AKT

**Electronic Requests:** Submit Travel Service Authorization form to [PriorAuth@ykhc.org](mailto:PriorAuth@ykhc.org).

**Call Center:** 800.478.3321 ext 6489 or 907.543.6489

**When to Call:**

- New Prior Authorizations for referral to YKHC
- New Prior Authorizations for referral outside of YKHC referred by YKHC
- New Prior Authorizations for Yukon Kuskokwim Service Unit village to hub travel
- New Prior Authorizations for Anchorage Service Unit village to hub travel

## Tribal Transportation Service Areas

### Service Area Listing by Location

Location	Region Code
Aatna	TC
Akhiak	AN
Akiachak	YK
Akiak	YK
Akutan	AN
Alakanuk	YK
Alaknagik	BB
Allakaket	TC
Ambler	MA
Anaktuvuk Pass	BA
Anchor Point	AN
Anderson	TC
Angoon	SE
Aniak	YK
Anvik	YK
Arctic Village	TC
Atka	AN
Atmautiuak	YK
Atkasuk	BA
Auke Bay	SE
Badger	TC
Barrow	BA

Location	Region Code
Koyukuk	TC
Kwethluk	YK
Kwigillingok	YK
Lake Minchumina	TC
Larsen Bay	AN
Levelock	BB
Igiugig	BB
Lime Village	AN
Lower Kalskag	YK
Ivanof Bay	BB
Manley Hot Springs	TC
Manokotak	BB
Marshall	YK
McGrath	AN
Medfra	AN
Mekoryuk	YK
Mendehall	SE
Mentasta Lake	AN
Metlakatla	SE
Minto	TC
Moose Pass	AN
Mountain Village	YK

Location	Region Code
Beaver	TC
Beluga	AN
Bethel	YK
Bettles	TC
Big Lake	AN
Birch Creek	TC
Border	TC
Brevig Mission	NS
Buckland	MA
Cantwell	AN
Cape Yakatage	SE
Central	TC
Chalkyitsik	TC
Chatanika	TC
Chefornak	YK
Chenega Bay	AN
Chevak	YK
Chickaloon	TC
Chicken	TC
Chignik Bay	BB
Chignik Lagoon	BB
Chignik Lake	BB
Chistochina	AN
Chitina	AN
Chuathbaluk	YK
Chugiak	AN
Circle	TC
Clam Gulch	AN

Location	Region Code
Mt. Edgecumbe	SE
Naknek	BB
Nanwalek	AN
Napakiak	YK
Napaskiak	YK
Nelson Lagoon	AN
Nenana	TC
New Stuyah	BB
Newhalen	AN
Newtok	YK
Nightmute	YK
Nikolai	AN
Nikolski	AN
Ninilchik	AN
Noatak	MA
Nome	NS
Nondalton	AN
Noorvik	MA
North Pole	TC
Northway	TC
Nuiqsut	BA
Nulato	TC
Nunapitchuk	YK
Old Harbor	AN
Ouzinkie	AN
Palmer	AN
Paxson	AN
Pedro Bay	AN

Location	Region Code
Clarks Point	BB
Cold Bay	AN
Coldfoot	TC
College	TC
Cooper Landing	AN
Copper Center	AN
Cordova	AN
Craig	SE
Crooked Creek	YK
Deering	MA
Delta Junction	TC
Dillingham	BB
Diomedes	NS
Dot Lake	TC
Douglas	SE
Dutch Harbor	AN
Eagle	TC
Eagle River	AN
Eek	YK
Egegik	BB
Eielson AFB	TC
Ekwok	BB
Elfin Cove	SE
Elim	NS
Emmonak	YK
Ester	TC
Evansville	TC
Fairbanks	TC

Location	Region Code
Pelican	SE
Perryville	BB
Petersburg	SE
Pilot Point	BB
Pilot Station	YK
Platinum	BB
Point Hope	MA
Point Lay	BA
Port Alexander	AN
Port Alsworth	AN
Port Graham	AN
Port Heiden	BB
Port Lions	AN
Prudhoe Bay	BA
Quinhagak	YK
Rampart	TC
Red Devil	YK
Ruby	TC
Russian Mission	YK
Salcha	TC
Sand Point	AN
Savoonga	NS
Scammon Bay	YK
Selawik	MA
Seldovia	AN
Seward	AN
Shageluk	YK
Shaktolik	NS

Location	Region Code
False Pass	AN
Flat	TC
Fort Wainwright	AN
Fort Yukon	TC
Gakona	AN
Galena	TC
Gambell	NS
Girdwood	AN
Golovin	NS
Goodnews Bay	BB
Grayling	YK
Gulkana	AN
Gustavus	SE
Haines	SE
Halibut Cove	AN
Healy	TC
Healy Lake	TC
Holy Cross	YK
Homer	AN
Hoonah	SE
Hooper Bay	YK
Hope	AN
Houston	AN
Hughes	TC
Huslia	TC
Hydaburg	SE
Hyder	SE
Iliamna	AN

Location	Region Code
Sheldon Point	YK
Shishmaref	NS
Shungnak	MA
Siena	AN
Sitka	SE
Skagway	SE
Skwentna	AN
Sleetmute	YK
Soldotna	AN
South Naknek	BB
St. George	AN
St. Mary's	YK
St. Michael	NS
St. Paul	AN
Stebbins	NS
Sterling	AN
Stevens Village	TC
Stony River	YK
Sutton	TC
Takotna	AN
Talkeetna	AN
Tanacross	TC
Tanana	TC
Tatitlek	AN
Teller	NS
Tenakee Springs	SE
Tetlin	TC
Thorne Bay	SE

Location	Region Code
Indian	AN
Juneau	SE
Kake	SE
Kaktovik	BA
Kalskag	YK
Kaltag	TC
Karluk	AN
Kasigluk	YK
Kasiloff	AN
Kenai	AN
Kiana	MA
King Cove	AN
King Salmon	BB
Kipnuk	YK
Kivalina	MA
Klawock	SE
Klukwan	SE
Kobuk	MA
Kodiak	AN
Kokhanok	AN
Koliganek	BB
Kongiganak	YK
Kotlik	YK
Kotzebue	MA
Koyuk	NS

Location	Region Code
Togiak	BB
Tok	TC
Toksook Bay	YK
Trappers Creek	AN
Tuluksak	YK
Tuntutuliak	YK
Tununak	YK
Twin Hills	BB
Two Rivers	AN
Tyonek	AN
Ugashik	BB
Unalakleet	NS
Unalaska	AN
Valdez	AN
Venetie	TC
Waintwright	BA
Wales	NS
Ward Cove	AN
Wasilla	AN
White Mountain	NS
Whittier	AN
Willow	AN
Wrangell	SE
Yakutat	SE



## Tribal Transportation Service Areas

### Service Area Listing by Region Code

#### Anchorage Service Area

Location	Region Code
Akhiak	AN
Akutan	AN
Anchor Point	AN
Atka	AN
Beluga	AN
Big Lake	AN
Cantwell	AN
Chenega Bay	AN
Chistochina	AN
Chitina	AN
Chugiak	AN
Clam Gulch	AN
Cold Bay	AN
Cooper Landing	AN
Copper Center	AN
Cordova	AN
Dutch Harbor	AN
Eagle River	AN
False Pass	AN
Fort Wainwright	AN
Gakona	AN
Girdwood	AN
Gulkana	AN
Halibut Cove	AN
Homer	AN
Hope	AN
Houston	AN
Iliamna	AN
Indian	AN
Karluk	AN
Kasiloff	AN

Location	Region Code
Mentasta Lake	AN
Moose Pass	AN
Nanwalek	AN
Nelson Lagoon	AN
Newhalen	AN
Nikolai	AN
Nikolski	AN
Ninilchik	AN
Nondalton	AN
Old Harbor	AN
Ouzinkie	AN
Palmer	AN
Paxson	AN
Pedro Bay	AN
Port Alexander	AN
Port Alsworth	AN
Port Graham	AN
Port Lions	AN
Sand Point	AN
Seldovia	AN
Seward	AN
Siena	AN
Skwentna	AN
Soldotna	AN
St. George	AN
St. Paul	AN
Sterling	AN
Takotna	AN
Talkeetna	AN
Tatitlek	AN
Trappers Creek	AN

Kenai	AN
King Cove	AN
Kodiak	AN
Kokhanok	AN
Larsen Bay	AN
Lime Village	AN
McGrath	AN
Medfra	AN

Two Rivers	AN
Tyonek	AN
Unalaska	AN
Valdez	AN
Ward Cove	AN
Wasilla	AN
Whittier	AN
Willow	AN

#### *Barrow Service Area*

Location	Region Code
Anaktuvuk Pass	BA
Atkasuk	BA
Barrow	BA
Kaktovik	BA
Nuiqsut	BA
Point Lay	BA
Prudhoe Bay	BA
Wainwright	BA

#### *Maniilaq Service Area*

Location	Region Code
Ambler	MA
Buckland	MA
Deering	MA
Kiana	MA
Kivalina	MA
Kobuk	MA
Kotzebue	MA
Noatak	MA
Noorvik	MA
Point Hope	MA
Selawik	MA
Shungnak	MA

#### *Bristol Bay Service Area*

Location	Region Code
Alaknagik	BB
Chignik Bay	BB
Chignik Lagoon	BB
Chignik Lake	BB
Clarks Point	BB
Dillingham	BB
Egegik	BB
Ekwok	BB
Goodnews Bay	BB
King Salmon	BB
Koliganek	BB

#### *Nome Service Area*

Location	Region Code
Brevig Mission	NS
Diomedes	NS
Elim	NS
Gambell	NS
Golovin	NS
Koyuk	NS
Nome	NS

Levelock	BB
Igiugig	BB
Ivanof Bay	BB
Manokotak	BB
Naknek	BB
New Stuyah	BB
Perryville	BB
Pilot Point	BB
Platinum	BB
Port Heiden	BB
South Naknek	BB
Togiak	BB
Twin Hills	BB
Ugashik	BB

#### *Southeast Region Service Area*

Location	Region Code
Angoon	SE
Auke Bay	SE
Cape Yakatage	SE
Craig	SE
Douglas	SE
Elfin Cove	SE
Gustavus	SE
Haines	SE
Hoonah	SE
Hydaburg	SE
Hyder	SE
Juneau	SE
Kake	SE
Klawock	SE
Klukwan	SE
Mendehall	SE
Metlakatla	SE

Savoonga	NS
Shaktoolik	NS
Shishmaref	NS
St. Michael	NS
Stebbins	NS
Teller	NS
Unalakleet	NS
Wales	NS
White Mountain	NS

#### *Tanana Chiefs Conference Service Area*

Location	Region Code
Aatna	TC
Allakaket	TC
Anderson	TC
Arctic Village	TC
Badger	TC
Beaver	TC
Bettles	TC
Birch Creek	TC
Border	TC
Central	TC
Chalkyitsik	TC
Chatanika	TC
Chickaloon	TC
Chicken	TC
Circle	TC
Coldfoot	TC
College	TC
Delta Junction	TC
Dot Lake	TC
Eagle	TC
Eielson AFB	TC
Ester	TC
Evansville	TC

Mt. Edgecumbe	SE
Pelican	SE
Petersburg	SE
Sitka	SE
Skagway	SE
Tenakee Springs	SE
Thorne Bay	SE
Wrangell	SE
Yakutat	SE

*Yukon Kuskokwim Service Area*

Location	Region Code
Akiachak	YK
Akiak	YK
Alakanuk	YK
Aniak	YK
Anvik	YK
Atmautiuak	YK
Bethel	YK
Chefornak	YK
Chevak	YK
Chuathbaluk	YK
Crooked Creek	YK
Eek	YK
Emmonak	YK
Grayling	YK
Holy Cross	YK
Hooper Bay	YK
Kalskag	YK
Kasigluk	YK
Kipnuk	YK
Kongiganak	YK
Kotlik	YK
Kwethluk	YK

Fairbanks	TC
Flat	TC
Fort Yukon	TC
Galena	TC
Healy	TC
Healy Lake	TC
Hughes	TC
Huslia	TC
Kaltag	TC
Koyukuk	TC
Lake Minchumina	TC
Manley Hot Springs	TC
Minto	TC
Nenana	TC
North Pole	TC
Northway	TC
Nulato	TC
Rampart	TC
Ruby	TC
Salcha	TC
Stevens Village	TC
Sutton	TC
Tanacross	TC
Tanana	TC
Tetlin	TC
Tok	TC
Venetie	TC

Kwigillingok	YK
Lower Kalskag	YK
Marshall	YK
Mekoryuk	YK
Mountain Village	YK
Napakiak	YK
Napaskiak	YK
Newtok	YK
Nightmute	YK
Nunapitchuk	YK
Pilot Station	YK
Quinhagak	YK
Red Devil	YK
Russian Mission	YK
Scammon Bay	YK
Shageluk	YK
Sheldon Point	YK
Sleetmute	YK
St. Mary's	YK
Stony River	YK
Toksook Bay	YK
Tuluksak	YK
Tuntutuliak	YK
Tununak	YK