Alaska Medicaid Provider Billing Manual

General Program Information

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About This Manual

The Department of Health (DOH) is the state agency designated to administer the Alaska Medical Assistance program, which includes:

- Medicaid
- Denali KidCare (DKC)

Unless otherwise specified, references to the Alaska Medical Assistance program or Alaska Medical Assistance mean Medicaid and DKC. References to Alaska Medicaid, or Medicaid, mean only Medicaid and DKC.

This manual, *General Program Information*, is to be used by enrolled providers in conjunction with the

- Program-Specific Manual
- Claims Management Manual

Updates to this manual will be necessary from time to time as federal and state medical assistance regulations are adopted. As updates are made, each affected policy or procedure will be annotated with the date of the change in the below Revision History section of this manual. Providers will be informed of these updates by remittance advice messages and announcements through Alaska Medicaid Health Enterprise. Previously published manuals are available upon request.

Thank you for your participation in the Alaska Medicaid program and for the services you provide.

Legal Authority

The Alaska Medicaid program is governed by the following:

- 42 CFR Subchapter C (430-456)
- AS 47.07
- 7 AAC 105 - 160

Revision History

Revision Date	Revision Summary
11/24/2025	• Policies reviewed and language brought up to date, links validated and updated, additional clarification added and added Provider Essentials section.

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7/18/2023	• Department of Health rebrand • Revised hyperlinks • Updated processes

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Program Introduction

The Alaska Medicaid program is authorized by the provisions of Title XIX (Medicaid) and Title XXI (Denali KidCare [DKC]) of the Social Security Act. Together, Medicaid and DKC, provide medical assistance to more than 255,000 low- income individuals, approximately 34 percent of Alaska's residents.

Alaska Department of Health

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

Division of Health Care Services

Responsible for administration of the Alaska Medicaid program, the Division of Health Care Services (DHCS) oversees fiscal agent operations, including payment of six million medical claims annually to more than 20,000 enrolled health care and support providers who care for over 255,000 of the most medically and f inancially fragile Alaskans. DHCS ensures functionality of the Medicaid Management Information System (MMIS), the state's largest single source of health care data, maintains and leads efforts in rate review and rate setting, policy and planning, Medicaid reform, quality assurance, certificate of need and health facility survey. DHCS also provides regulatory oversight and direct support to both Native, through the Tribal Health Program, and non-Native hospitals, physicians, pharmacies, therapists, clinics, and most other health care provider types.

Division of Behavioral Health

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

Division of Senior and Disabilities Services

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

Division of Public Assistance

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

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Division of Public Health

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

Medicaid Contractors

Classic Optical

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

Comagine Health

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

- Alaska Medicaid Coordinated Care Initiative (AMCCI)
- Health utilization management/service authorization for
  - Select inpatient and outpatient diagnoses and procedures
  - All acute care inpatient stays as requried
  - Psychiatric inpatient admissions
- Quality of care reviews
- Case management services
- Provider education
- TEFRA (Tax Equity and Fiscal Responsibility Act) application and renewal review

Conduent

The State of Alaska contracts with Conduent to serve as Alaska's Medicaid Management Information System (MMIS) operations and maintenance vendor.

Corporate Travel Management

Corporate Travel Management (CTM) serves as Alaska Medicaid's primary Medicaid Travel Office assisting members with airfare and ferry reservations for medically necessary transportation.

HMS

The State of Alaska contracts with HMS, a Gainwell Technologies Company, to serve as its fiscal agent. Utilizing Alaska's Medicaid Management Information System (MMIS), the fiscal agent is responsible for:

- Receiving, processing and payment of claims
- Provider enrollment and revalidation

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- Provider inquiry, problem resolution, and first level appeals
- Service authorization (SA) for:
  - Non-emergent travel
  - Dental
  - Physician Administered Drugs
  - Durable Medical Equipment
  - Home Health Services
  - Hearing Services
  - Home Infusion
  - Hospice
  - Behavior Health Services
  - Surgical Procedures
  - Therapy Services
  - Services that exceed an annual or periodic service limit
- Provider communication, training and outreach
- Publications
- Member eligibility verification and assistance

Prime Therapeutics

Prime Therapeutics provides pharmacy benefits administration for Alaska Medicaid. Prime Therapeutics 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 Prime Therapeutics, Alaska Medicaid realizes millions in annual savings through multi-state pharmaceutical rebate agreements and the Preferred Drug List (PDL) managed by Prime Therapeutics.

Prime Therapeutics operates a Clinical Call Center (Service Authorization Help Desk) for the Managed Access Program.

Provider Communication and Training

Provider Correspondence

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

- Remittance advice (RA) messages
- Provider newsletters
- Flyers
- Training seminars
- Provider message center announcements

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- Website
- Other written correspondence

More information is available on the Documentation page in Alaska Medicaid Health Enterprise.

Provider Inquiry

The Provider Inquiry Unit assists providers with Medicaid-related questions. The following tips will help to ensure successful inquiries:

- Review the provider billing manual and bulletins before calling.
- Have all material related to the call available for reference, such as remittance advice, claim forms, member's Medicaid identification number, etc.
- Have the provider's Medicaid identification number available.
- Note the name of the person who answered the call. This saves duplication if the provider needs to clarify a previous discussion or ask the status of a previous inquiry.

Provider Training

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

Provider training is free of charge. Training Schedules and computer-based training modules are available on the Alaska Medicaid Learning Portal, provider training presentations can also be found here as a recourse for all providers. of To meet the needs of all providers, the fiscal agent also offers live provider training in a variety of locations throughout the state and via web-based presentations; register for these classes through the Learning Portal.

Provider Enrollment

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

Group Providers and Sole Proprietor must enroll each location where they intend to render services.

Provider Enrollment Process

Providers may enroll with Alaska Medicaid by submitting an application through Alaska Medicaid Provider Enrollment Portal, a secure website that is accessible 24 hours a day, seven days a week. Alaska Medicaid Health Enterprise includes links to numerous websites that can help provide information needed to complete

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enrollment.

Provider Enrollment is a presentation available to guide providers through enrollment. To view this training, visit the Alaska Medicaid Learning Portal.

If extenuating circumstances prevent a provider from enrolling online, please contact the Provider Enrollment Unit.

Upon enrollment approval by the Department, providers will receive a Medicaid Contract ID and a welcome letter.

Provider Agreement & Required Forms

As part of the enrollment process, providers must sign and submit a provider agreement certifying that the provider agrees to comply with applicable federal and state laws and regulations. The provider agreement remains in effect so long as the provider renders services to Alaska Medicaid members and applies to the provider and all of the provider's employees and contractors.

Some Provider types may require additional addendums or attestations as part of their enrollment. Please see the Provider Resources website to determine what information is needed for enrollment.

Application Fees

Group provider and sole proprietor enrollments require a provider application fee payment and attestation form at Enrollment and at Revalidation. There are exceptions, please see the Provider Application Fee Payment Form and the Frequently Asked Questions.

If you are unable to pay the fee and would like to request a hardship waiver, please include a letter of justification and any financial records to support the hardship request as listed on the Attestation of Provider Enrollment Fee Payment Form.

National Provider Identifier

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

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

To research which NPI type you have, please visit the NPPES NPI Registry Public Search. Providers may obtain an NPI through one of the following options:

- By web: https://nppes.cms.hhs.gov/login

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- By e-mail: customerservice@npienumerator.com
- By phone:
  - 800.465.3203 (Toll-Free)
  - 800.692.2326 (TTY)
- By mail: NPI Enumerator
  PO Box 6059
  Fargo, ND 58108-6059

Taxonomy Codes

Taxonomy codes are used by healthcare providers to self-identify their specialty based on the taxonomy code set best matching their specialty. These may be found in the National Uniform Claims Committee code set list.

Provider Business License Requirement

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

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

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

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

Locum Tenens

A provider who is practicing under a temporary or locum tenens permit, license, or authorization, and who is substituting for another provider, being evaluated for permanent employment, or temporarily employed by a facility while it attempts to fill a vacant position must enroll with Alaska Medicaid as required to be reimbursed for services rendered. Enrolled locum tenens may receive reimbursement for covered medical services provided to eligible members. To be reimbursed for services rendered, a provider practicing as locum tenens must:

- Have an active permit, license, or authorization under AS 08.
- Enroll as a provider in Alaska Medicaid and obtain a Medicaid Contract ID. Enrollment will be approved only for the period on the license or permit.

Alaska permits only medical and osteopathic physicians, advanced practice registered nurse, physician assistants, chiropractors, nurses, certified registered nurse anesthetists and nurse midwives to be locum tenens. The process usually takes eight weeks to receive the permit. To apply for a permit, contact the Alaska Department of Commerce, Community, and Economic Development's Division of Corporations, Business

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and Professional Licensing.

Physician Assistant who have a Locum Tenens Permit must also have a collaborative plan with a supervising physician.

Out-of-State Provider Participation Requirements

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

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

Exclusions and Sanctions

Providers are required to answer 9 questions regarding exclusions and sanctions at enrollment and revalidation. If the provider answers yes to any of the questions, the provider must supply documentation regarding the sanction question.

Site Visits

Group providers and sole proprietors who enroll as moderate, or high-risk provider types are required to have a pre and post site visit completed per 42 CFR §455.432 at enrollment, revalidation, or a service location address change. At initial enrollment, the site visit completion date is factored into the enrollment effective date.

Any enrolled provider is required to permit CMS or a State Medicaid Agency to conduct unannounced site inspections.

Backdate Enrollment Requests

Providers applying for enrollment who seek to have a retroactive enrollment effective date must submit the Request to Backdate form within 30 days of submitting the enrollment application. Providers seeking a retroactive enrollment can request a date for up to one year from the application approval date to accommodate for timely filing requirements.

The provider may receive a backdated enrollment if they have a concurrent enrollment with Medicare, concurrent enrollment with another state's Medicaid program, or have provided services to an Alaska Medicaid recipient covered under 7 AAC 105 – 7 AAC 160. All enrollment factors must be met prior to issuing an effective start date, which include licensing, site visits, certifications, background checks, etc.

Changes in Enrollment

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Providers must report all changes to their enrollment information within 30 days of the change. Notifications of enrollment changes must be made in writing, and an original signature is required; changes will not be made based on oral requests. Use the Update Provider Information Request Form to report any change in the following:

- Name
- Doing business as Name
- Service Location Address
- Billing Address
- Area of Specialty
- Mailing Address
- Phone number
- Fax Number
- Email address
- Publication/Distribution Address
- Taxonomy Code
- NPI
- DEA
- CLIA
- NCPDP

Use the Ownership Or Organizational Change Form (see FAQ) to update ownership. You will then need to complete the following actions depending on the ownership change:

- New application if changing the following information:
  - Tax ID number
  - Sale of Business - 100% ownership change with or without a new Tax ID number
  - Change in business structure (ex: change in structure from sole proprietor to a LLC, corporation, or non-profit, etc.)
- Provider Disclosure Statement if changing the following information:
  - Removing Owner
  - Changing Ownership Percentage between Existing Owners
  - Adding Additional Owner
- If a license or certification is required, notify the certification or licensing entity of the change.

If you are adding or removing affiliations to the group membership, fill out the Change Affiliation Request Form. Adding affiliations does not change the individual provider's enrollment address information. Address changes must be submitted separately using the Update Provider Information Request Form.

Provider Revalidation

Providers are required to revalidate with Alaska Medicaid on a regular basis to remain an active provider. Revalidation timeframes are determined by the provider type risk level and may be altered by workload. Providers can find more information regarding their revalidation due date on the Provider Enrollment website. They can also find the forms for revalidation on the Provider Revalidation Page.

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Providers who do not submit their revalidation to the Fiscal Agent before their revalidation due date will have reimbursement payments delayed until the revalidation is processed.

Portal Access

Group provider and sole proprietor enrollments who would like to have access to the Alaska Medical Assistance Portal but do not currently have access can submit the Organization Administrator Change Request Form. Organization administrators will receive an e-mail containing instructions on logging into the portal and best practices regarding how to keep the user ID active.

Disenrollment after 18 months of no claims

The department may disenroll a provider if claims have not been submitted for at least 18 months per 7 AAC 105.210(d). A provider may reapply for enrollment.

Enrollment Appeals

Providers may appeal no later than 180 days after the date of the decision to deny or disenroll the provider to the address listed in the department's Second Level Provider Appeals list, except for reasons other than in 7 AAC 105.400 and 7 AAC 105.210(d). This written request must specify the basis upon which the decision is challenged and includes any supporting documentation; and a copy of the original denial of enrollment or notice of disenrollment.

A decision on appeal under this section is a final administrative decision, and the department will notify the provider of the provider's right to appeal to the superior court under the Alaska Rules of Appellate Procedure. Appeal information may be found under 7 AAC 105.270.

Provider Participation Requirements and Responsibilities

Equal Treatment

Federal laws, including Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and the 1975 Age Discrimination Act, prohibit discrimination against any person in the United States on the grounds of race, color, national origin, age, or handicap, which would deny that person participation in or benefits of any program or activity with federal financing. In addition, a provider must not discriminate against a person

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receiving Medicaid services who has a third-party resource. Payments can only be made to providers who comply with federal laws. Billing for medical assistance services or supplies is considered evidence that the provider is complying with the Acts named above. Failure to comply may result in a determination by the Department of Health that the provider is not qualified to participate in Alaska Medicaid.

Translation/Interpretation Services

Medicaid-enrolled providers are obligated under federal law to provide access to health care services, including language interpreting services, when needed, for members who have Limited English Proficiency (LEP).

Guidance from the U.S. Department of Health and Human Services includes a four-factor analysis that guides providers in determining the extent of their obligation to offer LEP services, and development of a plan to meet the needs of the LEP population.

Documentation

Provider Records Requirements and Retention

Providers[1] must maintain records necessary to support the care and services for which payment is requested, and to retain those records for at least **seven years** from the date services were provided. Records must include:

- Patient information for each service provided, including the name of the member receiving treatment; specific services provided; extent of each 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 or therapeutic information pertinent to each service provided (according to applicable professional standards, applicable state and federal law, applicable Alaska Medicaid provider billing manuals, and any pertinent contracts) to a patient for which services have been billed to Alaska Medicaid, including:
  - The member's diagnosis
  - The medical need for each service
  - Each service, prescription, supply, or plan of care prescribed by the provider
  - Prescription drugs dispensed (if applicable)
  - Start and stop times for time-based billing codes; may not be recorded on pre-populated time sheets
  - Annotated case notes, dated and signed or initialed by the individual who provided each service; for electronic records, providers must include an electronic signature under AS 09.80
  - Contemporaneous service records documented within 14 days from the end of the date of service

Providers must ensure that records are kept by employees, subcontractors, and grantees. Providers who do not keep and maintain records in accordance with the above requirements may not submit claims to Alaska Medicaid for reimbursement. If a provider fails to maintain appropriate documentation for a submitted claim, that claim is considered an overpayment and is subject to recoupment. Facilities listed under 7 AAC

[1] On November 13, 2018, the American Medical Association (AMA) adopted documentation standards, Resolution 804 (I-18) Arbitrary Documentation Requirements for Outpatient Services (Policy D-320.985, for AMA members). The Department of Health has determined that physician application of AMA standards D-320.985 meets the contemporaneous documentation requirements.

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12.990(26) are exempt from contemporaneous documentation requirements.

Documentation of start and stop times is not required for evaluation and management billing codes, but documentation must be maintained in accordance with professional guidance.

Electronic Records

Providers who maintain records in an electronic format must ensure that the stored data is available and readily accessible if requested. Electronic data storage systems must

- Comply with P.L. 104-191 (Health Insurance Portability and Accountability Act)
- Protect against unauthorized modification
- Identify the creator and date of initial data entry and any modification

The electronic health record or electronic visit verification system may generate prepopulated demographic data.

Request for Records

At the request of a Department of Health representative, an authorized federal representative, or another authorized representative, including an employee of the Department of Law, a provider 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 member.

Audits

Provider-Conducted Self-Audit

All enrolled providers who submit claims to Alaska Medicaid during a calendar year must conduct a review of a statistically valid random sample of submitted claims once every two years. The reviewed claims must have dates of service from the calendar year for the provider and may be identified at the tax ID level. Providers may use any widely accepted statistical software, such as RATS-STATS, to assist in sample size determination and sample selection, using a minimum of a 90% confidence interval.

Providers must wait one year following the end of the calendar year to conduct the review in order to allow for timely filing of all claims.

If any deficiencies are identified during the self-audit process, the provider must establish appropriate corrective actions to address all issues found. If a provider identifies overpayments through a self-audit or at any other time, then the provider must report each overpayment to the Department, Office of the Commissioner Medicaid Program Integrity within 10 business days. Each report must include:

- Method used to sample the claims
- Transaction control number(s) (TCN) of sampled claims
- Outcome of the individual claim audit
- Amount of overpayment to be paid back to Alaska Medicaid
- If applicable, a corrective action plan

Payments are to be submitted to the Department, Medicaid Program Integrity, 3601 C Street, Suite 902,

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Anchorage, AK 99503. Do not submit overpayments identified through the self-audit process to the fiscal agent.

Providers must meet the following reporting requirements according to their reimbursement from Alaska Medicaid within the examined calendar year:

- $30,000 or greater: submit a written report detailing the claims reviewed and the results of the review with a Provider Self-Audit Attestation attached by mail to the address listed on the attestation
- Between $10,000 and $30,000: must have the report available for review by Alaska Medicaid
- Less than $10,000: must have an Provider Self-Audit Attestation on file and available for review by Alaska Medicaid

Repayment Options

Within 60 days of identifying an overpayment, the provider must repay Alaska Medicaid unless the provider has a repayment agreement with DOH. DOH may, in the repayment agreement, authorize repayment through one of the following means:

- Lump sum within two months after the date of the discovery of the overpayment
- Payment plan not to exceed two years in length; the payment plan may be extended based on these factors:
  - Provider's history of compliance with the Medicaid program generally, including prior payment agreements
  - Amount of the overpayment
  - Amount of revenue the provider is receiving from Medicaid
  - Any other factors that would impact repayment, such as type of services being provided
- Offsetting future payments made to the provider with the full amount being repaid not later than two years from the date of the agreement

If a provider defaults on any of the above repayment options, DOH may require immediate payment of the total amount due. A provider that defaults on paying the total amount is subject to sanctions up to and including termination from the Medicaid program.

At any time, DOH may review the results of a provider-conducted self-audit for accuracy. If the provider's self-audit is found to be inaccurate or if DOH is not given an opportunity to or is obstructed from examining the provider's self-audit, then DOH may impose sanctions on the provider.

Providers must keep all audit documents, reports, and attestations created as a result of the review for at least seven calendar years.

For additional information regarding provider-conducted self-audits, refer to the Medicaid Program Integrity webpage.

Fiscal Audits

The Department of Health, or its designee, may conduct fiscal audits of Medicaid providers, their subcontractors, and their grantees. A fiscal audit may include a desk audit, a field audit, or both, to determine the provider's compliance with state and federal regulatory requirements. For purposes of conducting the audit, providers must allow DOH or its designee, the federal government, or the Department of Law access to original financial, clinical, and other records documenting care provided to Medicaid members.

Notice of Audit

When DOH decides to conduct an audit, the provider will be given 30 days advance notice specifying the

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- Place where the audit will be conducted
- Records that must be produced for purposes of the audit
- Delivery date and address for the records to be delivered or inspected

The entity conducting the audit may act without advance notice if there is reason to believe, based on credible evidence, that the provider is engaging in a course of conduct or performing an act in violation of state or federal regulations. The provider must produce the requested records for an immediate audit within 24 hours of the request at the provider's place of business or other specified location. If the provider is unable to produce the records in that timeframe, they must notify DOH within 24 hours of the request with the reason for the delay together with the estimated timeframe to comply.

Audit Findings

Once a fiscal audit has been completed, the entity conducting the audit will provide the written preliminary findings identifying claim-line inaccuracies. The provider has 30 days from the date of the letter containing preliminary findings to respond and submit additional documentation.

The final audit report will be sent to the provider no more than 60 days after DOH has considered any documentation or response submitted by the provider and the audit is complete. The final audit report will include audit findings and overpayment amounts identified through the audit. DOH will recoup or require repayment of any identified overpayments plus interest as calculated under AS 47.05.200(b). In addition to requiring repayment, DOH may take one or more of the following actions:

- Impose sanctions against the provider
- Initiate other administrative or civil actions
- Refer the matter to another state, federal, or local agency

Appealing Audit Findings

Providers have the right to appeal the findings of a fiscal audit and overpayment determinations. Providers also have the right to request reconsideration of the audit findings before a formal appeal. If a provider requests reconsideration, they may still request a formal appeal within 30 days from the date of the notice of decision on reconsideration. A written formal appeal of audit findings must be submitted within 30 days of the letter transmitting the provider's final audit report and must include:

- 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
- All information and materials that the provider requests the commissioner to consider in resolving the appeal

The request for appeal must be sent to:

Department of Health
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

After the appeal is referred to the Office of Administrative Hearings and reviewed by an administrative law judge, the commissioner will render a decision based on the hearing record and judge's proposed decision. Providers have the right to appeal the commissioner's decision to the superior court under the Alaska Rules of Appellate Procedure.

Payment Error Rate Measurement Program

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

Alaska will be selected to participate in this program once every three years. In the event a provider enrolled in Alaska Medicaid is selected for claims review, the provider will be required to furnish all records requested within 75 days from the date the records are requested. Prompt response and provider cooperation are critical to this CMS project. In order to facilitate the success of this program, Alaska Medicaid requests a person in each provider office be designated as the PERM contact – this information may be relayed to Alaska Medicaid by contacting Medicaid Program Integrity.

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

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

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

Medicaid Integrity Program Audits

Under 7 AAC 160.100, Program integrity, the department is required to conduct program integrity activities that support the economical and effective administration of the Medicaid Program. Medicaid Program Integrity audit activities are designed to investigate fraud, waste, abuse, or Medicaid program compliance by providers. Medicaid Program Integrity coordinates with the Department of Law, the United States Department of Justice, and the United States Office of Inspector.

Additionally, 7 AAC 160.140, Quality assurance program, requires the department to conduct program reviews of providers. If the department proposes adverse action as a result of the review, a written report of the findings is issued to the provider, and the case is referred to Medicaid Program Integrity for further review and potential recovery of overpayments.

Surveillance Utilization Review Subsystem (SURS)

Section 42 CFR Part 456, Utilization Control, requires states to include a statewide SURS in the Medicaid Management Information System (MMIS). SURS is used to analyze post-payment data for multiple claims at a time to identify suspicious provider billing patterns by developing and reviewing beneficiary utilization profiles, provider service profiles, and exceptions criteria. The SURS unit identifies patterns, conducts reviews and preliminary investigations, refers potential cases to Medicaid Program Integrity, the Medicaid Fraud Control Unit, and assists in criminal investigations.

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Fraud, Waste, and Abuse

Medicaid Provider Fraud Control Unit

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

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

Surveillance and Utilization Review

Surveillance and Utilization Review (SUR) is a program that monitors and reviews services and claims to detect and prevent fraud, waste, abuse, and misuse of the Medicaid program by members and/or providers.
The goal of SUR is to provide a manageable approach to the process of aggregating and presenting medical care and service delivery data to meet two major concerns:

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

The principal functions performed in SUR are as follows:

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

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

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

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

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Member Fraud and Abuse

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

Key factors in establishing member fraud:

- The fraudulent misrepresentation is intentionally represented as a statement of fact by the member.
- 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.

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

Factors associated with member abuse include:

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

Provider Fraud and Abuse

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

Key factors in establishing provider fraud:

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

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

Factors associated with provider abuse include:

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

Fraud, Waste, and Abuse Reporting

Report suspected provider or member fraud and/or abuse to the Surveillance and Utilization Review (SUR) fraud and abuse hotline at 800.256.0930, or 907.644.5975. Use the Suspected Fraud and Abuse Form to make reports in writing and submit to:

Alaska Medicaid
Surveillance and Utilization Review
PO Box 240807
Anchorage, AK 99524-0807

Reporting suspected fraud or abuse to SUR in no way restricts or relieves a citizen of the right and responsibility to report suspected criminal activity to the proper law enforcement authorities. Anyone who knowingly helps a member or a provider commit fraud are considered to be aiding in the act and may be held liable.

Sanctions

Sanctioning Providers

Grounds for Sanctions

Sanctions may be imposed by the Department for any one or more of the following reasons:

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

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

Types of Sanctions

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

- Termination from participation in the Medicaid program.
- Suspension from participation in the Medicaid program.
- Suspension or withholding of payments to a provider.
- Referral to peer review such as a professional association.
- Transfer to a closed-end provider agreement not to exceed 12 months or the shortening of an already existing closed-end provider agreement.
- Attendance at provider education sessions.
- Prior authorization of services.

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- Complete review of the provider's claims before payment.
- Referral to the state licensing board for investigation.
- Recovery of funds from the provider.

Imposition of Sanctions

The decision as to the sanction to be imposed will be at the discretion of the DOH, with the following exceptions:
If a provider has been convicted of defrauding the Medicaid program, or has been previously suspended due to program abuse, or has been terminated from the Medicare program for abuse, DOH will institute proceedings to terminate the provider from the Medicaid program.

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

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

Scope of Sanction

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

Suspension or termination from participation of any provider will preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association, to DOH or its fiscal agents for any services or supplies provided after the suspension or termination.
A clinic, group, corporation, or other association that is a provider of services may not submit payment claims to Alaska Medicaid or its fiscal agents for any services or supplies provided by a person within that organization who has been suspended or terminated from participation in the Medicaid program, except for those services or supplies provided before the suspension or termination.
When these provisions are violated by a provider of services which is a clinic, group, corporation, or other association, DOH may suspend or terminate the organization or any individual person within it who is responsible for the violation, or both.

Notice of Sanction

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

- The nature of the discrepancies or violations.

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

The notice shall state whether or not DOH intends to withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question, or that DOH intends to suspend all payments to the provider.
When sanctions have been imposed on a provider, DOH will notify, as appropriate, the provider's professional societies, the Department of Commerce, Community, and Economic Development's Division of Corporations, Business and Professional Licensing, and any other interested federal or state agency of the findings made and the sanctions imposed.

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

Appealing Sanctions

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

Department of Health
Office of the Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601

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

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

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Member Eligibility

Medicaid Eligibility Requirements

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

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

Individuals in need of medical or other assistance may contact DPA or may consult the Medicaid Member Handbook.

Medicaid Benefit Packages

Once a member is approved for Medicaid, they will be assigned an eligibility code. The eligibility code reflects the Medicaid category they are covered through. The eligibility code directly ties to which benefit package the member is approved for. The eligibility code is identified on the member's Medicaid ID card.

Medicaid Benefit Package Chart & Medicare Savings Programs

Medicaid Benefit Package Chart identifies what benefits are available for each eligibility code. This document provides general coverage information; other restrictions may apply in some scenarios.

Basic Medicaid Coverage	
Medicaid Coverage	**Eligibility Codes**
• Medical Services • Dental • Behavioral Health • Preventive Care • Emergency Services • Hospital • Prescription Drugs • Transportation	*(11) Medicaid for pregnant women* *(20) Family Medicaid or Adult Public Assistance related* *(50) Children under age 21 not in state custody* *(51) Children under age 21 in state custody, including Title IV-E foster care* *(52) Transitional Family Medicaid for ineligibility due to excess earnings (TM & 4M)* *(54) Disabled child receiving SSI (Plus TEFRA Services)* *(69) APA/QMB Dual Medicaid and Medicare eligibility - Medicaid plus Medicare buy-in*

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Basic Medicaid Coverage - Plus Home and Community Based Waiver Coverage	
Medicaid Coverage	**Eligibility Codes**
• Medical Services • Dental • Behavioral Health • Preventive Care • Emergency Services • Hospital • Prescription Drugs • Transportation • HCB Waiver	*(24) LTC 300% Institutional Long-Term Care* *(30) APDD HCB Waiver adults with physical & developmental disabilities - Waiver only* *(31) APDD HCB Waiver adults with physical & developmental disabilities & Medicaid* *(34) APDD HCB Waiver adults with physical & developmental disabilities – Dual Medicaid/QMB* *(40) ALI HCB Waiver older or disabled adults - Waiver only* *(41) ALI HCB Waiver older or disabled adults - Waiver & Medicaid* *(44) ALI HCB Waiver older or disabled adults – Dual Medicaid/QMB* *(70) IDD HCB Waiver intellectual & developmental disability - Waiver only* *(71) IDD HCB Waiver intellectual & developmental disability - Waiver & Medicaid* *(74) IDD HCB Waiver Intellectual & developmental disability - Dual Medicaid/QMB* *(80) CCMC HCB Waiver Medically Complex Children - Waiver only* *(81) CCMC HCB Waiver Medically Complex Children - Waiver & Medicaid* *(91) ISW Individualized Supports Waiver - special LTC* *(92) ISW Individualized Supports Waiver* *(93) ISW Individualized Supports Waiver - Pregnant Woman* *(94) ISW Individualized Supports Waiver - Dual Medicaid/QMB*

Coverage Specific to Exams for Determination of Program Eligibility and Emergency Services for Certain Events	
Medicaid Coverage	**Eligibility Codes**
Exam for Program Eligibility	*(15) Pregnancy or ICAP incapacity determination only*
Exam for program eligibility determination Transportation benefits may be covered	*(19) Waiver determination only* *(25) Disability/blindness/waiver determination only*
Emergency Services for a specific event	*(53) Emergency alien Medicaid – does not meet Medicaid qualified alien criteria*

Medicare Savings Program

Medicare Savings Program helps Medicare recipients pay all or part of their Medicare premiums, and in some cases copays and deductibles. Medicare recipients who meet income and resource requirements qualify for the program. Programs available include:

Medicare Savings Program
(66) Qualified Disabled Working Individual (QDWI): Medicaid pays Parts A premiums only. Excludes Prescription Copay Medicaid & Waiver Benefit Package Included
(67) Qualified Medicare Beneficiary Program (QMB) Medicaid pays Part A and B premiums, Medicare Part A, B, and D

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deductibles, and Medicare Part A and B copays only
(68) Specified Low Income Medicare Beneficiary (SLMB) Medicaid pay Part B monthly premium only
(69) APA/QMB Dual Medicaid and Medicare eligibility – full Medicaid plus Medicare buy in
(78) SLMB Plus Specified Low – Income Medicare Beneficiary Program Medicaid pays Parts B premiums only
Medicare Part D (Prescription Coverage)
Part D plans are run by private insurance companies that follow rules set by Medicare. To be eligible for Medicare Part D prescription drug coverage, you must be entitled to Part A or enrolled under Part B. You do not need both Part A and Part B coverage to choose prescription drug coverage. Medicare Part D prescription drug coverage replaces Medicaid prescription drug coverage for members who are eligible fo programs. Medicare pays for prescription drugs through private plans.
Members with other Credible Prescription Drug Coverage
People with both Medicare and Medicaid, known as "dual eligible", are automatically enrolled in a plan. A member who ha creditable prescription drug coverage, such as employer or union coverage (including COBRA) is not required to join a Me drug plan. This is because an applicant or member who drops employer or union coverage may not be able to get it back. may also affect coverage for spouses and dependents. Call Medicare at 1-800-633-4227 or the plan listed in your letter to them you don't want to be in a Medicare drug plan. TTY users can call 1-877-486-2048.

Automatic Plan Assignment – Option to Opt-Out

If a member has been automatically assigned to a prescription drug plan, they can opt-out of a plan or change plans at any time as long as they remain eligible for Medicaid. However, if they choose to opt-out of a prescription drug plan without enrolling in another plan, Medicaid will not pay for the cost of your prescription drugs, and they will have a lapse in drug coverage.

For more information on Medicare contact:
The Alaska Medicare Information Office at 907.269.3680 (Anchorage) or 800.478.6065 (toll free). The official U.S. Government Medicare office at 800.633.4227 or visit https://www.medicare.gov/.

Member Eligibility Verification

Providers are responsible for verifying that a patient is eligible for Medicaid 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 Medicaid 270/271 Companion Guide.
- Call the Automated Voice Response System (AVRS) at 855.329.8986.
- Request to see and photocopy the member's Medicaid coupon or card.
- Send a fax to the Provider Inquiry Unit at 907.644.8126 using the appropriate form below
  - Dental Services

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- Vision Services
- Subtype Inquiry
- All Other Inquiries

Call the Provider Inquiry Unit at 907.644.6800, option 1, 2, or 800.770.5650, option 1, 1, 2 (toll-free in Alaska).

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. Instructions for using the AVRS are available for providers.

Providers may also use the AVRS to submit inquiries for:

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

Medicaid ID Cards and Coupons

The Division of Public Assistance (DPA) produces and distributes Medicaid identification cards and coupons (samples are shown below) that verify member eligibility for Medicaid or Denali KidCare services for a specific month. Providers should photocopy the member's coupon/card for proof of eligibility.

Temporary Medicaid coupons, also referred to as *Medical Manual Coupons*, may be issued when a delay in obtaining the identification card would be harmful or when the authorization is limited to a pregnancy or incapacity determination, disability examination, partial-month eligibility, or when the member is enrolled in the Care Management Program. Temporary coupons may be computer-generated or typed.
The Medicaid identification card is not an authorization for payment of services that require a service authorization.

Codes on Member's Card or Coupon

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

- Client (Member) I.D. Number: This is a 10-digit number that begins "060XXXXXXX" or "200XXXXXXX"
- Month and Year of Eligibility
- Program Eligibility Codes
- Resource Codes (other insurance, also called Carrier IDs)
- Special Information or Authorization Statements

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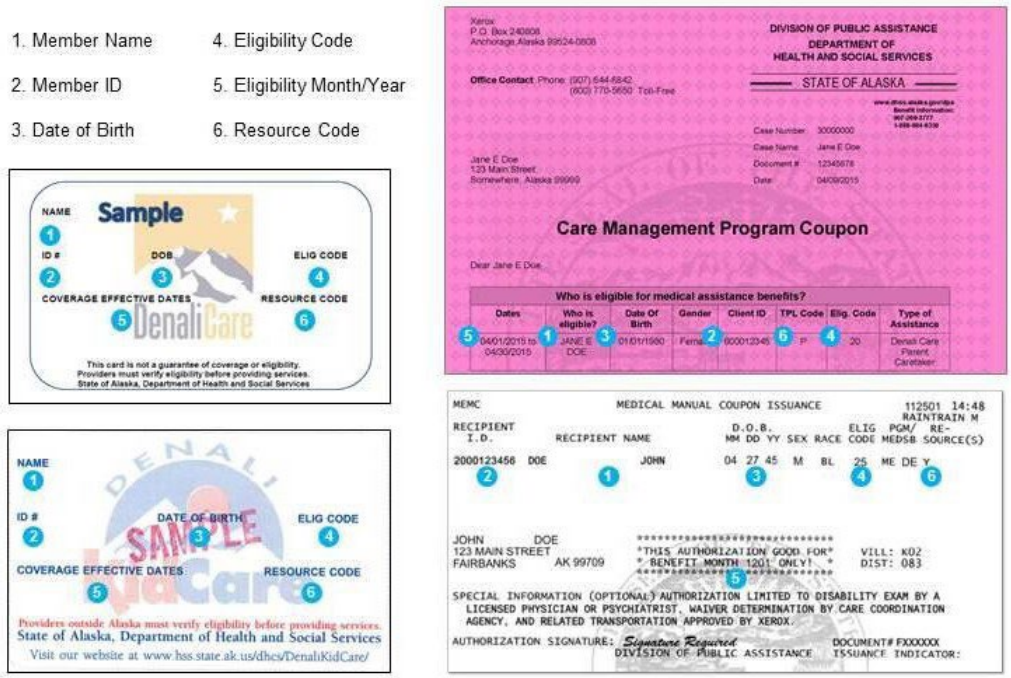

Providers must check all medical manual coupons for any special information or authorization statements. The coupons specify what services are eligible for Medicaid reimbursement. Special information statements commonly found on the Medical Manual Coupon are:

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

Resource Codes

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

Federal Resource Codes

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

G - Medicare Part A

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H - Medicare Part B
J - Medicare Parts A and B
M - TRICARE
N - US Department of Veterans Affairs (VA)
N2 - Veterans Greater than 50% Disabled
P - Alaska Area Native Health Service (AANHS) (not primary to Medicaid)

G, H, J

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

M

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

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

N / N2

Military personnel and Veterans may also receive health care benefits from the US Department of Veterans Affairs (VA). VA eligibility is indicated by resource code "N" or "N2." When members have VA, Medicare, and Medicaid coverage, the providers must first bill VA, and then Medicare, before billing Medicaid. Since the VA payment is considered payment in full, and Medicare has a 20 percent coinsurance amount, VA is always considered the primary resource over Medicare.

It is the Veteran's responsibility to:

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

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

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

P

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

No Other Insurance Available Resource

Providers may bill Alaska Medicaid.

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

Commercial Insurance Resource Code

Any two-character resource code, also referred to as carrier ID, refers to a specific commercial insurance company, and that company must be billed before submitting a claim Alaska Medicaid. Refer to the TPL Carrier Information page for a current list of commercial insurance resource codes.

Care Management Program

The Care Management Program (CMP) was established to control harmful and costly inappropriate use of Medicaid-covered services. The CMP assigns a member to one primary care provider and one pharmacy, which encourages continuity of care and promotes communication between the member's primary care provider and pharmacy. The department may also assign a behavioral health provider and/or a dental provider if needed.

While most members who could benefit from the CMP are often identified by the Department or by its fiscal agent, they may also be referred to the program by medical providers or other concerned individuals by using the Care Management Referral Form.
If after a utilization review DOH determines the individual meets criteria for CMP, the member is notified of:

- The reason for placement,
- The begin date and length of placement into the program, and
- The names of the primary care and pharmacy providers assigned to the member for the duration of their CMP placement.

The primary care provider for a CMP member 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 and is responsible for writing those referrals.

For a provider, other than the primary care provider (PCP), to be reimbursed by Alaska Medicaid, a written referral must be submitted with the claim and must include:

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

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Note: Retroactive referrals will not be accepted. A referral must be signed by the members assigned PCP prior to services rendered by the receiving provider.

In the event of a medical emergency, a CMP member may receive emergency services from any enrolled provider without restriction. A medical emergency exists when a member has a severe, life-threatening, or potentially disabling condition that requires immediate intervention. See Alaska Administrative Code 7 AAC 105.600(i).

A CMP member's identification card is marked "RESTRICTED," identifies the name of the designated CMP provider(s) and includes the members CMP placement date span.

A change in the members assigned providers may be authorized if the reason for the change aligns with 7 AAC 105.6100(g) which states "The designation of a provider under (d) of this section may be changed only if the (1) provider requests the change; (2) provider disenrolls from the Medicaid program; (3) recipient moves to a new geographic area; or (4) department finds that the recipient does not have reasonable access to Medicaid services of adequate quality."

Note: Change requests must be submitted and approved prior to the appointment date with the new requested provider. Retroactive change requests will not be accepted.

For questions or additional information, contact the Surveillance and Utilization Review Department.

Medicaid Services

Alaska Medicaid covers only medically necessary services provided to members by enrolled providers. For more information, please refer to your individual program manual.

Covered Services for Alaska Medicaid and Denali KidCare

Services for Children and Adults

- Accommodations for non-emergency medical care
- Advanced practice registered nurse services
- Ambulance
- Ambulatory surgical care
- Anesthesia
- Dental care
- Durable medical equipment
- End Stage Renal Disease dialysis facility services
- Family planning
- Federally qualified health center
- Hearing services
- Home and community-based waiver services

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- Home health care
- Hospice
- Hospital inpatient and outpatient
- Inpatient psychiatric services (members must be over 65 or under 21)
- Intermediate care facility (ICF) services
- Intermediate care facility for individuals with developmental disabilities (ICF/IDD) services
- Laboratory and X-ray
- Mental health clinic services
- Nurse midwife services
- Nutrition services for pregnant women and children under 21
- Occupational therapy
- Personal care
- Physical therapy
- Physician services
- Prescribed drugs
- Prosthetic devices and medical supplies
- Respiratory therapy
- Rural health clinic services
- Screening and brief intervention services
- Skilled nursing facility (SNF) services
- Speech-language therapy
- Substance abuse rehabilitative services
- Tobacco cessation services
- Transportation services for emergency and non-emergency medical care
- Vision care

Services for Members Under 21 Years of Age

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

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

Case Management Services

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

- Chronic illnesses like diabetes, asthma, and congestive heart failure
- Acute catastrophic injuries
- Burns, wounds, and non-healing ulcers
- Organ transplants
- Cancer
- Terminal illnesses
- Neonatal complications

Comagine Health accepts case management requests from the following individuals:

- A member or his/her family member

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- A physician, hospital, or other medical provider
- Alaska Medicaid
- A community or state agency

To refer a member for CM, contact Comagine Health or submit a Case Management Referral Request.

Upon referral, a case manager will contact the member to discuss his/her specific healthcare needs and goals, create a plan of care, and coordinate with the necessary providers to meet the needs of the member. For additional information, refer to the Alaska Medicaid Provider Manual.

Out-of-State Services

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

- The member 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 member is out of state and the member's health would be endangered if the member 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 Medicaid may deny a request for a service provided out-of-state that requires a service authorization if these conditions are not met.

Payment for services provided to Alaska Medicaid members outside the state of Alaska is dependent on the provider type and services provided. For more information about payment methodologies, please refer to the manual below that applies to your provider type.

- Claims Management Institutional
- Claims Management Professional
- Claims Management Dental
- Durable Medical Equipment

Non-covered Medicaid Services

The Department of Health will not pay for the following services, unless otherwise provided by regulation:

- A service that is not medically necessary and not reasonably necessary for the diagnosis and treatment of an illness or injury, or for the correction of an organic system, or not identified in an EPSDT screening (refer to 7 AAC 110.205)
- A service that is provided outside the scope of the provider's licensure or not properly prescribed
- Advance nurse practitioner serving as a primary surgeon
- Alternative therapy or other service including acupuncture, homeopathic or naturopathic remedy, and Ayurvedic medicine

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- Case management services[2]
- Chiropractic manipulation for members age 21 and older, unless the member is also a Medicare Part B beneficiary
- Double-occupancy rates for hotel rooms
- Brand-name drugs if a therapeutically equivalent generic drug is on the market
  - Excepting brand name drugs included on the Alaska Medicaid Preferred Drug List (PDL)
  - Excepting instances where the prescriber indicates "brand-name medically necessary"
- Drugs for which more than a 30-day supply is ordered per prescription
  - Excepting birth control drugs and drugs listed on the Alaska Medicaid PDL if dispensed in an unopened container
- Drugs used for the symptomatic relief of coughs and colds
- Drugs used to treat infertility, obesity, or baldness
- Drugs that are prohibited from receiving federal Medicaid matching funds (refer to 42 CFR 441.25)
- Educational services and supplies
- Experimental or investigative services
- Hysterectomies performed for sterilization purposes only
- Impotence treatment or services
- Infertility services
- Interpreter services
- Maintenance therapy
- Medical testimony
- No-show or cancelled appointments
- Non-prescription drug, vitamin, or dietary or herbal supplements unless otherwise indicated in 7 AAC 120.110(a)(4)
- Office supplies
- Operating room assistance provided by an intern, registered nurse or licensed practical nurse
- Plastic or cosmetic services for enhancement purposes, hair or wrinkle removal
- Podiatry services for members age 21 and older, unless the member is also a Medicare Part B beneficiary
- Programs to improve overall fitness
- Selected special services and report codes
- Services billed using non-covered CPT or HCPCS codes
- Special reports
- Sterilization for members institutionalized in psychiatric facilities, for members who are under 21 years of age, or for members determined by a court to be incompetent
- Surgical Trays
- Swimming therapy
- Travel by the provider
- Vaccine products that are available for free

This list is comprehensive, but not exhaustive.

Provider Essentials

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

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Timely Filing

Providers are required to submit a claim to the Department of Health within 12 months of the date of service. Any claim received by the fiscal agent outside of 12 months is required to include additional documentation to support why timely filing should be overridden. Any claim submitted outside of timely filing that does not include additional documentation and the appropriate attachment indicator will be denied without review. Below are some instances where timely filing may be overridden.

- Retroactive member eligibility
- Retroactive provider enrollment
- Court order or administrative hearing
- Good Cause
    - Good cause includes unexpected or uncontrollable events such as a natural disaster, fire, storm, etc.
    - Good cause does not include provider or billing staff errors, provider's staffing deficiencies or the members' failure to notify the provider of a hearing decision.

The following types of documentation can be accepted to support your

- Remittance Advice showing that claim was submitted timely, but processed incorrectly
- Proof of retroactive member eligibility
- Proof of retroactive provider enrollment
- A dated court or administrative hearing decision

Ordering Provider Requirements

An ordering Provider is any practitioner who is responsible for ordering diagnostic tests (laboratory, radiology, imaging etc.). All ordering/referring providers must be enrolled in Alaska Medicaid and even if they do not intend to bill Alaska Medicaid for reimbursement. When submitting a claim for a service that was ordered by a provider other than the rendering provider, you are required to report the ordering provider in the appropriate field of the claim form. This allows the Division to ensure that the ordering provider is licensed and credentialed during claims adjudication. If the ordering or referring provider is not actively enrolled, services may be denied until enrollment is completed.

Ordering providers can submit an order in writing, electronically or verbally (if verbal the order must be documented promptly) and must be signed, legible, linked to a valid NPI and supported by medical necessity and the members medical record. An order must include the following

- Member name and date of birth
- Date of the order
- Ordering providers name, signature and credentials
- Ordering providers NPI
- Description of the service, test, item or medication
- Clinical justification (if applicable)
- Quantity, frequency or duration (or DME, medications, therapies)

Orders may not be required to be submitted with your claim, however, should be kept within the member file and made available upon request. Additional documentation for certain services may be required, please review your individual provider manual for more information.

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For more information, please refer to 42 CFR 455.410(b) and 42 CFR 455.440.

Service Authorizations

Service Authorizations (SAs) are approvals from Alaska Medicaid or one of it contractors that verify the service is medically necessary, covered and allowable before it is delivered. Many, but not all, SAs are required to be submitted prior to the service being delivered. While requirements vary by provider type the following often requires an SA:

- Some Durable Medical Equipment (DME) and supplies
- Personal Care Services (PCS)
- Home and Community-Based Waiver Services
- Advanced Imaging (e.g., MRI CT)
- Specialized medical procedures or surgeries
- Non=emergency medical transportation
- High-cost medications or drugs not on the preferred list
- Some inpatient stays
- Some diagnosis codes

Please note this list is not complete

When you are submitting an SA request, please ensure that you accurately complete the request form and include any required supporting documentation (e.g. physician orders or prescriptions, treatment plans, assessments or evaluations, referral, progress notes…). Once the SA is approved and the service or item has been rendered, make sure you include the authorization on number on your claim. An approved SA does not guarantee payment; the claim must still meet all Medicaid billing requirements.

Providers are responsible for verifying SA requirements before delivering the services and ensuring that the authorization matches what is billed. If needed, providers are responsible for monitoring remaining units approved on the SA and requesting updates to the SA as needed.

For more information about specific SA requirements, please see your individual program manual.

Appeals

Filing an appeal is the official process providers can follow if they disagree with an adverse decision made by Alaska Medicaid, this includes claim denials or reductions, prior authorization denials, recoupments, disenrollment or sanctions. Appeals must be submitted within the appropriate timeline and to the appropriate entity, an appeal should not be submitted for a denial due to an error created by the provider or their office. If you receive a denial that was due to an error created in your office, please submit as a new day request with corrected information.

Type of appeal	Appeals Timely
First level appeal for a claim or service	180 days from the adverse action

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authorization	
Recoupment of overpayment notice	60 days from the adverse action
Sanctions	30 days from the adverse action
Enrollment	180 days
Second Level Appeal	60 days from the first-level determination

Appeals must be submitted in writing to the appropriate entity and must include the following

- A copy of the original claim or prior authorization request (if applicable)
- A copy of the remittance advice, denial notice or recoupment letter
- The basis for the appeal includes an explanation why you believe the original decision was incorrect and any supporting documentation.
- A copy of the first level determination when filing a second level appeal

Providers should act quickly to meet the relevant deadline and provide through documentation and explanation. Please ensure that you submit an appeal once, if you receive a denial follow any guidance provided in the denial notice. Information on where to submit an appeal, please refer to the Alaska Medicaid Appeal Process.
Before appealing a claim payment or denial of payment, the provider should try other methods to resolve the decision. Providers should only submit an appeal for a claim when the claim was billed correctly to Alaska Medicaid, and the provider disagrees with the outcome of the claim. If there was a billing error on the claim, please follow the appropriate step below.

- **Paid Claim**: Payment may be adjusted by submitting an Adjustment/Void Request Form (AK-05), correcting the information that was originally submitted, within the timely filing period for that date of service or within 60 days from the date of adjudication of the claim (refer to Adjustment/Void Request Form in this section). The payment amount will be recalculated based upon the corrected claim information.

- **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.

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