

Division of Behavioral Health

Medicaid Billing Processes & Fiscal Agent Services



Training: Integrated Behavioral Health Regulations

- 7 AAC Chapter 70
- 7AAC Chapter 135

August/ September 2011

Billing and Payment

A new manual is in development and will be available for training purposes during September 2011 in DRAFT form with finalized Version 1 planned to be available by October 1, 2011 implementation date

Most billing and payment mechanisms remain as before

- Claims billed with same required information to be submitted in the same fashion as currently
- Payment will be made using the same MMIS functionality and with the same Remittance Advice Statements and Checks as currently

Fiscal Agent - Contracted with the Department of Health and Social Services

Affiliated Computer Services, Inc (ACS)

1835 South Bragaw Street, Suite 200

Anchorage, Alaska 99508-3438

www.medicaidalaska.com

Anchorage: (907) 644-6800

Outside Anchorage: (800) 770-5650

(In State Toll Free)

How to find Alaska Medicaid Information using Affiliated Computer Services, Inc (ACS) Website

- start at the fiscal agent's Alaska Medical Assistance page (<http://www.medicaidalaska.com>)
- select "Providers" located in the horizontal list at the top of the page
- select "Billing Manuals" click on the boxed word "Accept" at the bottom of the page to indicate your agreement and acceptance of the copyright notice
 - Claim form instructions
 - CMS-1500 Professional Services (Set B is for use by outpatient behavioral health services providers)
 - UB-04 Institutional Services (inpatient and residential psychiatric treatment center services)
 - Provider Billing Manuals for all covered services are listed alphabetically
 - Behavioral Health Services (Community Mental Health Clinic, Substance Abuse Rehabilitative Services)
 - Day Treatment Services (community mental health clinic and school district agreement)
 - Inpatient Psychiatric (includes residential psychiatric treatment centers)
 - Mental Health Physician Clinic
 - Other Service Providers (Physician, Advanced Nurse Practitioner, Federally Qualified Health Center, School Based Services)
- select "Forms"
 - Provider Enrollment Application forms
 - Information Submission Agreements
 - Prior Authorization Forms
- select "Updates"
 - Behavioral Health Billing Manual replacement pages
- select "HIPAA"
 - Companion Guides for all Electronic Transactions
 - Tool kit , testing procedures, and other information for becoming an electronic submitter/receiver
- select "Training" to view the training schedule, register for a class or view past materials
- select "Contact Us" for designated work units, staff, mailing addresses, etc.

Fiscal Agent Functions

- Processes all Medical Assistance claims, including technical support to accommodate electronic submission of claims and other transactions
- Provides customer service for providers and recipients
- Enrolls providers in Medical Assistance
- Provides Medical Assistance billing training to the provider community
- Publishes and distributes provider billing manuals
- Maintains website of information for providers
- Prior authorizes some services
- Performs First Level Provider Appeals
- Performs Intake for Recipient Fair Hearing Requests
- Generates and issues claim payments and tax information
- Performs Surveillance and Utilization Review (program integrity)

Claims Billing and Payment Tools & Support

- Provider Billing Manuals
- Provider Training
- Provider Inquiry; Enhanced Provider Support Chandra Lewis in-state, toll free: (800) 770-5650 or Anchorage (907) 644-6800
- Websites
 - Fiscal Agent (ACS) – www.medicaidalaska.com
 - DHSS/DBH – www.hss.state.ak.us/dbh
 - DHSS/DHCS – www.hss.state.ak.us/dhcs
- Technical Support for Electronic Claims

Provider Manual Overview

Section I – Program Policies and Claims Billing Procedures for Community Behavioral Health Services

- PART A – General Requirements
- PART B – Service Detail Sheets
- Section I Appendices
 - Appendix I-A – Medical Assistance Provider Enrollment and Provider Agreement
 - Appendix I-B – Department Approval of Community Behavioral Health Services
 - Appendix I-C – Clinical Documentation Requirements
 - Appendix I-D – Billing and Payment Information
 - Appendix I-E – Medical Assistance Recipient Eligibility

Section II – Attachments and Remittances

- Attachments
- Supplemental documents
- Remittance Advice (RA) Reconciliation
- Adjustments/Voids
- Claim Inquiry
- Forms Order

Section III – General Medical Assistance Information

- Claims Processing Overview
- Eligible Recipients for ALL programs
- General Program Regulations and Restrictions

Fiscal Agent Recipient Information Help Line

(907) 644-6800; Option 6 or (800) 780-9972 (in state, toll free)

Fiscal agent staff available 8:00 am to 5:00 pm

Calls from Medical Assistance recipients only

- Coverage and benefit questions
(including questions about denied services)
- Billing inquiries
- Questions about travel procedures
- Fair hearing requests

Claims Billing - General

- Use CMS-1500 Claim Form for Professional Services - ACS, Inc Website [via Providers/Billing Manuals] Set B is for use by outpatient behavioral health services providers
- Paper or Electronic
- Ensure services are:
 - Performed as active treatment, documented in treatment plan, stated as a need in assessments, etc
 - Performed by staff qualified
- Include Service Authorization number as required if services billed exceed annual service limits

Billing and Payment of Authorized Services

- CMS-1500 Claim Form
 - Block 23 – Prior Authorization Number
 - Enter 8-digit Authorization Number
- 837-Professional EDI Transaction
 - Loop 2300 – Claim Document REF Segment
 - Enter 8-digit Authorization Number
 - Loop 2400 – Service Line REF Segment
 - Enter 8-digit Authorization Number

Claims Filing Limits

- ALL CLAIMS MUST BE FILED WITHIN 12 MONTHS OF THE DATE SERVICES WERE PROVIDED TO THE PATIENT!
- The 12-month timely filing limit applies to all claims, including those that must first be filed with a third party carrier.

Claims Editing

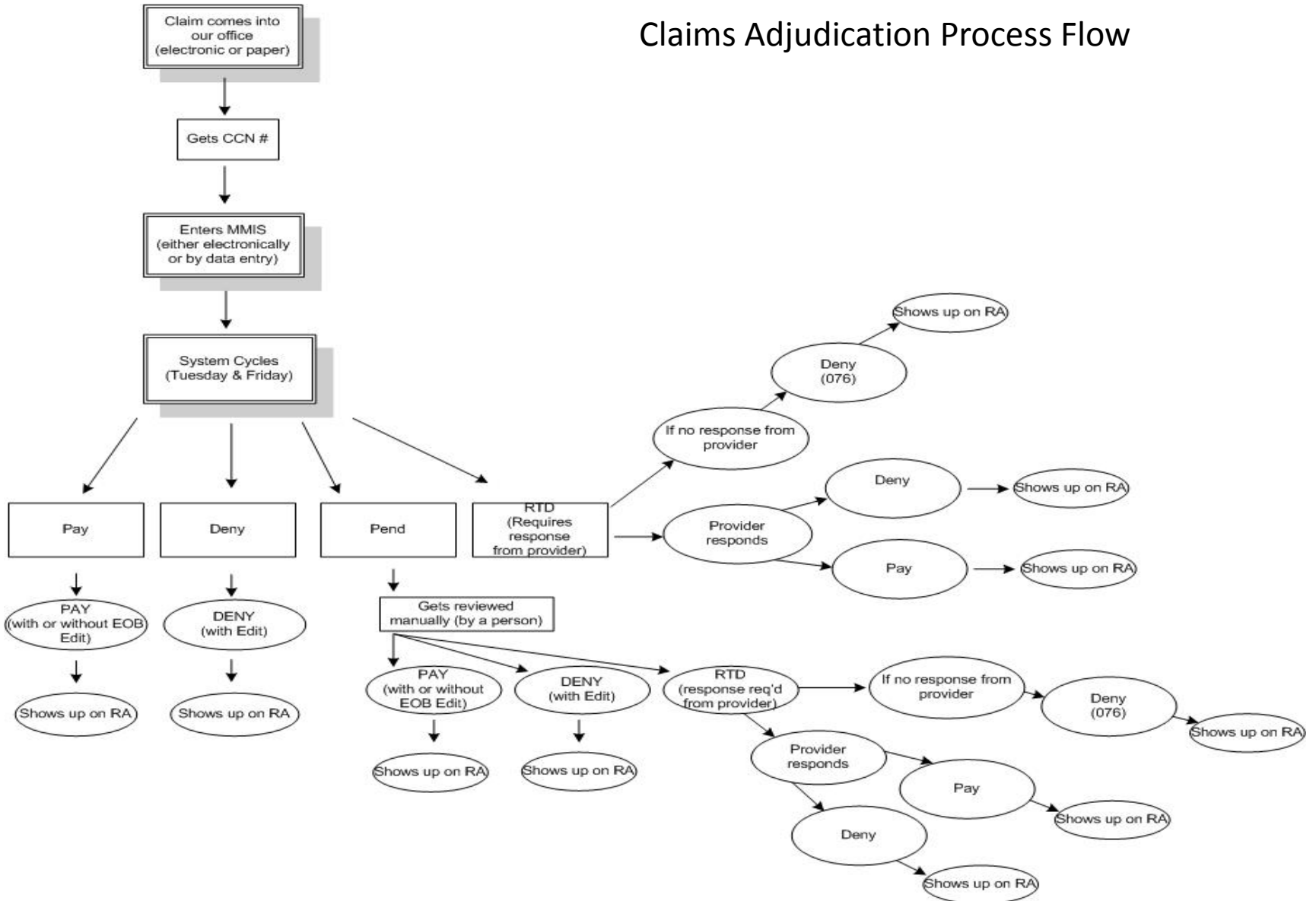
All edits are three-digit codes with explanations of how the claim was processed

- Adjudicated Claims (Paid or Denied)
 - reduction in payment
 - denial of service
- In-process claims (further internal review or information needed)
 - pending status requiring internal staff review
 - additional information requested from the provider (via RTD)

The Remittance Advice (RA) statement includes an Explanation of Benefit (EOB) description page that lists all EOB codes and a brief description of each found within that specific Remittance Advice

- Contact ACS, Inc. Provider Inquiry for clarification as needed

Claims Adjudication Process Flow



Provider Appeals

7 AAC 105.270

REASONS to Request an Appeal

- Denied or reduced claims (180 days)
- Denied or reduced prior authorization (180 days)
- Disputed recovery of overpayment (60 days)

Three Levels of Appeals

- First level appeals
- Second level appeals
- Commissioner level appeals

First Level Appeals- Fiscal Agent, ACS

Must be submitted in writing within 180 days of remittance advice for claim or authorization

Appeal form is available, include:

- A copy of the Claim or Disputed Authorization Decision
- A copy of the Remittance Advice Statement
- Supporting Documentation
- Completed Adjustment Request, if applicable
- Mail to

Affiliated Computer Services, Inc.

Provider Services Unit

P. O. Box 240808

Anchorage, AK 99524-0808

Second Level Appeals

- Must be submitted in writing within 60 days of First Level Appeal Decision
- Include
 - Reason for Appeal including a description of the issue or decision being appealed
 - Copy of decision from First Level Appeal
 - Copy of denial or payment notice (Remittance Advice)
 - Copy of Original Claim
 - All information and materials for consideration

Commissioner Level Appeals

- ONLY used to challenge/appeal adverse timely filing denials/reductions
- Must be submitted in writing within 60 days of Second Level Appeal decision
- Include clear

Recommended Keys to Achieve Success in Billing/Payment

- Read and maintain your billing manual
- Verify recipient eligibility
- Verify eligibility code
- Verify dates of eligibility
- Verify Third Party Liability
- Verify the services you are eligible to provide
- Verify procedure codes
- Obtain Service Authorization, if applicable
- File your license renewals and/or certification/permits timely (keep your enrollment current)
- Ensure completion of claim forms (reference provider manual)
- Document Third Party Liability payment on claim, if applicable
- Include attachments as required
- FILE TIMELY
- RECONCILE PAYMENTS (Remittance Advice (RA) Statements)
- Read and distribute RA messages
- Address problems/issues promptly
- Call Provider Inquiry with questions

Alaska Medicaid Regulations

Request for Records

At the request of a DHSS representative or authorized federal, or other representative, including an employee of the Department of Law, **a provider shall provide records**, including financial, clinical, and other records, that relate to the provision of goods or services on behalf of a recipient:

- To the person making the request at the address specified in the request
- No later than the deadline specified in the request
- Without charge and in the format stated in the request

7 AAC 105.240 – Request for records

Audits and Reviews

- Federal audits
 - Department of Health and Human Services
 - Department of Justice
 - U. S. Government Accountability Office (GAO)
- State audits
 - Department of Health and Social Services (DHSS)
 - Department of Law
 - Legislative Audits
- Fiscal audits
- Provider Reviews

Previous AUDIT FINDINGS

- No client signature on treatment plan
- No treatment plan reviews to cover dates of service
- No documentation to match billed services
- Progress notes do not match service billed
- Duplicates of notes for the same service on a different day
- Units billed and documented do not match notes
- Duration of service is not supported by content of note
- No treatment plan
- Insufficient documentation to support units of service billed
- Wrong service code submitted
- Agency forms that contained check boxes contained boxes that were unchecked and the missing information was not supported by a narrative explanation elsewhere in the note