# Alaska Administrative Services Organization
# Provider Manual

## September 2023

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# Introduction

## 1. Introduction

### 1.1 Program Introduction

The Alaska Medical Assistance program is authorized by the provisions of Title XIX (Medicaid) and Title XXI (Denali KidCare, “DKC”) of the Social Security Act. The Alaska Medical Assistance program offers services to an average of 219,000 eligible participants within the program. The Division of Behavioral Health, “the Division”, manages the behavioral health (mental health and substance use disorder) services within the program.

The Alaska Medical Assistance program has received approval from the Centers for Medicare and Medicaid Services, “CMS” to implement an 1115 waiver demonstration for substance use disorder “SUD”, and behavioral health “BH” services. The intent of this demonstration is to create a data-driven, integrated behavioral health system of care for Alaskans experiencing serious mental illness, severe emotional disturbance, substance use disorder, co-occurring substance use and mental illness, and at-risk families and children. To meet this goal, the Division has partnered with Optum.

### 1.2 Alaska Department of Health

The Alaska Department of Health, "the Department", is the single state agency responsible under 42 C.F.R. 431 for administration of Alaska's Medicaid program. The Division within the Department has a key role in the administration of Medicaid in Alaska.

### 1.3 Division of Behavioral Health

Overseeing mental health for Alaskans, the Division provides programmatic management and oversight of substance use disorder and mental health services throughout the state.

### 1.4 Medical Assistance Contractors

The State of Alaska contracts with Optum to serve as its Administrative Services Organization “ASO”. The ASO is responsible for:

- First level appeals
- Processing and payment of claims
- Provider billing manual
- Provider communication
- Provider inquiry
- Provider outreach
- Provider training
- Service Authorizations:
    - 1115 Waiver Services
    - Autism Services

- Community Behavioral Health Services
- Mental Health Physician Clinic

# 2. Website and Electronic Services

## 2.1 Optum Alaska

The Optum Alaska website includes both public information and access to secure transactions. For providers, publicly accessible information is located under the For Alaska Medicaid Providers tab and includes:

- Provider Billing Resources
- Provider Trainings
- Alerts, Updates and Announcements
- Clinical Tools
- Service Authorization
- Provider Newsletter

The Optum Alaska website contains information about Optum Alaska and its business. Links to information and documents that are important to providers are located here under the For Alaska Medicaid Providers tab. Providers can also access a copy of Optum Alaska's Notice of Privacy of Practices regarding the use of the website.

**Please note:** Optum Alaska's website includes Terms and Conditions that cover areas specific to "No Warranties," "Exclusion of Liability," "Indemnification," "Jurisdiction" and "General Provisions," as well as technical assistance related to the installation and use of this software. Technical assistance includes, but is not limited to, any guidance, recommendation, instruction, or action taken by Optum Alaska or its employees, including where such activity is performed directly on your system, device, or equipment by an Optum employee or other representative.

# 3. General Provider Information

## 3.1 Provider Training

Technical Assistance Teleconferences are held on the 2nd Wednesday of every month.

New Trainings, training opportunities and related materials are posted on the Alaska Optum website under the Provider Trainings section.

## 3.2 Provider Communication

### Provider Alerts

Optum will email Provider Alerts to announce important information, such as changes within behavioral health services, Departmental and Divisional announcements, and important regulatory guidance. Providers can register for Provider Alerts by subscribing on the Optum Alaska website.

Provider Alerts are also posted on the Optum Alaska website under Alerts, Updates & Announcements.

## 3.3 Enrollment and Application Information

### Regulations

Providers must meet the requirements specific to their accrediting authority and those are not included in this document. Behavioral health service providers must also meet the requirements in the Behavioral Health Services Integrated Regulations 7 AAC 70 and 7 AAC 135.

The Department has granted statutory authority to allow the Division on-site access to all documents related to Medicaid service delivery (including participant files), per AS 47.05 for mental health treatment and AS 47.37 for substance use treatment.

At the request of the Department, a provider must provide records in accordance with 7 AAC 105.240. The Department may review records of Medicaid providers without prior notice from Medicaid providers if the Department has cause that is based on reliable evidence to do so, per 7 AAC 160.110 (e).

The Department may investigate complaints made by a participant or interested parties, per AS.47.30.660 (b) (12).

All behavioral health service providers are required to have a written grievance policy and procedure that will be posted and made available to all participants upon admission. The Department encourages participants currently enrolled with a provider to follow that provider's grievance policies and procedures.

### Department Approval

Behavioral health service providers that are described in 7 AAC 70.010 must have Departmental Approval to operate in Alaska. To obtain Department Approval, submit an application to Medicaid Provider Assistance Services Section, "MPASS Unit".

### Provider Enrollment

HMS, a Gainwell Technologies Company will continue to maintain all provider enrollment for the Alaska Medical Assistance program. Providers must be enrolled with HMS, a Gainwell Technologies Company

to receive reimbursement for services rendered to eligible participants. 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 Medical Assistance program provider.

Behavioral health service providers may enroll with Alaska Medical Assistance by applying to HMS, a Gainwell Technologies Company through the Alaska Medicaid Health Enterprise website. A secure website that is accessible 24 hours a day, 7 days a week. Health Enterprise includes links to numerous websites that can help you complete your provider enrollment.

Online training is 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 Department.

Once your enrollment is approved you will receive a Medicaid Provider ID and a welcome packet.

**Provider Agreement**

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 Medical Assistance participants and applies to the provider and all the provider's employees and contractors.

The provider agreement is available as part of the enrollment application process.

**Changes in Provider Enrollment**

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:

- Ownership
- Licensure, certification, or registration status
- Federal tax identification number
- Type of service or area of specialty
- Additions, deletions, or replacements in group membership
- Mailing address or phone number
- Medicare provider identification number

**Enrollment Fees**

An enrollment fee is required for Community Mental Health Centers, Hospitals, and Residential Psychiatric Treatment Centers under 42 CFR 455.460. The fee is adjusted annually.

Providers that are required to pay an enrollment fee must remit a check or cashier's check in the exact amount established by CMS for the current calendar year, annotated "Medicaid Provider Enrollment Fee" and payable to **State of Alaska**. Checks for any amount other than the exact amount required will be returned and the enrollment application will be rejected. There are exceptions if a provider has already paid an enrollment fee to Medicare or another state's Medicaid or CHIP program. The provider must submit evidence of having paid the enrollment fee to Medicare or another state Medicaid or CHIP

program.

Additional information about enrollment fees is located on the Division of Health Care Services website.

**Approval**

HMS, a Gainwell Technologies Company will send notification letters to providers to notify them of their enrollment status. This notification will contain the providers' ID numbers and effective dates. Alaska Medicaid does not backdate applications. The effective date of the account is the date the completed application was processed.

Services delivered before the provider ID is active, or those services that have not been authorized by the ASO will not be reimbursed.

# 4. Covered Services

Alaska Medicaid information about covered behavioral health services can be found on the Divisions Medicaid Related Information web page.

## 4.1 1115 Waiver Covered Services

### 4.1.1 1115 Waiver Substance Use Disorder (SUD) Services:

Claims for 1115 Waiver SUD Services should be submitted to Optum for dates of service on and after February 1, 2020.

1115 Waiver SUD Information, including Waiver SUD service descriptions and rates can be found on the Divisions Medicaid Related Information web page.

### 4.1.2 1115 Waiver Behavioral Health (BH) Services:

Claims for 1115 Waiver BH Services should be submitted to Optum for dates of service on and after May 21, 2020.

1115 Waiver Information, including Waiver Behavioral Health service descriptions and rates can be found on the Divisions Medicaid Related Information web page.

## 4.2 Medicaid State Plan Covered Behavioral Health Services

The current fee schedules can be found on the Divisions Medicaid Related Information web page.

### 4.2.1 Community Behavioral Health Services (CBHC):

**Behavioral Health Screening**

A behavioral health screening may be conducted for each new or returning participant of behavioral health services. A provider may use a screening tool recommended by the department or one they have identified as appropriate for use with the participant. Alaska Medicaid covers one screening per participant per program admission for new or returning participants.

**Professional Behavioral Health Assessments**

If a behavioral health screening, court referral, or referral from another agency has identifies an individual as possibly having a behavioral health disorder that could require behavioral health services, Alaska Medicaid may cover one or more of the following assessments conducted by a CBHC:

- Mental health intake assessment
- Substance use intake assessment
- Integrated mental health and substance use intake assessment
- Psychiatric assessment
- Psychological testing and evaluation

The individual who conducts a professional behavioral health assessment must document in the written

assessment that the results of the behavioral health screening were reviewed and considered during the assessment.

**Mental Health Intake Assessment:** conducted upon admission to services and periodically during treatment to assess and document:

- Participant's mental status and social and medical history
- Nature and severity of any identified mental health disorder
- Diagnosis consistent with the:
  - Diagnostic and Statistical Manual of Mental Disorders
  - International Classification of Diseases
  - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single mental health intake assessment per participant per state fiscal year consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. The assessment must be conducted by a mental health professional clinician, physician, physician assistant, or advanced nurse practitioner working within the scope of the provider's education training, and experience. A written record of the mental health intake assessment must be included in the participant's clinical record and updated as new information becomes available.

**Substance Use Intake Assessment:** conducted upon admission to services and during active treatment for the purpose of determining and documenting:

- If the participant has a substance use disorder
- The nature and severity of any identified substance use disorder
- The correct diagnosis
- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single substance use intake assessment per participant per state fiscal year (July 1 – June 30) consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. A substance use intake assessment may be conducted by only a substance use disorder counselor, social worker, or other qualified program staff member performing duties regularly within the scope of the individual's authority, training, and job description. However, if the assessment is conducted as part of detoxification services, the individual providing detoxification services may conduct the assessment. A written record of the assessment must be included in the participant's clinical record and updated as new information becomes available.

**Integrated Mental Health and Substance Use Intake Assessment:** a combination of the previous two types of assessments that may be conducted by only a mental health professional clinician, physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's

education, training, and experience. Alaska Medicaid covers one integrated assessment per participant per state fiscal year at the start of services and one integrated assessment every six months afterward. The integrated assessment must be included in the participant's clinical record and updated as new information becomes available.

**Psychiatric Assessment:** may serve as the professional behavioral health assessment if the participant's condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication. A psychiatric assessment interview must:

- Be conducted by an enrolled dispensing physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience
- Include a review of any general medical and psychiatric history or problem the participant is presenting
- Include a relevant participant history
- Include a mental status examination
- Result in a diagnosis consistent with the:
    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Include a listing of any identified psychiatric problems, including functional impairments, with treatment recommendations

Alaska Medicaid covers up to four psychiatric assessments per participant per state fiscal year.

**Interactive Psychiatric Assessment:** may serve as the professional behavioral health assessment if the participant's condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication. An interactive psychiatric assessment using equipment and devices must:

- Be conducted by an enrolled dispensing physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience
- Include a review of any general medical and psychiatric history or problem the participant is presenting
- Include a relevant participant history
- Include a mental status examination
- Result in a complete diagnosis consistent with the multi-axial classification system used in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders
- Include a listing of any identified psychiatric problems, including functional impairments, with treatment recommendations

**Psychological Testing and Evaluation:** used to assist in the diagnosis and treatment of mental and emotional disorders. Psychological testing and evaluation includes:

- Assessment of functional capabilities

- Administration of standardized psychological tests
- Interpretation of findings

**Case Management**

Alaska Medicaid covers case management provided to a participant that is a child experiencing a severe emotional disturbance or an adult experiencing a serious mental illness or to the participant 's family for one or more of the following purposes:

- Coordinating assessments, treatment planning, and service delivery
- Providing linkage between the participant and other needed services
- Monitoring, by direct observation by the directing clinician, the delivery of behavioral health services other than case management as those services are provided to the participant to ensure that interventions and techniques are:
    - Appropriate to the participant 's needs
    - Delivered at an adequate skill level
    - Achieving the treatment goals
- Providing advocacy and support to the parents and the foster parents of a child in foster care to preserve the placement
- Providing overall advocacy and support for the participant 's social, educational, legal, and treatment needs

Case management may be provided in any appropriate community setting and does not require the participant to be present and may be provided at the same time the participant is receiving other services. Services may not exceed 180 hours per participant per state fiscal year. Alaska Medicaid will cover no more than one hour per week per participant of monitoring by the directing clinician. Only one case manager may be reimbursed for time setting up, traveling to or from, and attending a treatment team meeting conducted that participant. Claims for case management services provided by any additional providers will not be paid.

**Day Treatment Services for Children**

Day treatment services are covered for children experiencing a severe emotional disturbance in order to:

- Promote the participant's ability to be successful, independent of behavioral health services, in the community-based school environment
- Assist the participant in developing self-management skills consistent with academic progress

To qualify as day treatment services for children, the services must be provided on the school premises on days that the participant's school is in session as group treatment by an individual who delivers rehabilitation services within the educational setting. Day treatment services may not be provided more than six hours per school day and no more than 180 hours per state fiscal year. These services may include the following forms of active treatment:

- Teaching self-management skills designed to improve the participant's academic and behavioral functioning
- Counseling focused on overall functional improvement in the school setting

- Encouraging and coaching to achieve academic and behavioral success in school

The CBHC must establish with the local school district a written agreement that specifies the overall goals of the collaborative effort, guidelines for meeting the criteria for services, roles and responsibilities of the parties to the agreement, and the resources, including personnel, contributed by each of the parties to the agreement.

**Withdrawal Management Services**

Alaska Medicaid covers the following alcohol and drug withdrawal management services when delivered face-to-face to a child or adult experiencing a substance use disorder:

- Ambulatory withdrawal management with extended on-site monitoring
- Clinically managed residential withdrawal management
- Medically monitored residential withdrawal management

Only one service episode of withdrawal management services may be covered per day, but there is no service limit on the amount of withdrawal management services provided to a participant in a fiscal year. The only services that are covered on the same day as alcohol and drug withdrawal management services are:

- Behavioral health screening
- Professional behavioral health assessments
- Case management services
- Behavioral health clinic services
- A medical evaluation

**Medical Evaluation**

Alaska Medicaid covers one medical evaluation of a participant in an opioid use disorder treatment program per admission that may include:

- Consultation and referral
- Verification of one year of addiction
- Establishing dosage for methadone or another agonist/partial agonist

Participants not receiving methadone may also receive one medical evaluation upon admission to withdrawal management treatment.

**Medication Administration**

Alaska Medicaid covers medication administration provided by medical personnel on the premises of the CBHC or off-premises at the participant's home, school, or any other appropriate community setting. Services must be authorized on the participant's behavioral health treatment plan.

**Peer Support Services**

Alaska Medicaid covers peer support services including:

- One-on-one or family activities designed to facilitate a smooth transition from an institutional setting to the community

- Assisting the participant or participant's family in regaining balance and control of their lives
- Enhancing the participant's community living skills
- Supporting a self-directed recovery and independence

Peer support services are based on the unique therapeutic relationship between the provider, the participant, and the participant's family. All peer support services listed on the participant's behavioral health treatment plan should focus on specific goals and objectives including identified benchmarks or other measurable outcomes. The behavioral health clinical associate who providers peer support services must:

- Maintain frequent contact with the participant either in-person or over the phone in order to support the participant and participate in group activities
- Have experienced personal behavioral health issues or issues with family members
- Be supervised by a mental health professional clinician who the CBHC has determined is competent to supervise peer support services

Peer support services may only be offered in combination with individual therapeutic behavioral health services for children, family therapeutic behavioral health services for children, or individual comprehensive community support services.

**Pharmacologic Management Services**

Pharmacologic management services are covered when provided directly by a physician, physician assistant, or advanced nurse practitioner that is enrolled in Alaska Medicaid as a dispensing provider. The provider must monitor a participant for the purposes of:

- Assessing the need for pharmacotherapy
- Prescribing appropriate medications
- Monitoring the response to medication, including:
    - Documenting medication compliance
    - Assessing and documenting side effects
    - Evaluating and documenting the effectiveness of the medication

Coverage is limited to one visit per participant per week during the first four weeks of receiving pharmacologic management services. After the initial four weeks, coverage is further limited to one visit per participant per month unless more frequent monitoring is required because of the requirements of the specific medication or a participant's unusual clinical reaction to a medication.

**Psychotherapy**

Alaska Medicaid covers up to thirty hours per participant per state fiscal year of combined individual, group, or family psychotherapy services which may include:

- Insight oriented individual psychotherapy
- Interactive individual psychotherapy
- Group psychotherapy
- Family psychotherapy – with or without participant

- Multi-family group psychotherapy

Biofeedback or relaxation therapy may be covered as an element of insight oriented individual psychotherapy and interactive individual psychotherapy when prescribed by a physician or ordered by a mental health professional clinician and included in the behavioral health treatment plan as a recognized treatment for chronic pain syndrome, panic disorder, or phobias.

Family psychotherapy may be provided through telemedicine, with or without participant involvement, if the services could not be provided in person and the clinician documents the reason for providing the service telephonically in the participant's treatment notes for each session.

**Residential Substance Use Treatment Services**

Alaska Medicaid covers residential substance use treatment services if the provider is operating a structured residential program to treat substance use disorders. To qualify as residential substance use treatment services, a CBHC must provide the following active treatment each day the participant is in treatment:

- Teaching of life skills designed to restore or improve the participant's overall functioning relative to their substance use disorder
- Counseling focused on functional improvement, recovery, and relapse prevention
- Encouraging and coaching

Residential substance use treatment services may be provided within the structured residential program as individual, group, or family services with no limit on the number of hours that may be provided in a fiscal year.

The only behavioral health services that the department will pay for on the same day as residential substance use treatment services are:

- Behavioral health screening
- Professional behavioral health assessments
- Case management services
- Behavioral health clinic services
- A medical evaluation

**Screening and Brief Intervention Services**

Alaska Medicaid covers screening and brief intervention services provided through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the participant's awareness of their substance use, the potential harmful effects of that substance use, and encouraging positive change. Brief intervention services may include feedback, goal setting, coping strategies, risk factor identification, information, and advice. The CBHC must refer the participant to a behavioral health treatment program that provides services that will meet the participant 's need if:

- The screening reveals that the participant is at severe risk of substance use problems
- The participant is already substance dependent

- The participant has already received brief intervention or treatment for substance use and was non-responsive

Delivery of screening and brief intervention services does not require an intake assessment or behavioral health treatment plan. All services provided must be documented in progress notes in the participant's clinical record.

**Short-term Crisis Intervention Services**

Alaska Medicaid covers short-term crisis intervention services provided by a mental health professional clinician that performs an initial assessment of the participant's mental, emotional, and behavioral status and overall functioning in relation to the short-term crisis. Any medically necessary and clinically appropriate behavioral health, rehabilitation, or intervention service may be provided as part of crisis intervention services to achieve the following:

- Reduce the symptoms of the acute mental, emotional, or behavioral disorder
- Prevent harm to the participant or others
- Prevent further relapse or deterioration of the participant's condition
- Stabilize the participant within the family system if one exists

Short-term crisis intervention may include individual or family psychotherapy, training, or education related to resolving the existing short-term crisis and preventing a future crisis as well as monitoring the participant for safety purposes. The mental health professional clinician is responsible for planning and directing all behavioral health services needed to respond to the short-term crisis (except for pharmacologic management services) and writing the intervention plan that contains:

- Treatment goals derived from the assessment of the crisis
- Descriptions of the medically necessary and clinically appropriate services provided to resolve the existing short-term crisis

Services may be provided in a hospital emergency room before the participant is admitted, crisis response facility, or in the participant's home, workplace, or school. Services may not exceed 22 hours during a state fiscal year. If a participant is receiving short-term crisis intervention services, Alaska Medicaid will only cover the behavioral health services identified in the short-term crisis intervention plan for the duration of the short-term crisis intervention regardless of any behavioral health treatment plan in place at the onset of the crisis. All services must be documented on an Emergency Service Contact form by the individual that provides the service and filed in the participant's clinical record.

**Short-term Crisis Stabilization Services**

Alaska Medicaid covers short-term crisis stabilization services provided by a substance use disorder counselor or a behavioral health clinical associate. The counselor or clinical associate must perform an initial assessment of the participant's overall functioning in relation to the short- term crisis and develop and document a short-term crisis stabilization plan. As part of the short- term crisis stabilization plan, any medically necessary and clinically appropriate behavioral health rehabilitation services necessary to return the participant to the participant's mental, emotional, and behavioral level of functioning before the short-term crisis occurred may be provided including:

- Individual or family counseling, training, or education related to resolving the existing short-term crisis and preventing a future crisis
- Monitoring the participant for safety purposes

- Any behavioral health rehabilitation services

Services may be provided at a CBHC, crisis response facility, or in the participant's home, workplace, or school. Short-term crisis stabilization services may not exceed 22 hours during a state fiscal year. If a participant is receiving short-term crisis stabilization services, Alaska Medicaid will only cover the behavioral health services identified in the short-term crisis stabilization plan for the duration of the short-term crisis stabilization regardless of any behavioral health treatment plan in place at the onset of the crisis. All services must be documented on an Emergency Service Contact form and filed in the participant's clinical record.

If the substance use disorder counselor or behavioral health clinical associate is unable to resolve the short-term crisis, a mental health professional clinician may assume responsibility for the case and begin providing short-term crisis intervention services.

**Non-covered Services**

The services listed below are non-covered for CBHCs. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. Daily supervisory activities provided to a child in a foster home or residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance:

- Any behavioral health service provided by the participant's foster parent on the same day, including residential behavioral rehabilitation services
- Day treatment services delivered by the teacher providing the academic program
- Outpatient mental health services provided by a hospital or psychiatric facility
- Experimental therapy
- Telephonic services other than allowed:
    - Case management
    - Family psychotherapy when circumstances are such that the service could not otherwise be provided
    - An assessment as part of crisis intervention when the assessment portion of these services cannot be performed face-to-face
- Preparation of reports as a separate service
- Narcosynthesis
- Socialization
- Recreation therapy
- Primal therapy
- Rage reduction or holding therapy
- Marathon group therapy
- Megavitamin therapy
- Pastoral counseling

- Explanation of an examination to a family member or other responsible individual that is provided outside of family therapy session
- Any therapy or evaluation if the documentation required is inadequate or absent from participant's behavioral health treatment plan or clinical record
- Room and board costs as part of a behavioral health clinic or rehabilitation service
- The cost of transportation or travel time as part of a behavioral health clinic or rehabilitation service other than the assigned case manager to a participant under the age of 21 experiencing a severe emotional disturbance
- Case management provided by a family member or foster parent of the participant

### 4.2.2 Autism Services

**Behavior Identification Assessment**

Alaska Medicaid covers an initial behavior identification assessment for a new or returning participant when conducted by a behavior analyst who interprets information from multiple sources including:

- A referral from a mental health professional or a health care professional who is qualified based on that individual's training, education, experience and scope of practice to assess and diagnose autism spectrum disorders in children
- Direct observation of the participant in different settings and situations
- Information on the participant's skills deficits, deficient adaptive behaviors, or maladaptive behaviors from the following sources:
    - In-person observation of the participant
    - Structured interviews with the guardian or caregiver
    - Standardized and non-standardized tests
    - Detailed behavioral history
    - Test results
- Intellectual and achievements tests
- Developmental assessments
- Assessments of comorbid mental health conditions
- Evaluations of family functioning and needs
- Results of neuropsychological testing
- Results of other standardized psychometric tests, including measure of general psychopathology

The behavior analyst who conducts the assessment must develop a written report that:

- Identifies the skill deficits and deficient adaptive behaviors or maladaptive behaviors that should be the focus of treatment
- Indicates if the participant's behaviors and level of functioning interferes with their ability to adequately participate in age-appropriate home, school, or community activities

- Indicates if the participant's behavior poses a danger to themselves or others
- Indicates that the treatment goals and treatment targets are expected to result in measurable improvement in either the participant's behaviors or level of functioning or both
- Identifies the potential functional relationship between behavior and environmental factors
- Identifies motivational and contextual factors that may be used in the course of treatment to assist with modification and reinforcement of behavior
- Recommends services and protocols that form the basis for an individualized treatment plan
- Avoids duplication of services by ensuring that a listing of all current services being delivered to the participant is provided, including:
    - Home and community-based waiver services
    - Behavioral health treatment plans
    - Individualized education plans offered through school-based services
    - Individualized family service plans
    - Services funded through a third-party payer, private foundations, or private donation campaigns

**Behavior Identification Reassessment**

Alaska Medicaid covers reassessments of a participant no more than once every six months when conducted by a behavior analyst who obtains a service authorization to extend autism services for the participant. Each reassessment must establish:

- The participant's measured progress over the course of treatment
- An adjusted baseline in the areas of social skills, communication skills, language skills, adaptive behaviors, and maladaptive behaviors that are the focus of treatment
- Recommended updates to the participant's treatment plan
- An estimated timeline and number of treatment hours necessary to achieve each of the participant's treatment goals

**Adaptive Behavior Treatment**

Alaska Medicaid covers adaptive treatment that follows protocols identified in the participant's treatment plan for the purposes of introducing and reinforcing incremental change in the participant's skills or behavior. Treatment may be provided in any of the following settings:

- Participant's home, school, and community
- Behavior analyst's office
- An outpatient clinic
- Another appropriate community setting

Within a six-month period, Alaska Medicaid covers up to 1,040 hours of adaptive behavior treatment, group adaptive behavior treatment, or a combination of both provided to each participant. 52 hours of treatment modification is also covered for each participant within a six- month period.

### Group Adaptive Behavior Treatment

Alaska Medicaid covers adaptive behavior treatment provided to a group of at least two but not more than eight participants. The group treatment must be provided according to the protocols identified in each participant's treatment plan to assist with the development of individually identifies social skills.

### Family Adaptive Behavior Treatment Guidance

Alaska Medicaid covers family adaptive behavior treatment guidance to instruct a participant's guardian and caregivers on the participant's problem behaviors and skills deficit. During treatment, the provider must teach the participant's guardian and caregivers to use planned treatment protocols to intervene with the participant to reinforce change and to maintain treatment progress. Up to 12 family guidance sessions may be covered in a 12-month period.

### Non-Covered Services

The services listed below are non-covered for autism services providers. This list is representative of non-covered services and procedures and is not intended to be all-inclusive:

- Respite for the family
- Increasing the participant's social activity
- Addressing a participant's antisocial behavior or legal problems
- Services provided by a participant's immediate family member, foster, parent, or legal guardian, unless a court has authorized that legal guardian to provide those services
- Any two or more autism services provided concurrently
- A behavioral health rehabilitation service provided concurrently with an autism service
- When a behavior analyst, assistant behavior analyst, or autism behavior technician acts as a different kind of paid treatment provider or caregiver at the same time
- Assisting a participant with schoolwork for the sole purpose of education in the home, school, or community
- Providing leisure or social activities solely for the purpose of entertainment, play, or recreation
- Providing autism services to a patient in an outpatient hospital, general acute care hospital, inpatient psychiatric hospital, residential psychiatric treatment center, intermediate care
- facility, skilled nursing facility, or intermediate care facility for individuals with an intellectual disability or related condition unless assisting with discharge from one of these facilities
- Services provided by an autism services provider without a criminal history check or who has failed a criminal history check

## 4.2.3 Mental Health Physician Clinic Services

### (MHPC) Professional Behavioral Health Assessments

If a behavioral health screening, court referral, or referral from another agency has identifies an individual as possibly having a behavioral health disorder that could require behavioral health services, Alaska Medicaid may cover one or more of the following assessments conducted by a MHPC:

- Mental health intake assessment

- Integrated mental health and substance use intake assessment
- Psychiatric assessment
- Psychological testing and evaluation

**Mental Health Intake Assessment:** conducted upon admission to services and periodically during treatment to assess and document:

- Participant 's mental status and social and medical history
- Nature and severity of any identified mental health disorder
- Diagnosis consistent with the:
    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single mental health intake assessment per participant per state fiscal year consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. The assessment must be conducted by a mental health professional clinician, physician, physician assistant, or advanced nurse practitioner working within the scope of the provider's education training, and experience. A written record of the mental health intake assessment must be included in the participant's clinical record and updated as new information becomes available.

**Integrated Mental Health and Substance Use Intake Assessment:** a combination of the previous two types of assessments that may be conducted by only a mental health professional clinician, physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience. Alaska Medicaid covers one integrated assessment per participant per state fiscal year at the start of services and one integrated assessment every six months afterward. The integrated assessment must be included in the participant's clinical record and updated as new information becomes available.

**Psychiatric Assessment:** may serve as the professional behavioral health assessment if the participant's condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication. A psychiatric assessment interview must:

- Be conducted by an enrolled dispensing physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience
- Include a review of any general medical and psychiatric history or problem the participant is presenting
- Include a relevant participant history
- Include a mental status examination
- Result in a diagnosis consistent with the:

    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Include a listing of any identified psychiatric problems, including functional impairments, with treatment recommendations

Alaska Medicaid covers up to four psychiatric assessments per participant per state fiscal year.

**Interactive Psychiatric Assessment:** may serve as the professional behavioral health assessment if the participant's condition indicates the need for a more intensive assessment, including an assessment to evaluate the need for medication. An interactive psychiatric assessment using equipment and devices must:

- Be conducted by an enrolled dispensing physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience
- Include a review of any general medical and psychiatric history or problem the participant is presenting
- Include a relevant participant history
- Include a mental status examination
- Result in a complete diagnosis consistent with the multi-axial classification system used in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders
- Include a listing of any identified psychiatric problems, including functional impairments, with treatment recommendations

**Psychological Testing and Evaluation:** used to assist in the diagnosis and treatment of mental and emotional disorders. Psychological testing and evaluation includes:

- Assessment of functional capabilities
- Administration of standardized psychological tests
- Interpretation of findings

**Pharmacologic Management Services**

Pharmacologic management services are covered when provided directly by a physician, physician assistant, or advanced nurse practitioner that is enrolled in Alaska Medicaid as a dispensing provider. The provider must monitor a participant for the purposes of:

- Assessing the need for pharmacotherapy
- Prescribing appropriate medications
- Monitoring the response to medication, including:
    - Documenting medication compliance
    - Assessing and documenting side effects
    - Evaluating and documenting the effectiveness of the medication

Coverage is limited to one visit per participant per week during the first four weeks of receiving pharmacologic management services. After the initial four weeks, coverage is further limited to one visit per participant per month unless more frequent monitoring is required because of the requirements of the specific medication or a participant's unusual clinical reaction to a medication.

**Psychotherapy**

Alaska Medicaid covers up to thirty hours per participant per state fiscal year of combined individual, group, or family psychotherapy services which may include:

- Insight oriented individual psychotherapy
- Interactive individual psychotherapy
- Group psychotherapy
- Family psychotherapy – with or without participant
- Multi-family group psychotherapy

Biofeedback or relaxation therapy may be covered as an element of insight oriented individual psychotherapy and interactive individual psychotherapy when prescribed by a physician or ordered by a mental health professional clinician and included in the behavioral health treatment plan as a recognized treatment for chronic pain syndrome, panic disorder, or phobias.

Family psychotherapy may be provided through telemedicine, with or without participant involvement, if the services could not be provided in person and the clinician documents the reason for providing the service telephonically in the participant's treatment notes for each session.

**Screening and Brief Intervention Services**

Alaska Medicaid covers screening and brief intervention services provided through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the participant's awareness of their substance use, the potential harmful effects of that substance use, and encouraging positive change. Brief intervention services may include feedback, goal setting, coping strategies, risk factor identification, information, and advice. The MHPC must refer the participant to a behavioral health treatment program that provides services that will meet the participant's need if:

- The screening reveals that the participant is at severe risk of substance use problems
- The participant is already substance dependent
- The participant has already received brief intervention or treatment for substance use and was non-responsive

Delivery of screening and brief intervention services does not require an intake assessment or behavioral health treatment plan. All services provided must be documented in progress notes in the participant's clinical record.

**Short-term Crisis Intervention Services**

Alaska Medicaid covers short-term crisis intervention services provided by a mental health professional clinician that performs an initial assessment of the participant's mental, emotional, and behavioral status and overall functioning in relation to the short-term crisis. Any medically necessary and clinically

appropriate behavioral health, rehabilitation, or intervention service may be provided as part of crisis intervention services to achieve the following:

- Reduce the symptoms of the acute mental, emotional, or behavioral disorder
- Prevent harm to the participant or others
- Prevent further relapse or deterioration of the participant's condition
- Stabilize the participant within the family system if one exists

Short-term crisis intervention may include individual or family psychotherapy, training, or education related to resolving the existing short-term crisis and preventing a future crisis as well as monitoring the participant for safety purposes. The mental health professional clinician is responsible for planning and directing all behavioral health services needed to respond to the short-term crisis (except for pharmacologic management services) and writing the intervention plan that contains:

- Treatment goals derived from the assessment of the crisis
- Descriptions of the medically necessary and clinically appropriate services provided to resolve the existing short-term crisis

Services may be provided in a hospital emergency room before the participant is admitted, crisis response facility, or in the participant's home, workplace, or school. Services may not exceed 22 hours during a state fiscal year. If a participant is receiving short-term crisis intervention services, Alaska Medicaid will only cover the behavioral health services identified in the short-term crisis intervention plan for the duration of the short-term crisis intervention regardless of any behavioral health treatment plan in place at the onset of the crisis. All services must be documented on an Emergency Service Contact form by the individual that provides the service and filed in the participant's clinical record.

**Non-covered Services**

The services listed below are non-covered for MHPCs. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. Daily supervisory activities provided to a child in a foster home or residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance:

- Outpatient mental health services provided by a hospital or psychiatric facility
- Experimental therapy
- Telephonic services other than allowed:
    - Case management
    - Family psychotherapy when circumstances are such that the service could not otherwise be provided
    - An assessment as part of crisis intervention when the assessment portion of these services cannot be performed face-to-face
- Preparation of reports as a separate service
- Narcosynthesis
- Socialization

- Recreation therapy
- Primal therapy
- Rage reduction or holding therapy
- Marathon group therapy
- Megavitamin therapy
- Pastoral counseling
- Explanation of an examination to a family member or other responsible individual that is provided outside of family therapy session
- Any therapy or evaluation if the documentation required is inadequate or absent from participant's behavioral health treatment plan or clinical record
- Room and board costs as part of a behavioral health clinic or rehabilitation service
- The cost of transportation or travel time as part of a behavioral health clinic or rehabilitation service other than the assigned case manager to a participant under the age of 21 experiencing a severe emotional disturbance

## 4.3 Independent Providers

### 4.3.1 Psychologist Services

**Recordkeeping Requirements:**

- Source and reason for the referral
- Questions and issues that the testing addressed
- Psychological tests and techniques used
- Interpretation of all completed and attempted tests with observations, conclusions, and recommendations

**Referral for Services**

Recipients receiving psychologist services must have a referral documenting the purpose for the testing, including the need to determine acuity of need, severity of symptoms, or level of impairment. The referral must be from the recipient's treating physician, a physician assistant, an advanced practice registered nurse, a community mental health clinic, a tribal health program, or an appropriate school official and documented in the recipient's medical record.

**Behavioral Health Screening**

A behavioral health screening may be conducted for each new or returning health services. A provider may use a screening tool recommended by the department or one they have identified as appropriate for use with the participant. Alaska Medicaid covers one screening per participant per program admission for new or returning participants.

**Psychologist Testing Services**

Alaska Medicaid covers psychological testing to determine the status of a recipient's mental, intellectual, and emotional functioning. Covered psychologist services are limited to the following:

- Psychological testing
- Assessment of aphasia
- Developmental testing, limited or extended
- Neurobehavioral status examination, including assessment of thinking, reasoning, and judgment
- Neuropsychological testing

Testing services must include administration of psychodiagnostic tests, the interpretation of the results of the tests, and a written report. Psychologist services may be provided in any setting appropriate for patientcare including:

- Psychologist's office
- Outpatient clinic
- Outpatient hospital
- General acute care hospital
- Tribal health clinic
- Inpatient psychiatric hospital
- Residential psychiatric treatment center

**Mental Health Intake Assessment:** conducted upon admission to services and periodically during treatment to assess and document:

- Participant 's mental status and social and medical history
- Nature and severity of any identified mental health disorder
- Diagnosis consistent with the:
    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single mental health intake assessment per participant per state fiscal year consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. The assessment must be conducted by a mental health professional clinician, physician, physician assistant, or advanced nurse practitioner working within the scope of the provider’s education training, and experience. A written record of the mental health intake assessment must be included in the participant’s clinical record and updated as new information becomes available.

**Integrated Mental Health and Substance Use Intake Assessment:** a combination of the previous two types of assessments that may be conducted by only a mental health professional clinician, physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's

education, training, and experience. Alaska Medicaid covers one integrated assessment per participant per state fiscal year at the start of services and one integrated assessment every six months afterward. The integrated assessment must be included in the participant's clinical record and updated as new information becomes available.

**Psychological Testing and Evaluation:** used to assist in the diagnosis and treatment of mental and emotional disorders. Psychological testing and evaluation includes:

- Assessment of functional capabilities
- Administration of standardized psychological tests
- Interpretation of findings

**Psychotherapy**

Alaska Medicaid covers psychotherapy services by an independent provider:

- Insight oriented individual psychotherapy
- Interactive individual psychotherapy
- Group psychotherapy
- Family psychotherapy – with or without participant
- Multi-family group psychotherapy

Biofeedback or relaxation therapy may be covered as an element of insight oriented individual psychotherapy and interactive individual psychotherapy when prescribed by a physician or ordered by a mental health professional clinician and included in the behavioral health treatment plan as a recognized treatment for chronic pain syndrome, panic disorder, or phobias.

Family psychotherapy may be provided through telemedicine, with or without participant involvement, if the services could not be provided in person and the clinician documents the reason for providing the service telephonically in the participant's treatment notes for each session.

**Screening and Brief Intervention Services**

Alaska Medicaid covers screening and brief intervention services provided through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the participant's awareness of their substance use, the potential harmful effects of that substance use, and encouraging positive change. Brief intervention services may include feedback, goal setting, coping strategies, risk factor identification, information, and advice. The CBHC must refer the participant to a behavioral health treatment program that provides services that will meet the participant's need if:

- The screening reveals that the participant is at severe risk of substance use problems
- The participant is already substance dependent
- The participant has already received brief intervention or treatment for substance use and was non-responsive

Delivery of screening and brief intervention services does not require an intake assessment or

behavioral health treatment plan. All services provided must be documented in progress notes in the participant's clinical record.

**Non-covered Services**

The services listed below are non-covered. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. Daily supervisory activities provided to a child in a foster home or residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance:

- Outpatient mental health services provided by a hospital or psychiatric facility
- Experimental therapy
- Telephonic services other than allowed:
    - Case management
    - Family psychotherapy when circumstances are such that the service could not otherwise be provided
    - An assessment as part of crisis intervention when the assessment portion of these services cannot be performed face-to-face
- Preparation of reports as a separate service
- Narcosynthesis
- Socialization
- Recreation therapy
- Primal therapy
- Rage reduction or holding therapy
- Marathon group therapy
- Megavitamin therapy
- Pastoral counseling
- Explanation of an examination to a family member or other responsible individual that is provided outside of family therapy session
- Any therapy or evaluation if the documentation required is inadequate or absent from participant's behavioral health treatment plan or clinical record
- Room and board costs as part of a behavioral health clinic or rehabilitation service
- The cost of transportation or travel time as part of a behavioral health clinic or rehabilitation service other than the assigned case manager to a participant under the age of 21 experiencing a severe emotional disturbance

### 4.3.2 Independent Licensed Clinical Social Worker Services

**Recordkeeping Requirements**

A clinical social worker services provider must maintain the provider's records in accordance with 7 AAC 105.230.

**Behavioral Health Screening**

A behavioral health screening may be conducted for each new or returning participant of behavioral health services. A provider may use a screening tool recommended by the department or one they have identified as appropriate for use with the participant. Alaska Medicaid covers one screening per participant per program admission for new or returning participants.

**Mental Health Intake Assessment:** conducted upon admission to services and periodically during treatment to assess and document:

- Participant's mental status and social and medical history
- Nature and severity of any identified mental health disorder
- Diagnosis consistent with the:
    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single mental health intake assessment per participant per state fiscal year consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. The assessment must be conducted by a mental health professional clinician, physician, physician assistant, or advanced nurse practitioner working within the scope of the provider's education training, and experience. A written record of the mental health intake assessment must be included in the participant's clinical record and updated as new information becomes available.

**Integrated Mental Health and Substance Use Intake Assessment:** a combination of the previous two types of assessments that may be conducted by only a mental health professional clinician, physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience. Alaska Medicaid covers one integrated assessment per participant per state fiscal year at the start of services and one integrated assessment every six months afterward. The integrated assessment must be included in the participant's clinical record and updated as new information becomes available.

**Psychotherapy**

Alaska Medicaid covers psychotherapy services by an independent provider.

- Insight oriented individual psychotherapy
- Interactive individual psychotherapy
- Group psychotherapy

- Family psychotherapy – with or without participant
- Multi-family group psychotherapy

Biofeedback or relaxation therapy may be covered as an element of insight oriented individual psychotherapy and interactive individual psychotherapy when prescribed by a physician or ordered by a mental health professional clinician and included in the behavioral health treatment plan as a recognized treatment for chronic pain syndrome, panic disorder, or phobias.

Family psychotherapy may be provided through telemedicine, with or without participant involvement, if the services could not be provided in person and the clinician documents the reason for providing the service telephonically in the participant's treatment notes for each session.

**Screening and Brief Intervention Services**

Alaska Medicaid covers screening and brief intervention services provided through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the participant's awareness of their substance use, the potential harmful effects of that substance use, and encouraging positive change. Brief intervention services may include feedback, goal setting, coping strategies, risk factor identification, information, and advice. The CBHC must refer the participant to a behavioral health treatment program that provides services that will meet the participant's need if:

- The screening reveals that the participant is at severe risk of substance use problems
- The participant is already substance dependent
- The participant has already received brief intervention or treatment for substance use and was non-responsive

Delivery of screening and brief intervention services does not require an intake assessment or behavioral health treatment plan. All services provided must be documented in progress notes in the participant's clinical record.

**Non-covered Services**

The services listed below are non-covered. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. Daily supervisory activities provided to a child in a foster home or residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance:

- Outpatient mental health services provided by a hospital or psychiatric facility
- Experimental therapy
- Telephonic services other than allowed:
    - Case management
    - Family psychotherapy when circumstances are such that the service could not otherwise be provided
    - An assessment as part of crisis intervention when the assessment portion of these services cannot be performed face-to-face

- Preparation of reports as a separate service
- Narcosynthesis
- Socialization
- Recreation therapy
- Primal therapy
- Rage reduction or holding therapy
- Marathon group therapy
- Megavitamin therapy
- Pastoral counseling
- Explanation of an examination to a family member or other responsible individual that is provided outside of family therapy session
- Any therapy or evaluation if the documentation required is inadequate or absent from participant's behavioral health treatment plan or clinical record
- Room and board costs as part of a behavioral health clinic or rehabilitation service
- The cost of transportation or travel time as part of a behavioral health clinic or rehabilitation service other than the assigned case manager to a participant under the age of 21 experiencing a severe emotional disturbance

### 4.3.3 Independent Licensed Marital and Family Therapist Services

**Recordkeeping Requirements**

A marital and family services provider must maintain the provider's records in accordance with 7 AAC 105.230.

**Behavioral Health Screening**

A behavioral health screening may be conducted for each new or returning participant of behavioral health services. A provider may use a screening tool recommended by the department or one they have identified as appropriate for use with the participant. Alaska Medicaid covers one screening per participant per program admission for new or returning participants.

**Mental Health Intake Assessment:** conducted upon admission to services and periodically during treatment to assess and document:

- Participant 's mental status and social and medical history
- Nature and severity of any identified mental health disorder
- Diagnosis consistent with the:
    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)

- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single mental health intake assessment per participant per state fiscal year consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. The assessment must be conducted by a mental health professional clinician, physician, physician assistant, or advanced nurse practitioner working within the scope of the provider's education training, and experience. A written record of the mental health intake assessment must be included in the participant's clinical record and updated as new information becomes available.

**Integrated Mental Health and Substance Use Intake Assessment:** a combination of the previous two types of assessments that may be conducted by only a mental health professional clinician, physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience. Alaska Medicaid covers one integrated assessment per participant per state fiscal year at the start of services and one integrated assessment every six months afterward. The integrated assessment must be included in the participant's clinical record and updated as new information becomes available.

**Psychotherapy**

Alaska Medicaid covers psychotherapy services by an independent provider.

- Insight oriented individual psychotherapy
- Interactive individual psychotherapy
- Group psychotherapy
- Family psychotherapy – with or without participant
- Multi-family group psychotherapy

Biofeedback or relaxation therapy may be covered as an element of insight oriented individual psychotherapy and interactive individual psychotherapy when prescribed by a physician or ordered by a mental health professional clinician and included in the behavioral health treatment plan as a recognized treatment for chronic pain syndrome, panic disorder, or phobias.

Family psychotherapy may be provided through telemedicine, with or without participant involvement, if the services could not be provided in person and the clinician documents the reason for providing the service telephonically in the participant's treatment notes for each session.

**Screening and Brief Intervention Services**

Alaska Medicaid covers screening and brief intervention services provided through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the participant's awareness of their substance use, the potential harmful effects of that substance use, and encouraging positive change. Brief intervention services may include feedback, goal setting, coping strategies, risk factor identification, information, and advice. The CBHC must refer the participant to a behavioral health treatment program that provides services that will meet the participant's need if:

- The screening reveals that the participant is at severe risk of substance use problems

- The participant is already substance dependent
- The participant has already received brief intervention or treatment for substance use and was non-responsive

Delivery of screening and brief intervention services does not require an intake assessment or behavioral health treatment plan. All services provided must be documented in progress notes in the participant's clinical record.

**Non-covered Services**

The services listed below are non-covered. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. Daily supervisory activities provided to a child in a foster home or residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance:

- Outpatient mental health services provided by a hospital or psychiatric facility
- Experimental therapy
- Telephonic services other than allowed:
    - Case management
    - Family psychotherapy when circumstances are such that the service could not otherwise be provided
    - An assessment as part of crisis intervention when the assessment portion of these services cannot be performed face-to-face
- Preparation of reports as a separate service
- Narcosynthesis
- Socialization
- Recreation therapy
- Primal therapy
- Rage reduction or holding therapy
- Marathon group therapy
- Megavitamin therapy
- Pastoral counseling
- Explanation of an examination to a family member or other responsible individual that is provided outside of family therapy session
- Any therapy or evaluation if the documentation required is inadequate or absent from participant's behavioral health treatment plan or clinical record
- Room and board costs as part of a behavioral health clinic or rehabilitation service
- The cost of transportation or travel time as part of a behavioral health clinic or rehabilitation service other than the assigned case manager to a participant under the age of 21 experiencing a severe

emotional disturbance

### 4.3.4 Independent Licensed Professional Counselor Services

**Recordkeeping Requirements**

A licensed professional counselor services provider must maintain the provider's records in accordance with 7 AAC 105.230.

**Behavioral Health Screening**

A behavioral health screening may be conducted for each new or returning participant of behavioral health services. A provider may use a screening tool recommended by the department or one they have identified as appropriate for use with the participant. Alaska Medicaid covers one screening per participant per program admission for new or returning participants.

**Mental Health Intake Assessment:** conducted upon admission to services and periodically during treatment to assess and document:

- Participant 's mental status and social and medical history
- Nature and severity of any identified mental health disorder
- Diagnosis consistent with the:
    - Diagnostic and Statistical Manual of Mental Disorders
    - International Classification of Diseases
    - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5)
- Treatment recommendations that form the basis of a subsequent behavioral health treatment plan
- Functional impairment

Alaska Medicaid covers a single mental health intake assessment per participant per state fiscal year consisting of one or more face to face sessions and a review of collaterally connected information at the start of services and one assessment every six months afterward. The assessment must be conducted by a mental health professional clinician, physician, physician assistant, or advanced nurse practitioner working within the scope of the provider's education training, and experience. A written record of the mental health intake assessment must be included in the participant's clinical record and updated as new information becomes available.

**Integrated Mental Health and Substance Use Intake Assessment:** a combination of the previous two types of assessments that may be conducted by only a mental health professional clinician, physician, physician assistant, or an advanced nurse practitioner working within the scope of the provider's education, training, and experience. Alaska Medicaid covers one integrated assessment per participant per state fiscal year at the start of services and one integrated assessment every six months afterward. The integrated assessment must be included in the participant's clinical record and updated as new information becomes available.

**Psychotherapy**

Alaska Medicaid covers psychotherapy services by an independent provider.

- Insight oriented individual psychotherapy

- Interactive individual psychotherapy
- Group psychotherapy
- Family psychotherapy – with or without participant
- Multi-family group psychotherapy

Biofeedback or relaxation therapy may be covered as an element of insight oriented individual psychotherapy and interactive individual psychotherapy when prescribed by a physician or ordered by a mental health professional clinician and included in the behavioral health treatment plan as a recognized treatment for chronic pain syndrome, panic disorder, or phobias.

Family psychotherapy may be provided through telemedicine, with or without participant involvement, if the services could not be provided in person and the clinician documents the reason for providing the service telephonically in the participant's treatment notes for each session.

**Screening and Brief Intervention Services**

Alaska Medicaid covers screening and brief intervention services provided through self-report questionnaires, structured interviews, or similar screening techniques to detect substance use problems and to identify the appropriate level of intervention. If the screening is positive for substance use problems, the provider may provide brief intervention services that involve motivational discussion focused on raising the participant's awareness of their substance use, the potential harmful effects of that substance use, and encouraging positive change. Brief intervention services may include feedback, goal setting, coping strategies, risk factor identification, information, and advice. The CBHC must refer the participant to a behavioral health treatment program that provides services that will meet the participant's need if:

- The screening reveals that the participant is at severe risk of substance use problems
- The participant is already substance dependent
- The participant has already received brief intervention or treatment for substance use and was non-responsive

Delivery of screening and brief intervention services does not require an intake assessment or behavioral health treatment plan. All services provided must be documented in progress notes in the participant's clinical record.

**Non-covered Services**

The services listed below are non-covered. This list is representative of non-covered services and procedures and is not intended to be all-inclusive. Daily supervisory activities provided to a child in a foster home or residential setting that a parent or foster parent would normally carry out to assure protection, emotional support, and care of a child who is not a child experiencing a severe emotional disturbance:

- Outpatient mental health services provided by a hospital or psychiatric facility
- Experimental therapy
- Telephonic services other than allowed:
    - Case management
    - Family psychotherapy when circumstances are such that the service could not otherwise be

provided

- An assessment as part of crisis intervention when the assessment portion of these services cannot be performed face-to-face

- Preparation of reports as a separate service
- Narcosynthesis
- Socialization
- Recreation therapy
- Primal therapy
- Rage reduction or holding therapy
- Marathon group therapy
- Megavitamin therapy
- Pastoral counseling
- Explanation of an examination to a family member or other responsible individual that is provided outside of family therapy session
- Any therapy or evaluation if the documentation required is inadequate or absent from participant's behavioral health treatment plan or clinical record
- Room and board costs as part of a behavioral health clinic or rehabilitation service
- The cost of transportation or travel time as part of a behavioral health clinic or rehabilitation service other than the assigned case manager to a participant under the age of 21 experiencing a severe emotional disturbance

## 4.4 Telemedicine

Alaska Medicaid will pay for a covered medical service furnished through telemedicine application if the service is:

- Covered under traditional, non-telemedicine methods
- Provided by a treating, consulting, presenting, or referring provider
- Appropriate for provision via telemedicine

**Covered Services**

Covered telemedicine services are limited to:

- An initial visit
- One follow-up visit
- A consultation to confirm a diagnosis
- Diagnostic, therapeutic, or interpretive services
- A psychiatric or substance use disorder assessment

- Psychotherapy
- Pharmacological management services on an individual participant basis

**Telemedicine Methods of Delivery**

Alaska Medicaid will pay for telemedicine services delivered in the following manner:

- Interactive method: Provider and patient interact in “real time” using video/camera and/or dedicated audio conference equipment.
- Store-and-forward method: The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis.
- Self-monitoring method: The patient is monitored in his or her home via a telemedicine application, with the provider indirectly involved from another location.

**Exclusions**

Alaska Medicaid will not pay for:

- The use of telemedicine equipment and systems
- Services delivered by telephone when not part of a dedicated audio conference system
- Services delivered by facsimile

# 5. Service Authorizations and Medical Necessity

## 5.1 Service Authorization Request Process

Service Authorization requests can be requested in one of several options through Optum Alaska.

- Online Portal
- Fax – **1.844.881.3753**
- Phone – **1.800.225.8764** (8 a.m. – 6 p.m., Alaska Time, Monday – Friday)
- Mail – **Optum Alaska**
  **911 W. 8th Ave., Suite 101**
  **Anchorage, Alaska 99501**

Providers can inquire about the status of a Service Authorization that has been requested in one of the following options:

- Email – akmedicaid@optum.com
- Phone - **1.800.225.8764** (8 a.m. – 6 p.m., Alaska Time, Monday – Friday)

Service Authorization Tips:

- Service Authorization requests submitted by fax should be submitted one participant at a time
- Service Authorization requests submitted by phone should be submitted by a clinician from within your agency
- Electronic signatures are acceptable on Service Authorization requests
- If a participant may have received services from another provider \ agency and exceeded their service limits in the state fiscal year, please submit a Service Authorization request

Service Authorization information and forms are accessible on the Optum Alaska website.

## 5.2 Medical Necessity

The ASO, will make clinical decisions about each participant based on the clinical features of the participant case, the medical necessity criteria, and the availability of accessible behavioral health resources at the time of the request.

The ASO, bases its decisions on medical necessity as established by State regulation and guidance from the Division. Medical necessity is met when a participant has a behavioral health disorder that requires professional evaluation and treatment, and the level of care provided is the least intensive, least restrictive level of care that can safely meet the participant's behavioral health and medical needs.

## 5.3 Description of Services

Optum maintains level of care criteria and guidelines, as directed by the Division, for behavioral health diagnoses. The description of services and medical necessity criteria for Substance Use Disorders and

Mental Health Services, can be accessed on the Divisions website.

Optum uses ASAM criteria to determine medical necessity for all substance use disorder (SUD) related service requests. The description of services and applicable ASAM criteria can be accessed on the ASAM website.

## 5.4 Discharge Planning

Providers are expected to initiate aftercare/discharge planning at the beginning of service delivery or at the time of admission. Providers are also required to submit the aftercare/discharge plan as part of the authorization request. Providers are expected to work collaboratively with the participants, parents, legal guardians and/or identified proxies of participants to develop a discharge plan that will provide stability and adequate behavioral health treatment services.

Providers should be working towards linking participants to the appropriate level services and all needed social determinants (such as housing, community supports and vocational endeavors) in the community.

## 5.5 Care Advocate Availability

Care Advocates are available from 8 a.m. to 5 p.m. Alaska Time, Monday through Friday. In addition, the call center is available 24 hours a day, 7 days a week, including holidays and weekends, to discuss urgent and emergent situations such as inpatient admissions, clinical benefit determinations and decisions, appeals, or any other questions about the care advocacy process. Contact Optum at **1.800.225.8764**.

# 6. Claim Submission

Claims may be submitted by Secure File Transfer Protocol (SFTP), Electronic Data Interchange (EDI), online by Direct Data Entry (DDE), U.S. Mail or fax.

### Billing Agents

A provider may use a billing agent or accounting firm to submit claims to Alaska Medical Assistance. However, payment by the provider for those services may **not** be based on the amount billed to or paid by Alaska Medical Assistance, such as a percentage basis.

## 6.1 Online and Electronic Claim Submission

Professional providers must submit HIPAA-compliant electronic claims which meet The Accredited Standards Committee X12 Version 5010 837 Professional (837P) guidelines. For technical details regarding 5010 compliance, providers may purchase a Technical Report, Type 3 through Washington Publishing Company.

### Advantages of Electronic Transactions:

- Reduced claims processing time
- Reduced pended or denied claims
- Reduced data entry error

1. **For Secure File Transfer Protocol (SFTP) using Optum Intelligent EDI:**

   Call **1.866.367.9778,** option **3**.

2. **For EDI/Electronic claims**:

   Electronic Data Interchange (EDI) is the exchange of information for routine business transactions in a standardized computer format; for example, data interchange between a practitioner (physician, psychologist, social worker) and a payer. You may choose any clearinghouse vendor of choice to submit claims using EDI. For more information, visit the 837p and 835 EDI Companion Guides website.

   **For claim submissions, use Optum Payer ID 87726**.

   Additional electronic claim information:

   Electronic Claim Submission and Electronic Data Interchange

   EDI and Clearing house Information

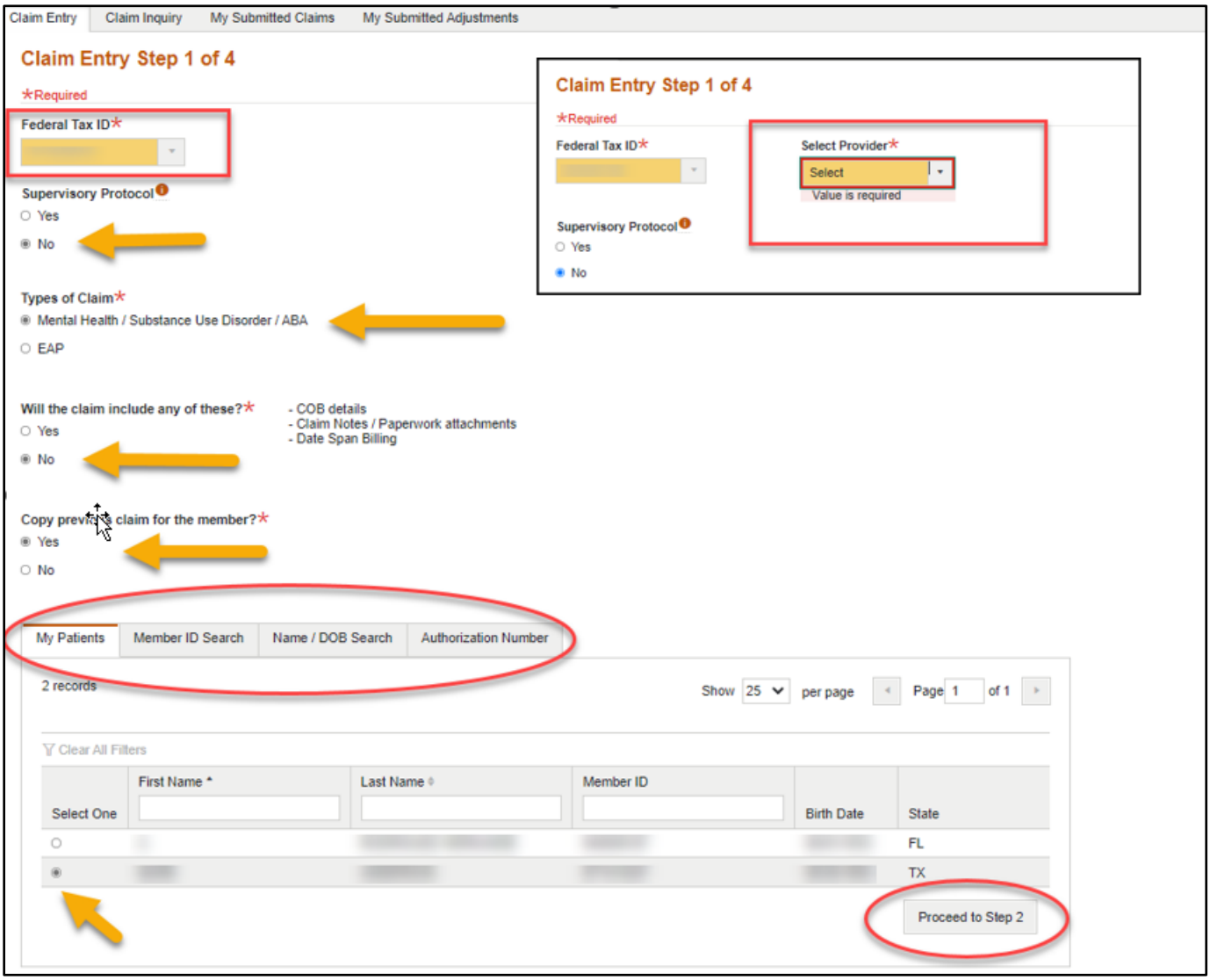
   **EDI Support: 1.800.210.8315** or email ac_edi_ops@uhc.com

3. **For Provider Express Online Direct Data Entry (DDE)**:

   Log in to Provider Express and select “Claim Entry”

## Completing and submitting the Short Form:

### Claim Entry – Short Form Step 1 of 4




### There are several required fields:

- Federal tax ID
- Select Provider (for a group login)
- Supervisory Protocol
- Type of claim
- "Will the claim include any of these?" (default of No is chosen which will bring up the Short Form)
- Copy previous claim for this member

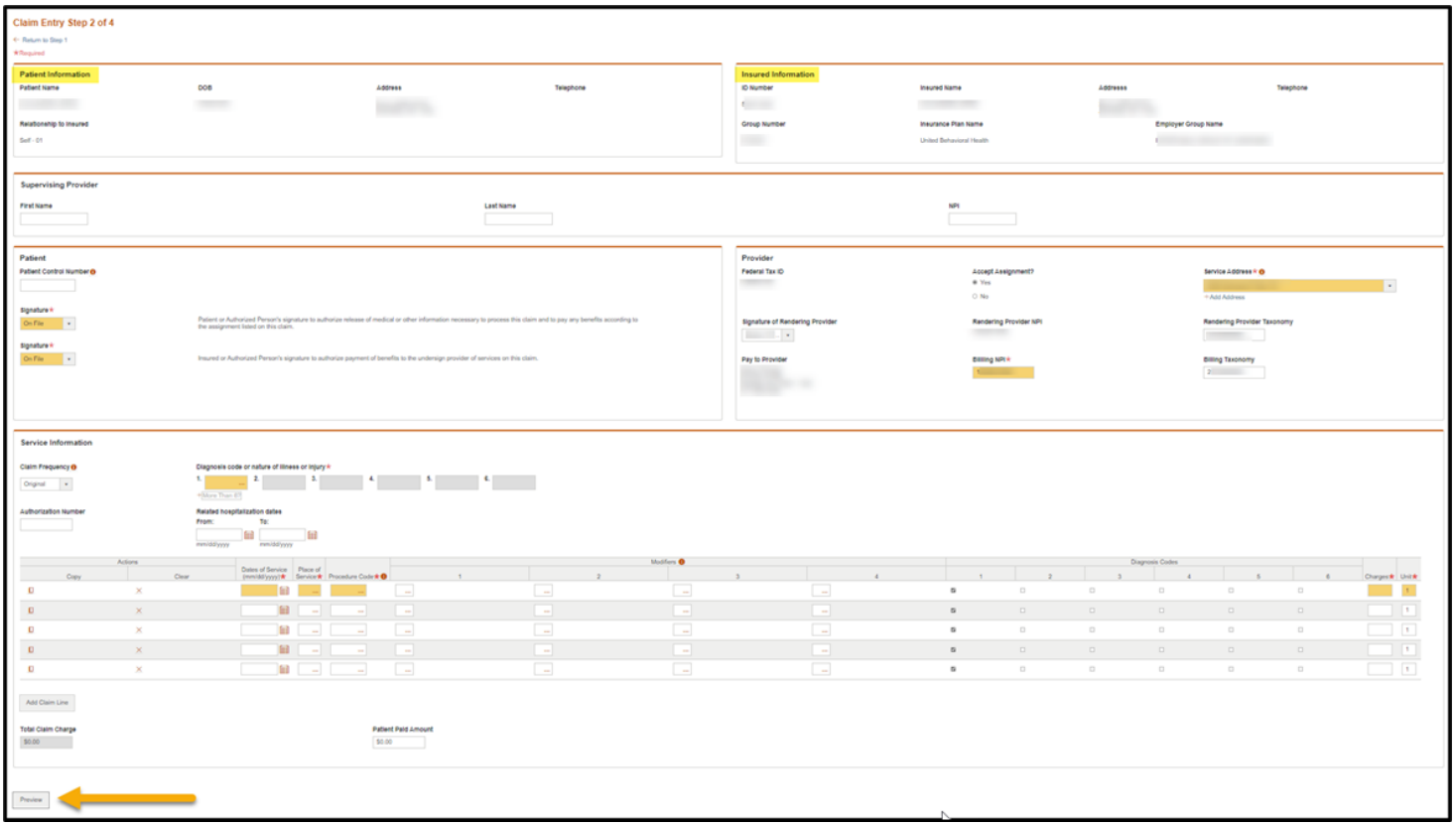
### Complete the member search by:

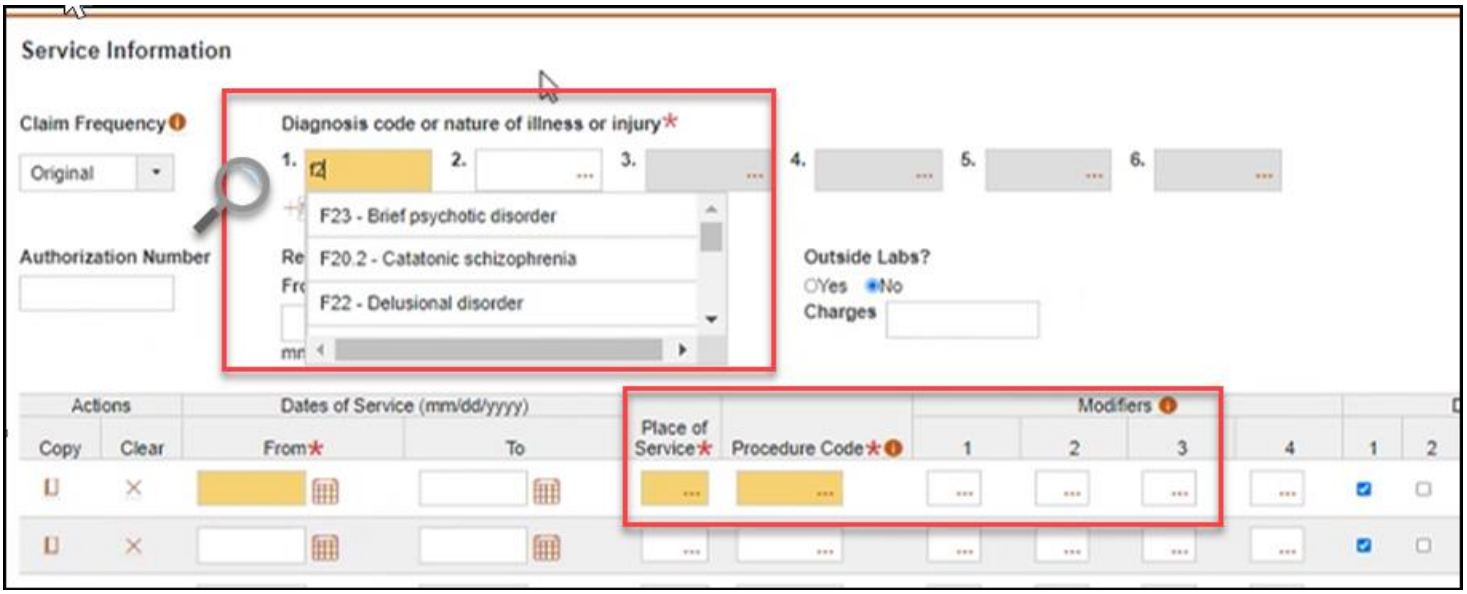
- Choosing the Member from your My Patients list
- Using one of the Member search options

OR

- Entering an Authorization number

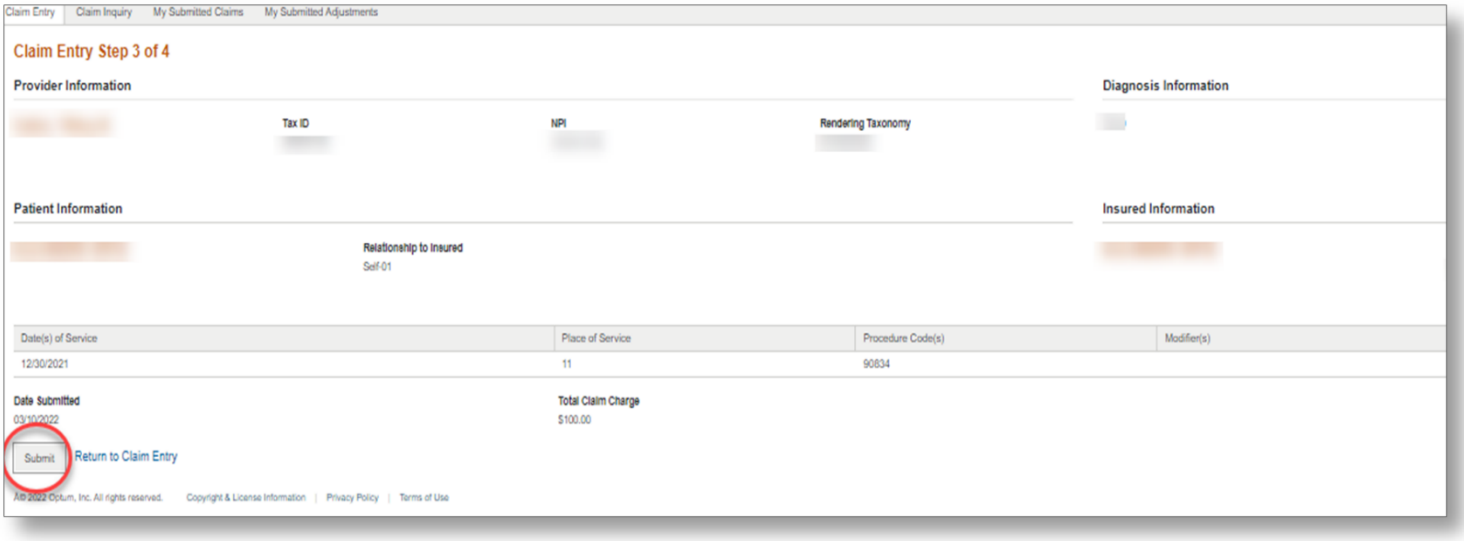
## Claim Entry – Short Form Step 2 of 4



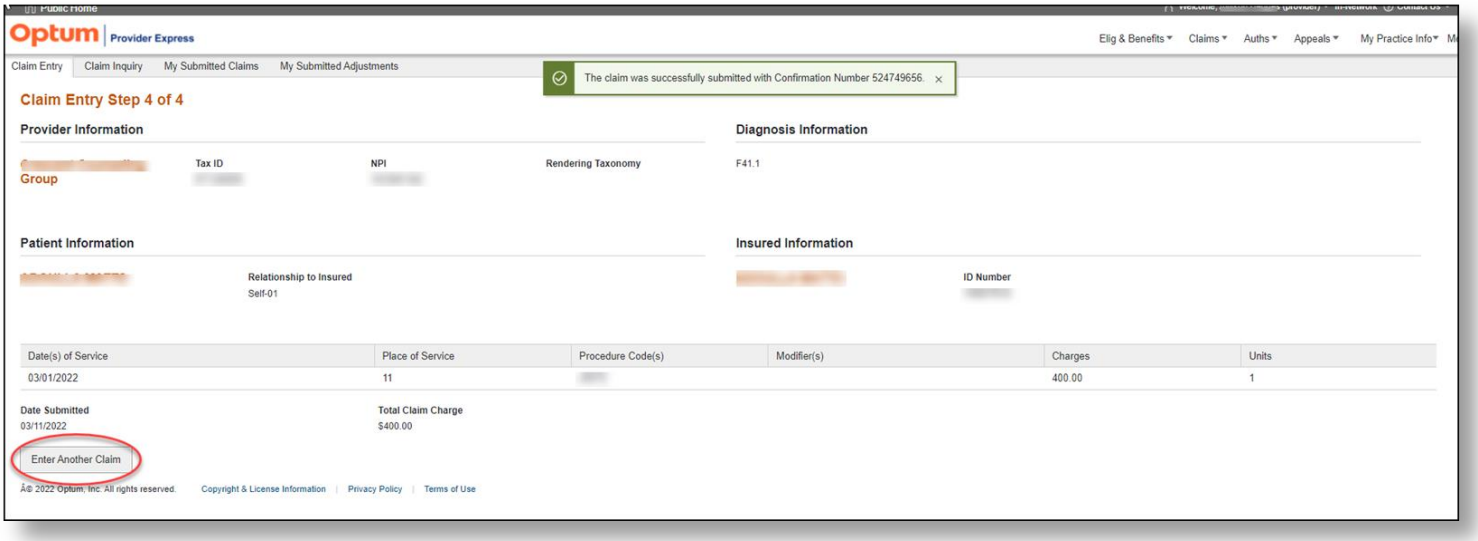

## Claim Entry – Short Form Step 3 of 4

- Step 3 allows users to preview basic information on the claim before sending for submission
- If all the information is accurate, click the ”Submit” button to continue to the final step, or click on the “Return to Claim Entry” option to return to Step 2




## Claim Entry – Short Form Step 4 of 4

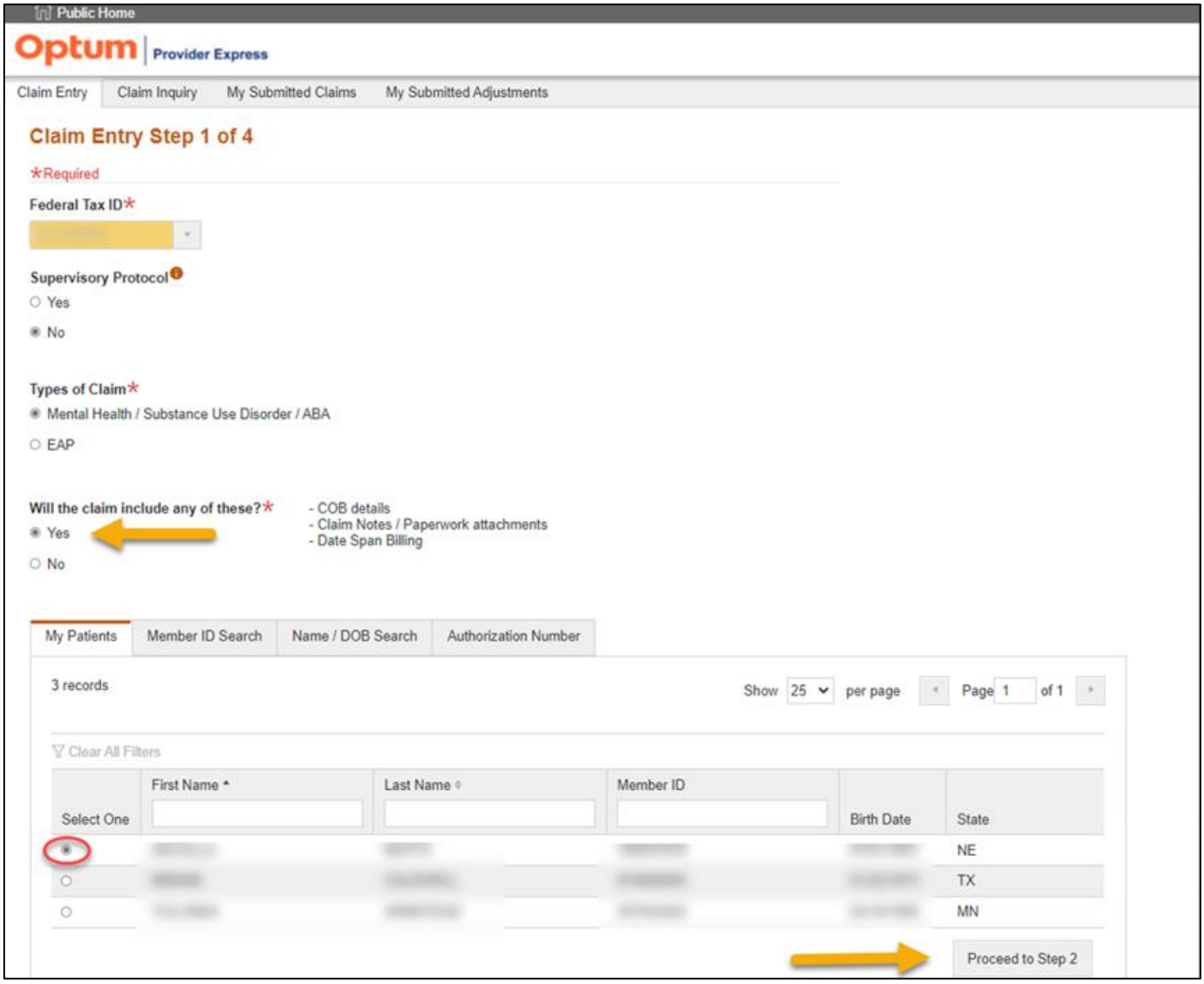
- Step 4 yields the same information as in Step 3, with the addition of a Confirmation Number, verifying the claim has been successfully submitted
- The user has the option to submit another claim by clicking the “Enter Another Claim” button at bottom of page and returning to Step 1




**NOTE: Provider Express recommends printing out this page or documenting the confirmation number. You can use that number with the Provider Express Tech Support staff if any questions arise about the submission of that claim.**

## Completing and submitting the Long Form:

### Claim Entry – Long Form Step 1 of 4

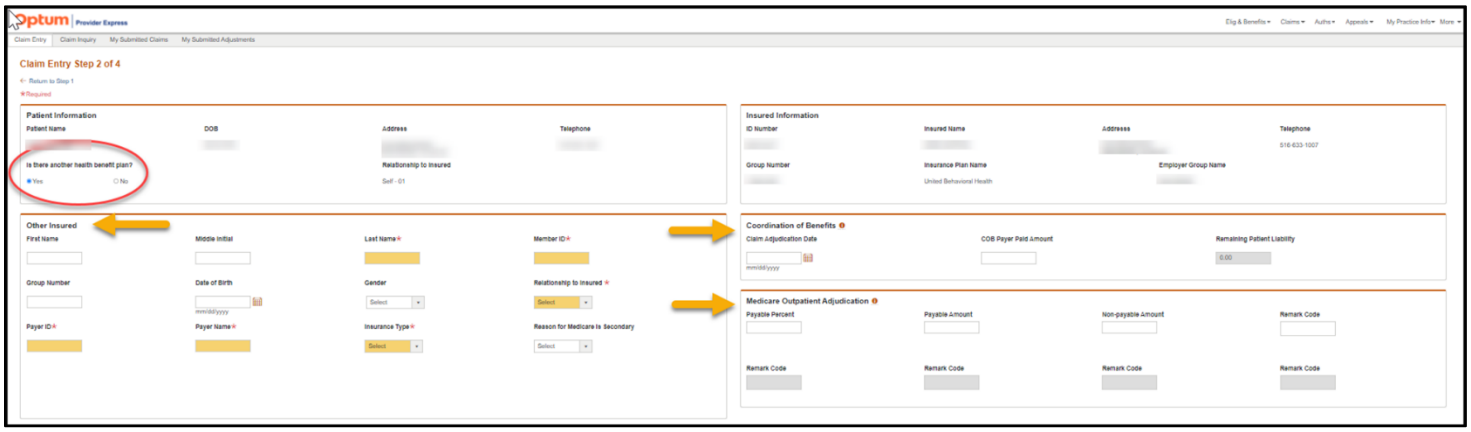



### There are several required fields:

- Federal tax ID
- Select Provider (for a group login)
- Supervisory Protocol
- Type of claim
- "Will the claim include any of these?" **(Clicking on Yes "Will the claim include any of these" will launch the Long Form on Step 2)**

## Claim Entry – Long Form Step 2 of 4

The Long Form displays a claim similar to the Short Form, pre-populating the Patient and Insured's information.

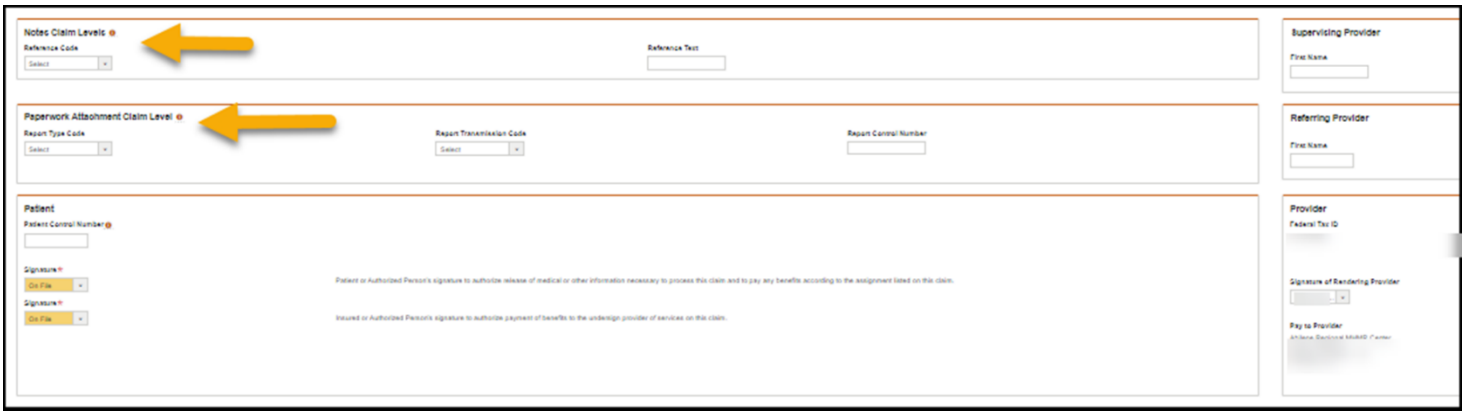



If the user selects "Yes" there is another health plan, additional fields will display to support entry of data needed for COB claim filing including:

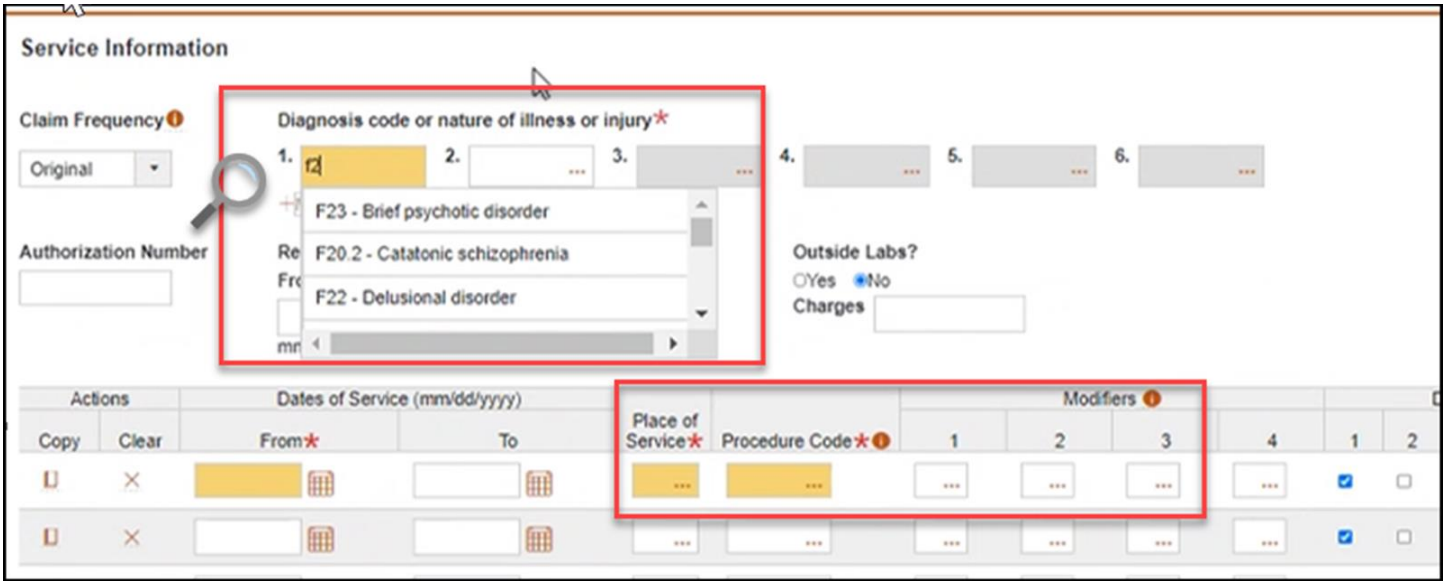
- Other Insured
- Coordination of Benefits
- Medicare Outpatient adjudication
- COB Claim Adjustments

### Other options on the Long Form include:

- Notes at the Claim Level
- Paperwork Attachment at the Claim Level

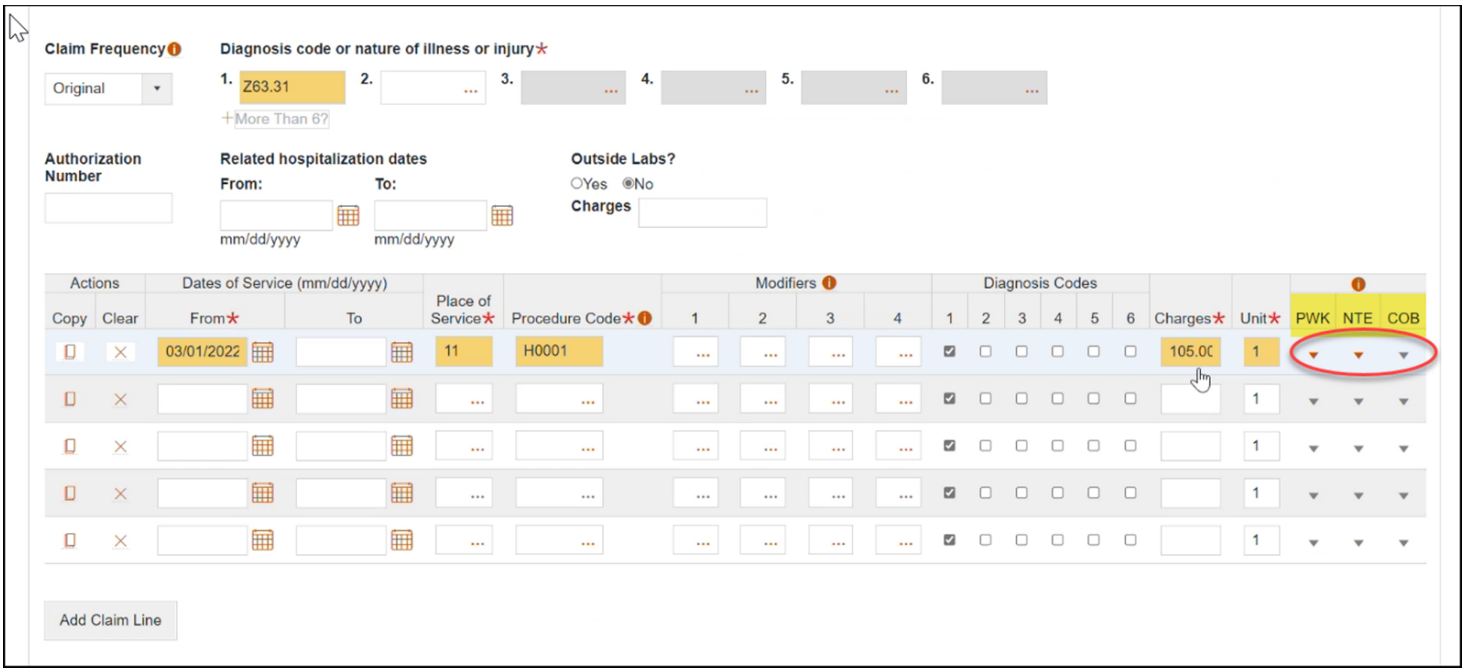


### In the Service Information section there are Type ahead fields:

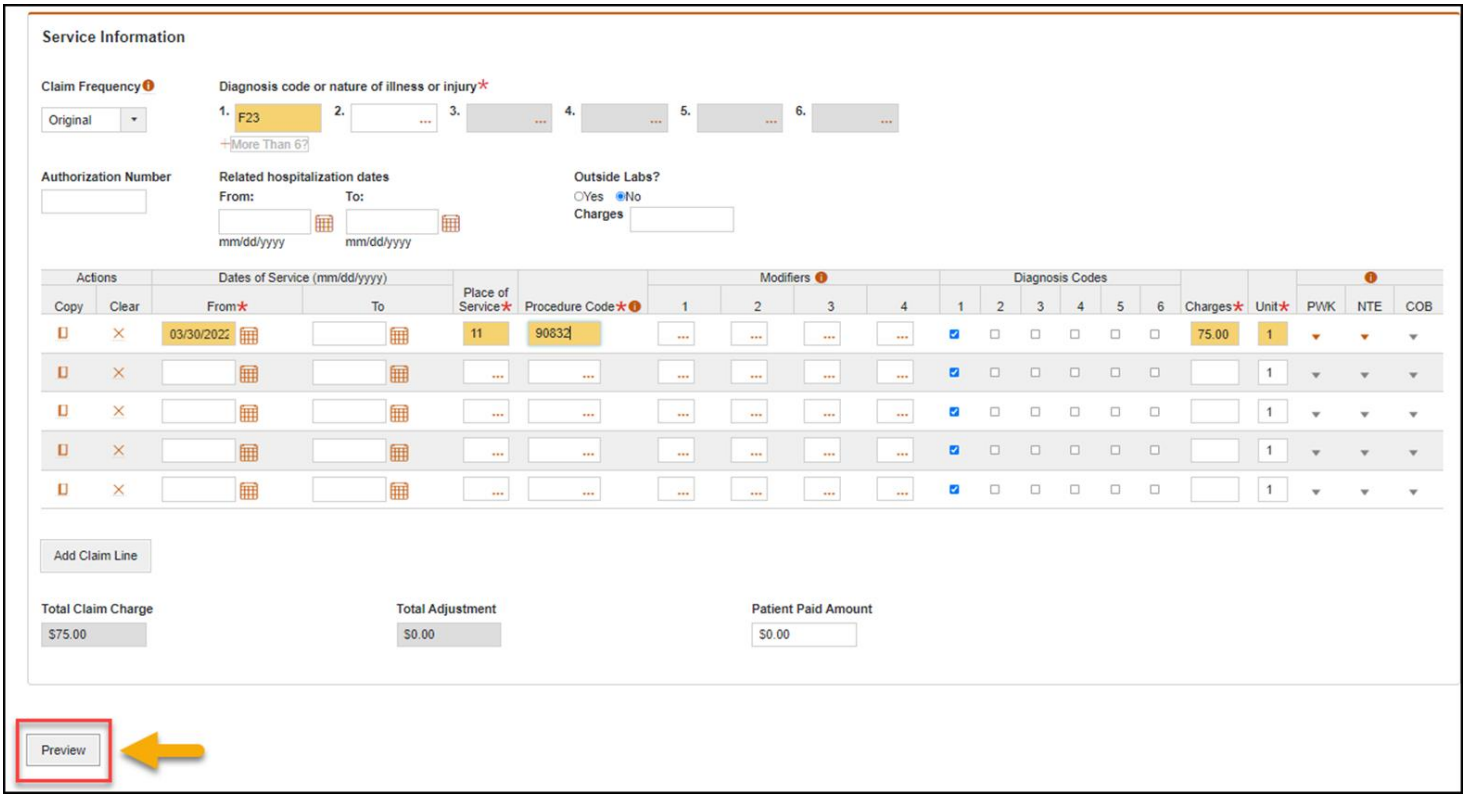



### To the right of each line of service are three Line Level options:

- PWK = Paperwork
- NTE = Notes
- COB = Coordination of benefits

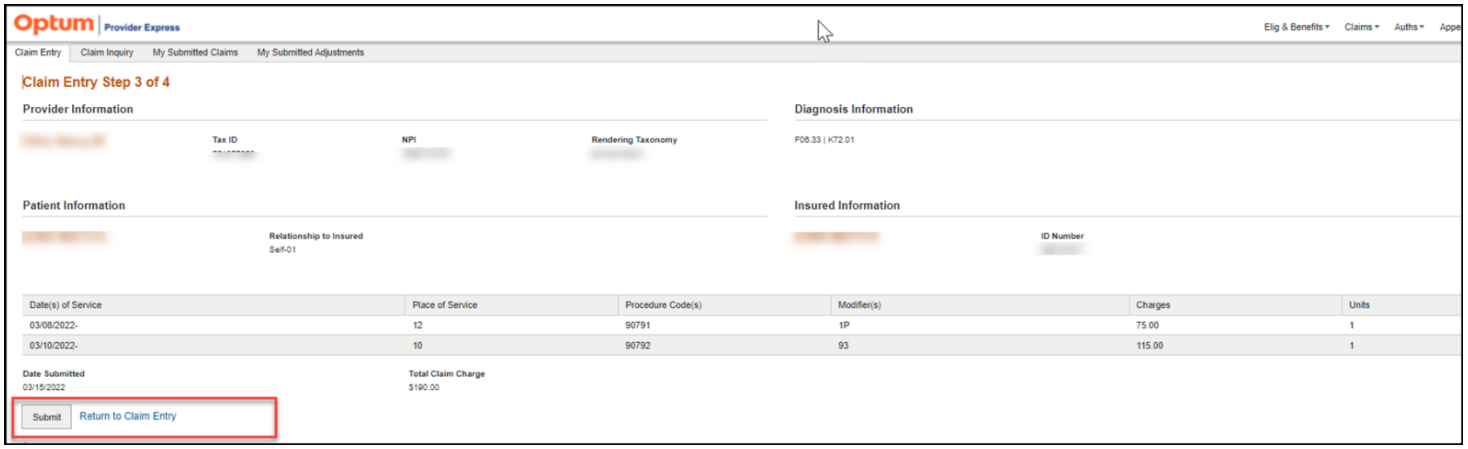


## When complete, Click on Preview:




## Claim Entry – Long Form Step 3

- Step 3 allows users to preview basic information on the claim before sending for submission
- If all the information is accurate, click the “Submit” button to continue to the final step, or click on the “Return to Claim Entry” option to return to Step 2



## Claim Entry – Long Form Step 4

- Step 4 yields the same information as in Step 3, with the addition of a Confirmation Number, verifying the claim has been successfully submitted
- The user has the option to submit another claim by clicking the “Enter Another Claim” button at bottom of page and returning to Step 1

**NOTE: Provider Express recommends printing out this page or documenting the confirmation number. You can use that number with the Provider Express Tech Support staff if any questions arise about the submission of that claim.**

### Provider Express Technical Support

**1.866.209.9320,** 4 a.m. – 4 p.m. Alaska Time

**Chat Now** is available 5 a.m. – 2 p.m. Alaska Time, Monday - Friday

### Paper Claim Submission

### General Guidelines – Outpatient Professional Claims Submitted on Form-1500

The provider shall submit claims using current Form-1500 with applicable coding including, but not limited to, ICD-10, CPT, and HCPCS coding. The provider shall include on the claim the participant ID number, provider’s Federal Tax I.D. number, National Provider Identifier (NPI) as specified below and/or other identifiers requested by Optum Alaska:

- Form-1500 claim submission may not span dates. Submit each date of service on a separate line
- Claims will be denied if the service requires an authorization and an authorization has not been issued
- Multiple units of the same service code/modifier on the same day must be submitted on ONE claim line
- Certain provider types require that a rendering provider must be referenced on the claims
- Paper claim forms contain information necessary to process claims for services rendered to Alaska Medical Assistance participants. Adhere to the following instructions for claims to be processed efficiently. Accuracy, completeness, and clarity are important:
- Use only an original, red Form-1500 claim form to bill for professional services. Do not submit black, photocopied, or faxed claims; these claims will be returned unprocessed
- Use only blue or black ink to fill out the claim form. Light-colored or red ink is not perceptible when the claim form is scanned using optical readers
- Do not fold or crease claims
- Fill in handwritten claims neatly and accurately
- Keep names, numbers, codes, etc., within the designated boxes and lines
- Make corrections carefully. Do not strike or write over errors to correct. Correction fluid or tape may be used as long as the corrected information is readable
- Include a return address on all claims and mailing envelopes

- Send only required attachments

**For U.S. Mail and Fax**: Optum Alaska will accept current versions of paper Form-1500 forms for practitioner/professional services or Uniform Billing (UB)-04 forms for inpatient and outpatient facility claims. The mailing address and fax number for completed claim forms and required attachments is:

Mail: **Optum**
**P.O. Box 30760**
**Salt Lake City, Utah 84130-0760**

Fax: **1.248.733.6085**

### Customer Service Claims Assistance

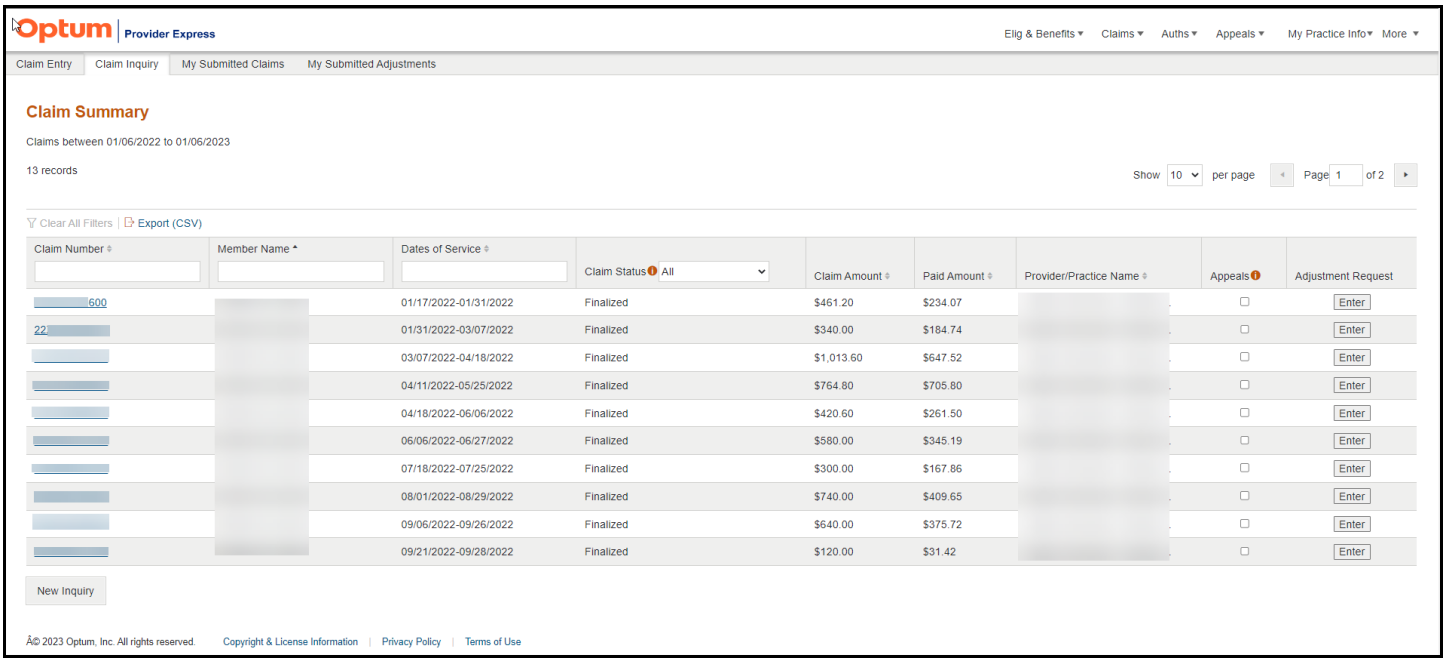
Optum Alaska has a dedicated customer service department with staff available 8 a.m. to 6 p.m. Alaskan Time, Monday - Friday to assist you with questions including eligibility inquiries or the status of a claim payment. The Optum Alaska customer service phone number is: **1.800.225.8764.**

Claims can also be viewed in Provider Express. Provider Express does a real-time look-up in the Optum claim system when a provider searches for a claim. If the claim is in the source claim system, it will show on Provider Express. There are 3 claim statuses displayed:

- Pending/In Process
- Finalized
- Finalized Adjusted

You may use the secure "Claim Inquiry" feature on Provider Express to gather claims status information.

Claim Summary page:




Additional support is available at *Provider Express* (providerexpress.com). Select "Claim Tips":

## Claim Tips

**Introduction**

Optum supports multiple ways of submitting a claim for service. We encourage our clinicians to submit claims electronically or through the Claim Entry feature of Provider Express.

Optum processes claims for its members on multiple claims systems, depending on the member's benefit plan. As a result, Optum has multiple mailing addresses for paper claim submissions. In order to ensure prompt and accurate payment, please **verify the mailing address prior to submitting your claim**. For EDI and online claims, a claim mailing address is not required.

- CPT Code Changes for 2021
- CPT Code Changes for 2020
- CPT Code Changes for 2019

- Claim Entry Through Provider Express
- Claim Corrections or Resubmission
- Claim Submission Hints
- EAP Claims
- Electronic Claim Submission (EDI)
- Optum Pay™
- Improve the Speed of Processing
- Facility Claims
- Outpatient Claims
- Where to Submit Your Optum Claim

**Frequently Asked Questions about Claim Submission**

## 6.2 Claim Cycle

### Payment Cycles

Times for claims submission:

Claims can be submitted 24 hours a day, 7 days a week, Optum intakes electronic claims nightly (Monday - Saturday @ 9:15 p.m. Alaska Time).

Electronic Fund Transfers (EDI/835) – Run on Tuesdays and Saturdays:

Claims need to be in “01” status by 8 p.m. Alaska Time on Monday and Friday. Status “01” means the claim is ready to be picked up for the next available check run.

Payments settle in the providers account on the following Friday (for Tuesday payments) and Thursday (for Saturday payments).

Only Paper checks – runs Tuesday through Saturday:

Claims need to be in “01” status by 8 p.m. Alaska Time, Monday through Friday. Status “01” means the claim is ready to be picked up for the next available check run.

### Claims Processing

Claims process through Optum; Optum checks claim information against master files using edits and audits to determine, for example, some of the following:

- Compatibility of procedures and diagnoses
- Provider eligibility at the time of service
- Participant eligibility at the time of service
- Third party liability (TPL)
- Duplication of previously paid claims
- Service authorization (SA) on file, when required

After the claim processes, it will adjudicate (pay, pend or deny).

**Adjudication:**

**Pay**

If Optum validates the information on the claim and information successfully passes all edits and audits, Alaska Medical Assistance will pay on the claim and record the payment in the provider's weekly remittance advice (RA). Payment, less any participant cost share owed, represents full and total reimbursement for those covered services under Alaska Medical Assistance. **Under federal regulations, providers may not "balance bill" participants.**

- Providers may not charge participants for the difference between the amount billed and the amount Alaska Medical Assistance allows for a covered service
- When a provider does not bill Alaska Medical Assistance correctly, the participant is not responsible for the charges
- When a provider does not bill Alaska Medical Assistance within timely filing limits, the participant is not responsible for the charges

**Suspend**

If Optum finds claim information that fails a validation check, the claim will suspend and a claims examiner will review the information provided:

- If the claims examiner finds a data entry keying error on a submitted paper claim, he or she will correct these errors and release the suspended claim for resubmission to the claims validation process
- If the claims examiner cannot correct the claim, the claim will be denied for the appropriate reason

**Deny**

A claim may be denied for reasons such as:

- The billed service is not a covered benefit
- The line item fails validation (the edit/audit process)
- The claim was submitted outside the timely filing limit

Denied claim lines represent those services that are unacceptable for payment. Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information within timely filing limits.

**Duplicate Billing**

Duplicate claims may occur when providers submit two or more claims with some or all of the same information, including:

- Date of service
- Charges
- Participant ID
- Provider Contract ID/National Provider Identifier

- Procedure codes

To avoid erroneous duplicate billing, providers should keep up-to-date records of all claims by reading their remittance advice and routinely checking on the status of claims. Providers can avoid duplicate billing errors by adjusting any claim already submitted and paid instead of re-billing. This can occur when:

- A provider needs to bill additional charges for a date of service
- Primary insurance pays on a claim after Alaska Medical Assistance

## 6.3 Timely Filing of Claims

All claims must be filed within 12 months of the date services that 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. In these cases, providers must bill Alaska Medical Assistance within 12 months of the service date and attach explanation of benefits documentation from the third- party carrier to the Alaska Medical Assistance claim.

The timely filing limit may be extended under the following conditions:

- **Court orders or administrative hearings:** The timely filing limit can be extended and payment made by court order. If a provider had reason to believe that the participant was ineligible at the time service was rendered, and the participant is subsequently determined eligible by a court or hearing authority, the claim may be paid if it is filed within the above timely filing guidelines after the date of the court or administrative hearing authority's decision that the participant was eligible. A letter or document from the court or agency establishing the decision to make payment must accompany the claim
- **Good cause:** The timely filing limit may be extended for "good cause." Good cause exists when an unexpected or uncontrollable event takes place which prevents a provider from submitting a timely claim (fire, storm, earthquake, etc.). Good cause does not include errors made by the provider or provider's billing staff. Good cause also does not include the participant’s failure to notify the provider of a court or administrative hearing authority's decision

### Proof of Timely Filing

Any time a claim is received after the timely filing period has expired; an attachment must accompany the claim to prove timely filing. Acceptable documentation must be dated within the timely filing period and must show that either the claim was previously received by Optum within the timely filing period or the claim met one of the conditions for timely filing extension.

Examples of acceptable documentation include:

- A copy of the remittance advice (RA) page showing claim denial
- A copy of the in-process claims page of an RA
- Provider Express or other electronic claim submission transmission report
- Correspondence from Optum, the Division of Behavioral Health (DBH), or the Division of Public Assistance (DPA)
- Court orders or administrative hearing documentation as outlined above

**Filing Limits for Adjustments**

Adjustment requests must be submitted within 60 days from the date of payment or within 12 months of the date of service if additional amounts are owed to the provider. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply.

## 6.4 Payer of Last Resort

Alaska Medicaid is always the payer of last resort. Therefore, if a patient is eligible for Department of Veterans Affairs "VA", Medicare, and Medicaid benefits, providers must exhaust all Medicare and VA benefits before billing Alaska Medicaid. Providers may verify VA eligibility by identifying resource code "N" or "N2" on the Medicaid participant's coupon.

Veterans identified with the resource code "N" have freedom of choice to utilize VA or Medicaid as desired. Alaska Medicaid does not require these participants to obtain a Medicaid denial letter from the Alaska VA Healthcare System.

When providing care to a Veteran with a resource code of "N2", a provider must submit valid documentation of non-coverage from Medicare and the VA when billing. Valid documentation may include an explanation of benefits (EOB) showing non-coverage or a Medicaid denial letter from the Alaska VA Healthcare System.

An Alaska Medical Assistance participant who is eligible for VA and Medicare can use either as his/her primary resource. However, the following conditions apply in regard to Alaska Medicaid paying anything for the claim:

- If VA is pursued as the participant's primary payer (instead of Medicare), the claim is considered satisfied and neither Medicare nor Medicaid will pay anything more
- If Medicare is pursued as the participant's primary payer (instead of VA)
    - VA will not pay for anything over the amount paid by Medicare
    - Alaska Medicaid may pay the Medicare copay and/or deductible if the Medicare Remittance Notice (MRN) and the VA denial are attached to the claim
    - Alaska Medicaid may reimburse according to the applicable Alaska Medicaid rates if the services billed are non-covered Medicare services and a Medicaid denial letter from the VA is attached to the SA request and/or claim

Therefore, if a participant is eligible for VA, Medicare, and Medicaid, Alaska Medicaid will not pay anything for the claim unless providers follow these steps:

1. Bill VA first and receive a formal denial (in writing) from VA or receive a Medicaid denial letter.

**NOTE: If the Veteran has an applicable Medicaid denial letter from the VA, the provider does not have to bill VA first.**

2. Bill Medicare correctly.
3. Bill Alaska Medicaid correctly and attach the denial from VA and the MRN.

If providers follow these steps bill the claim correctly, Alaska Medicaid may pay the Medicare copay and/or deductible.

**Explanation**

- VA is considered primary because they pay 100 percent of their allowed amount

- Medicare is considered secondary because they pay 80 percent of their allowed amount with a 20 percent copay, which Alaska Medicaid can cover under the correct billing process
    - However, Alaska Medicaid will not use state funds for a 20 percent Medicare copay if the claim could have been satisfied with 100 percent federal funds (VA is federally funded)

Please refer to the back of the Form-1500 claim form (under *Refers to Government Programs Only)* for rules and information related to billing multiple federally funded programs.

**Obtaining a VA Medicaid Denial Letter**

To provide freedom of choice for Veterans with medical needs, the Veteran can request a Medicaid denial letter from the Alaska VA Healthcare System. This letter, which is for specific services, can be submitted to the Alaska Medicaid program as an explanation of Veteran's health benefits. Therefore, if the Veteran (identified by resource code "N2") chooses not to use VA as his/her primary payer, attach a copy of this letter to any related service authorization request and/or claims sent to Alaska Medicaid.

**Important:** All other Alaska Medical Assistance billing requirements still apply to claims submitted with a Medicaid denial letter, including:

- Timely filing of claims
- Exhaustion of all other benefit resources (including Medicare) before billing Medicaid

The Veteran must request a Medicaid denial letter from the Alaska VA Healthcare System:

**Alaska VA Healthcare System**
**Anchorage Regional Office**
**1201 N. Muldoon Road**
**Anchorage, Alaska 99504**

Phone: **1.907.257.4780**
Toll Free: **1.888.353.7574 X 4780**

The VA Integrated Care Department will fax or mail the Medicaid denial letter to the requesting entity, including the Veteran, any affected medical providers identified by the Veteran, or Alaska Medicaid.

## 6.5 Coding

**HCPCS Coding Convention**

Alaska Medical Assistance, in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements, uses the Healthcare Common Procedure Coding System (HCPCS) convention. HCPCS coding must be used for all professional/outpatient claims (originals and re-submittals), adjustments, and requests for service authorization submitted for processing.

HCPCS coding has two levels. Each HCPCS procedure or service has a five-digit alpha-numeric code, with provision for a unique two-position modifier for each level of coding.

| | |
|---|---|
| **Level I** | American Medical Association current procedural terminology (CPT) codes as found in the annual revision of the Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). |

| | |
|---|---|
| **Level II** | The CMS codes for physician and non-physician procedures and services not found in the CPT. |

To order a CPT book, visit the American Medical Association website.

### Diagnosis Codes

The Centers for Medicare and Medicaid Services (CMS) requires that the World Health Organization's International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis codes be entered on all claims that require a diagnosis.

### National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) requires that all claims submitted to Alaska Medicaid must comply with NCCI methodologies and are subject to NCCI edits. Two types of edits are mandated by NCCI: procedure-to-procedure edits and medically unlikely edits.

Procedure to Procedure Edits:
Procedure-to-procedure edits define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together.

Medically Unlikely Edits:
Medically Unlikely Edits (MUE) are units-of-service edits that define for each HCPCS/CPT code the number of units of service beyond which the reported number of units of service is unlikely to be correct.

**Services denied for NCCI edits may not be billed to the participant.** The denied service is a provider liability. Providers may appeal individual claim denials to Optum; for instructions, refer to Appeals in this section.

For additional information about NCCI, visit the CMS NCCI webpage.

### Servicing or Rendering Provider Claims

Claims for certain services must include a rendering provider on the claim. If required to submit rendering information, use the following information to submit paper claims:

- The National Provider Identifier (NPI) for the rendering provider performing the service is entered in the un-shaded portion of field 24j. It must match the NPI of the enrollment record on file with Alaska Medical Assistance
- The taxonomy may be needed and is strongly recommended. When supplied, it is entered in the shaded portion of field 24j with the ZZ qualifier in the shaded portion of field 24i. The taxonomy code is entered in the shaded portion of field 24j must match the taxonomy code of the rendering provider's enrollment record
- The services that currently require a rendering provider on the claim are:
  - 1115 Waiver Behavioral Health Services
  - 1115 Waiver Substance Use Disorder Services
  - Autism Services
  - Independent Psychologist Services
  - Licensed Clinical Social Worker Services
  - Licensed Professional Counselor Services

- Marital and Family Therapist Services

- When billing for a daily service with many rendering providers on the same day, a provider may bill with only one of any one of the rendering providers for that day on the claim

**Billing Group Requirements**

The National Provider Identifier (NPI) of the billing group must be submitted (field 33a of the Form-1500). This information is used to determine the Pay-to Provider.

The corresponding taxonomy code may also be submitted (field 33b of the Form-1500). The ZZ qualifier immediately precedes the taxonomy.

Providers must submit the address with the full ZIP+4 postal code for the physical location of the group practice/business/agency (field 32 of the Form-1500). This ZIP+4 postal code is not the payment address ZIP+4 postal code. Submit this information on all claims, electronic or paper.

**Insurance Explanation of Benefits**

If the Alaska Medical Assistance participant has other health insurance coverage, enter the explanation of benefits (EOB) information from the insurance company in the claim, showing the payment or denial.

**Claim Attachments**

Provider Express Claim Entry and the standard 837P transaction are designed to allow for secondary claim billing. See below for how to submit an Explanation of Benefits (EOB) with a claim to Optum.

Find the Claim ID in Provider Express (this is the Claim ID that Optum assigned) and include the following information on an attachment:

- Member name
- Member date of birth
- Member ID
- Date of Service
- Claim ID

To submit a claim attachment, send a copy of the claim with the attachment. The mailing address for claims with attachments is:

**Optum**
**P.O. Box 30760**
**Salt Lake City, Utah 84130-0760**

When a claim is submitted to Optum BH through EDI or Provider Express and the Provider already has the primary carrier payment information, they should/need to put that information on the claim. There is a spot for other insurance information and payment information from the primary carrier. If that information is on the claim, then Optum can process the claim and NOT initiate the Department of Labor (DOL) Letter Process, nor does Optum need the EOB sent by mail to Optum. Optum would only send a DOL Letter as stated below:

Claims do not stay in a pend status. If a claim requires additional information a DOL letter is generated and the claim is closed with “F53 DOL Process Initiated; Refer to separate letter requesting additional information or additional explanation messages for final claim status.” The DOL Letter Process is initiated when incomplete information is received on a claim that prohibits benefit and eligibility

determination (such as procedure or diagnosis code). A letter is generated to request the missing or invalid information from the provider which initiates the process.

Optum allows 45 days from the date requested to receive this information. If the information is not received within that time frame, then the claim is denied with “additional information not received.” The Optum claims processing system will automatically send a denial letter to the member upon the final denial. It is not a manual selection or decision that a Claims Processor must make.

For EOB requests on claims, Optum denies the claim for one of the following reasons:

- EOB does not match claim – The Explanation of Benefits does not match the claim information submitted. Please resubmit correct information for Optum to consider the claim
- Send Medicare EOB – Optum will need a copy of the Medicare summary notice before your claim can be processed
- EOB Lacks correct Information – the Explanation of Benefits received lacks correct information

## 6.6 Recovery or Recoupment of an Overpayment

Adjusters must frequently reprocess a claim to release additional benefits or recoup overpaid benefits. Reasons include:

- Correction of billed information, such as a charge amount or procedure code that alters the original benefit calculation
- Pertinent documentation, which caused the original payment to be reduced or denied, such as a COB verification letter or missing required claim data, is received
- Required referral or pre-authorization is attained
- Reversal of deductible or another plan limit originally applied to the claim
- Eligibility

If Optum finds an overpayment, then Optum will send a provider an overpayment letter stating the overpayment reason and amount. The letters give the provider directions on how to reimburse Optum.

If a refund is not received and the provider continues to bill Optum, then Optum will recoup the funds from a future payment within 28 days.

## 6.7 Method of Payment

### Optum Pay is a highly secure transaction

With Optum Pay, formerly known as Electronic Payments & Statements (EPS), claim payments are deposited directly into your bank account as soon as possible. Optum Pay can dramatically shorten your revenue cycle. In fact, you may be paid five to seven days faster than by paper checks received through regular mail.

Now with an added layer of security, claims payments made by electronic funds transfer from health plans can be deposited directly into your designated bank.

For more information, please visit the Optum Pay website.

### Payment Prohibited Outside the United States

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

## 6.8 Remittance Advice, Adjustments, and Voids

### Remittance Advice

The remittance advice (RA) is a claim status report.

### Electronic Remittance Advice

**NOTE:** Providers must submit HIPAA compliant 837 transactions in order to receive an 835-transaction response.

Additional electronic Remittance Advice information is at:

- Operating Rules for Electronic EFT and ERA
- Electronic Remittance Advice (ERA) Authorization Agreement

### Remittance Summary

The remittance summary shows the total weekly and year-to-date dollars paid to and collected from the provider. After the calendar year, Optum sends each provider a 1099 tax information statement, showing total Alaska Medical Assistance reimbursement payments made during the year. Optum also provides this information to the US Internal Revenue Service (IRS). A provider's 1099 will match the year-to-date total paid amount shown on the last remittance advice issued for the calendar year.

### Adjustment Claims

Adjustments occur when Alaska Medical Assistance must correct previously paid claims. Adjustments may occur when an error in billing or processing occurred. The provider must complete positive adjustments (adjustments that result in additional money paid for the claim) within 12 months of the date of service or within 60 days of payment. If additional money is owed to Alaska Medical Assistance, the 60-day filing limitation does not apply. Providers may request an adjustment electronically as an 837-claim replacement or through Provider Express.

### Adjustments

Providers should request an adjustment to correct a paid claim that was billed or processed incorrectly. For example, submit an adjustment when:

- A procedure code billed needs correcting
- The charges billed need correcting
- The number of days needs correcting
- A third-party resource pays/recoups reimbursement for the claim
- An update to service authorization (SA) occurs

### Adjustments may increase or decrease the amount paid for the claim

All adjustments must be submitted within 12 months of the date of service when payment is owed to the provider (positive adjustment). If no money is owed to Alaska Medical Assistance or the

adjustment does not affect payment, there is no time limit.

### Adjustments for Third Party Liability

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

### How to Correct and Adjust a Claim in Provider Express

In the Service info section at Provider Express, the "Claim frequency" code is what is used to determine the type of claim you are filing. Provider Express defaults to "Original" but you can change it to "Corrected" or "Void."

Use the following guidelines to help decide when to submit a corrected claim through Claim Entry versus an adjustment through Claim Inquiry:

- If the issue with the claim was because of a problem in how it was originally filed by the provider/group that now needs to be corrected, submit a corrected claim through Claim Entry
    - e.g., filing an incorrect procedure code; forgetting a modifier
- If the issue with the claim was because of an alleged problem in how Optum processed it, submit an adjustment request through Claim Inquiry
    - e.g., processing against member's deductible when it was already met; noting an authorization was required when there is an authorization on file

### Correct a Claim in Provider Express

As the help icon next to Claim frequency indicates, to submit a Corrected or Void claim, you will need to enter the original Claim Number (Payer control number) found on the claim record in Claim Inquiry. The claim number will also be reported on the paper remittance advice or electronic 835 file. You cannot submit a Corrected or Void claim until a claim number has been assigned.

The following is the Claim Number break down:

Optum Claim Number

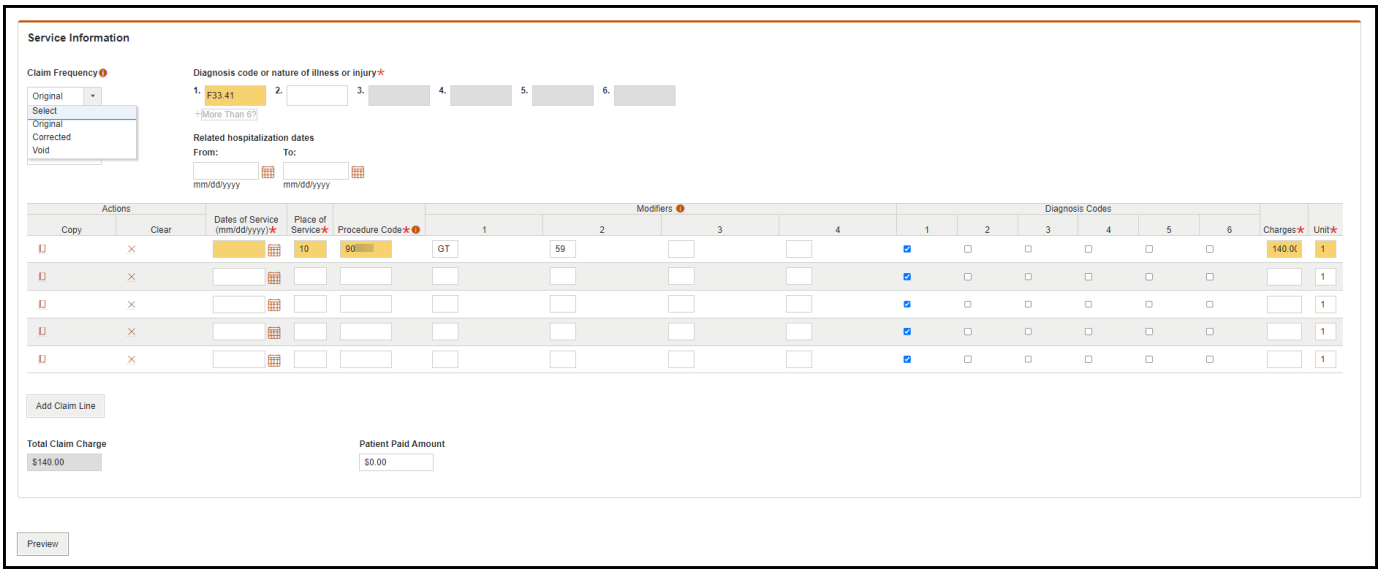
20|X|xxxxxxx|00

- Year the claim was received
- Claim submission method:

  X = Electronic
  0 = Paper Claim
- Claim document batch, number sequence
- Claim transaction type number:

  00 = Original
  01 = Adjustment

### Service Information on Claim Entry

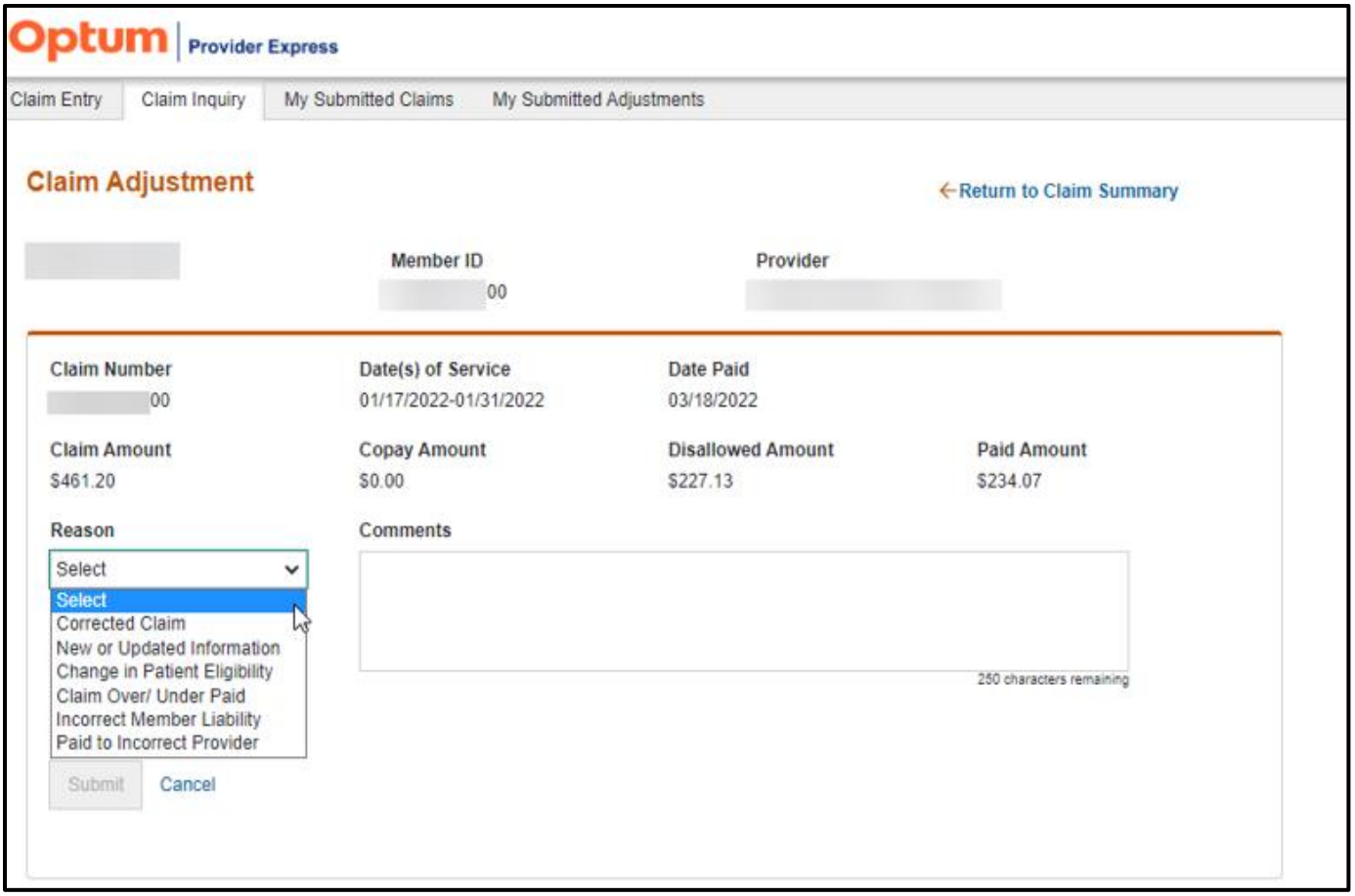



Reference the Guided Tour video titled "Claim Inquiry and Claim Adjustment Request" or for additional information, please visit the Provider Express website.

### Adjust a Claim in Provider Express

Submit an adjustment request through Claim Inquiry on the secure Transactions side of Provider Express.

Claim Adjustment:



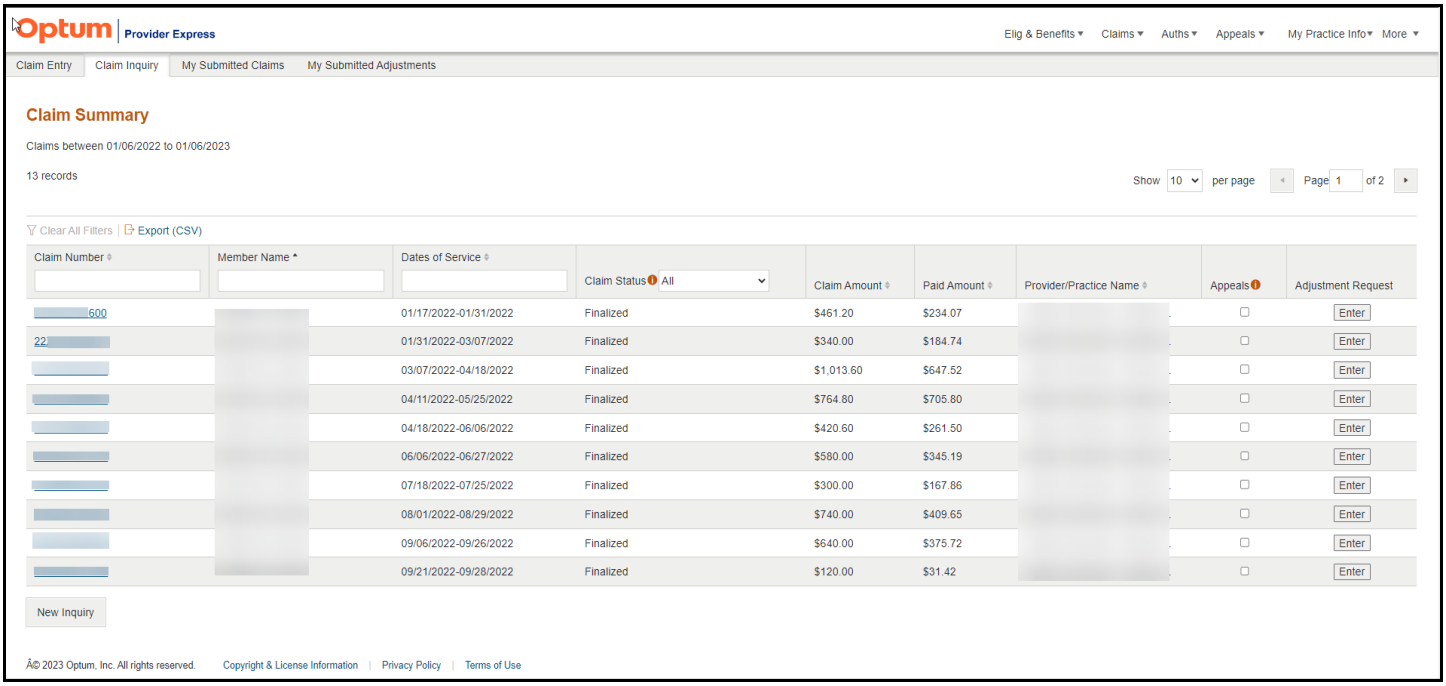
## In-Process Claims

Claims are available in Provider Express. Provider Express does a real-time look-up in the Optum claim system when a provider searches for a claim. As long as the claim is in the source claim system, it will show on Provider Express.

There are 3 statuses displayed:

- Pending/In Process
- Finalized
- Finalized Adjusted

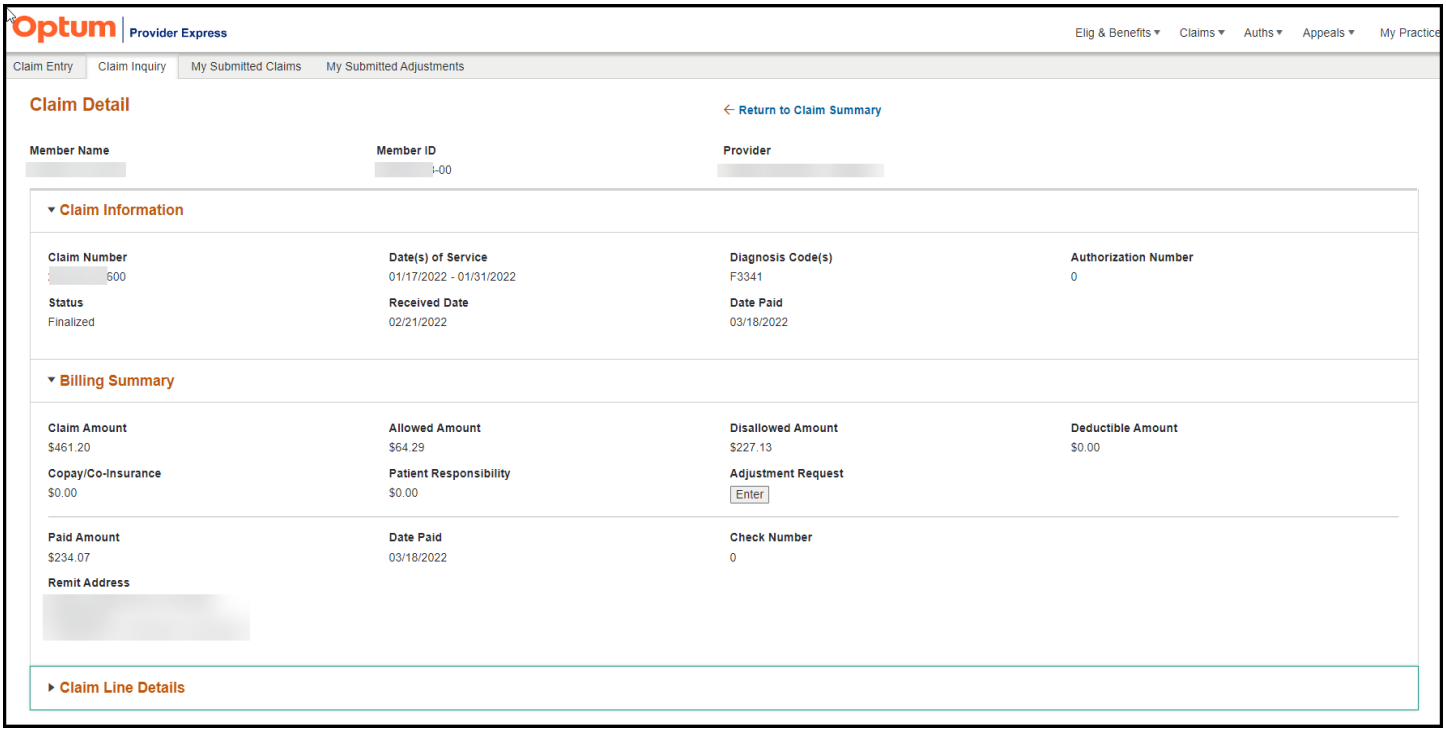
You may use the secure “Claim Inquiry” feature on Provider Express to gather claims status information.

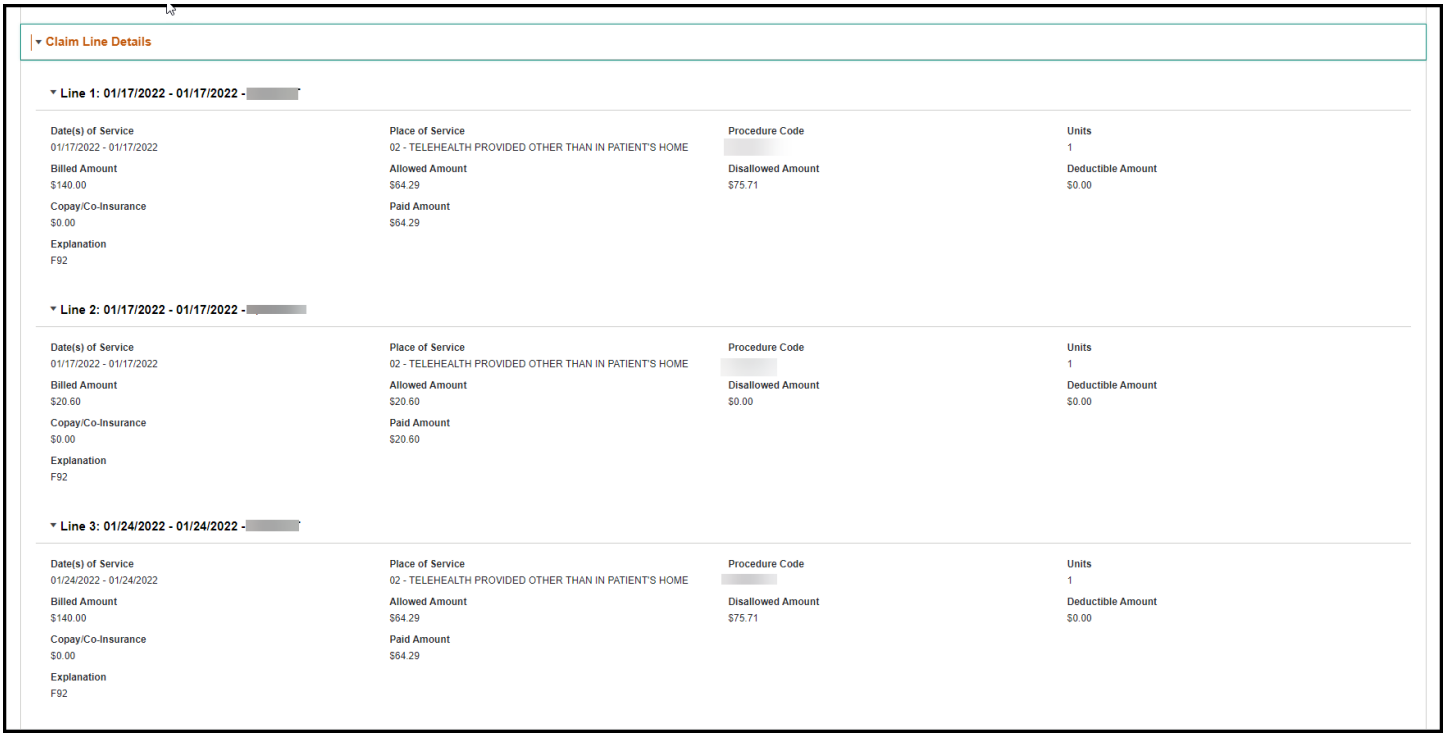


Claim Detail page:

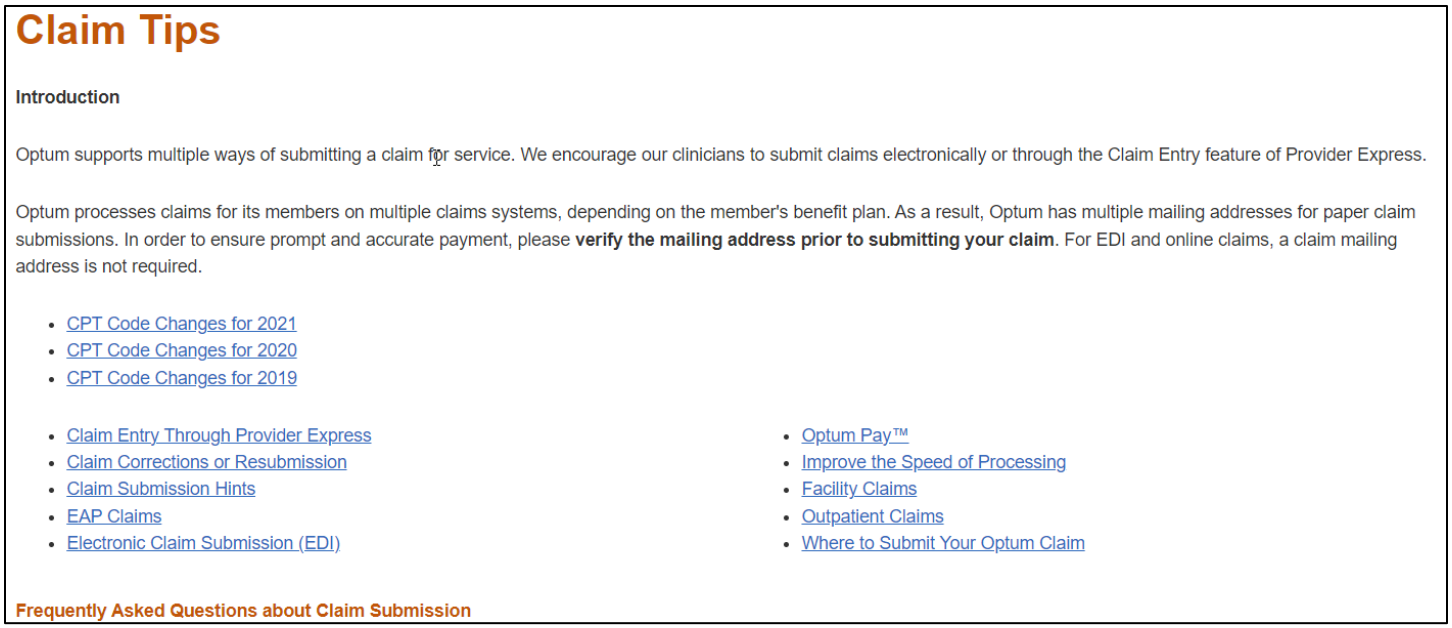
Top part of Claim detail which includes the claim information and billing summary.

Bottom part of Claim detail which shows the claim line details.



Additional support is available at Provider Express. Select “Claim Tips”.



## Claim Tips

**Introduction**

Optum supports multiple ways of submitting a claim for service. We encourage our clinicians to submit claims electronically or through the Claim Entry feature of Provider Express.

Optum processes claims for its members on multiple claims systems, depending on the member's benefit plan. As a result, Optum has multiple mailing addresses for paper claim submissions. In order to ensure prompt and accurate payment, please **verify the mailing address prior to submitting your claim**. For EDI and online claims, a claim mailing address is not required.

- CPT Code Changes for 2021
- CPT Code Changes for 2020
- CPT Code Changes for 2019

- Claim Entry Through Provider Express
- Claim Corrections or Resubmission
- Claim Submission Hints
- EAP Claims
- Electronic Claim Submission (EDI)
- Optum Pay™
- Improve the Speed of Processing
- Facility Claims
- Outpatient Claims
- Where to Submit Your Optum Claim

**Frequently Asked Questions about Claim Submission**

### Claim Submission Error Resolution

Here's an at-a-glance view of the most common claim submission errors with notation about how electronic filing can reduce these in your practice:

| Error | Paper Submission | Provider Express | EDI |
|---|---|---|---|
| NPI not entered in all required places | High error rate with no built-in mechanism for identifying and correcting problems | System corrects or prevents | Vendor will likely prevent prior to any actual filing with payor(s) allowing you to complete a one-time correction to your system to address all claims filed |
| Member demographic errors | High error rate with no built-in mechanism for identifying and correcting problems | System auto-populates member demographic information | Vendor will likely prevent prior to any actual filing with payor(s) allowing you to complete a single correction in your system to address multiple claims |
| Unclear rendering provider | High error rate with no built-in mechanism for identifying and correcting problems | Legibility assured; system auto- populates provider data from our database | Legibility assured |
| Incomplete Diagnosis Code | High error rate with no built-in mechanism for identifying and correcting problems | System will prevent submission of an incomplete code | Vendor may prompt for valid diagnosis code |
| Date of Service (DOS) - not legible or inaccurate | High error rate with no built-in mechanism for identifying and correcting problems | Legibility assured | Legibility assured |

**Recommendations:**

Electronic Filing

File claims electronically using:

- Provider Express
- EDI clearinghouse

## Denied Claims

When a claim line is denied, a new claim with corrected information should be submitted in order to be reconsidered for payment. To determine what corrections to make, refer to the explanation of benefits (EOB) code associated with the denied claim line.

- If a claim is denied for third party liability, the provider should bill all third-party resources first (with few exceptions) and re-bill Alaska Medical Assistance with proof of billing (EOB) or proof of non-coverage (Insurance booklet). Providers must bill all parties within 12 months timely filing
- If a claim is denied for participant eligibility, the provider should verify dates of eligibility and notify the participant to seek retroactive eligibility with the Division of Public Assistance to cover the date of service. If eligibility is updated, the provider should re-bill the claim thereafter
- If a claim is denied for non-coverage, consider the following:
  - Is there a more appropriate procedure code to bill for the service?
  - Is the procedure code current for the date of service, type or provider, or participant?
- If a claim is denied for missing service authorization (SA) information, providers should verify the SA number submitted is accurate. If the provider did not obtain SA, contact the authorizing agency for instructions
- If a claim is denied for exceeding timely filing limits, the provider must file an appeal within 180 days. For additional information, refer to Appeals in this section

If these errors can be addressed appropriately, providers should send in a new claim with corrected information.

## Voids

Providers must request to void a paid claim submitted with incorrect information, that include:

- Wrong participant ID number
- Services were not rendered
- Providers were paid by Medicare after receiving payment from Medicaid:
  - Providers MUST ALWAYS void these claims

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

Providers can avoid duplicate claim denials by allowing the voided claim to process before submitting any corrected claims. After the void appears on the remittance advice, it is safe to re-bill the claim.

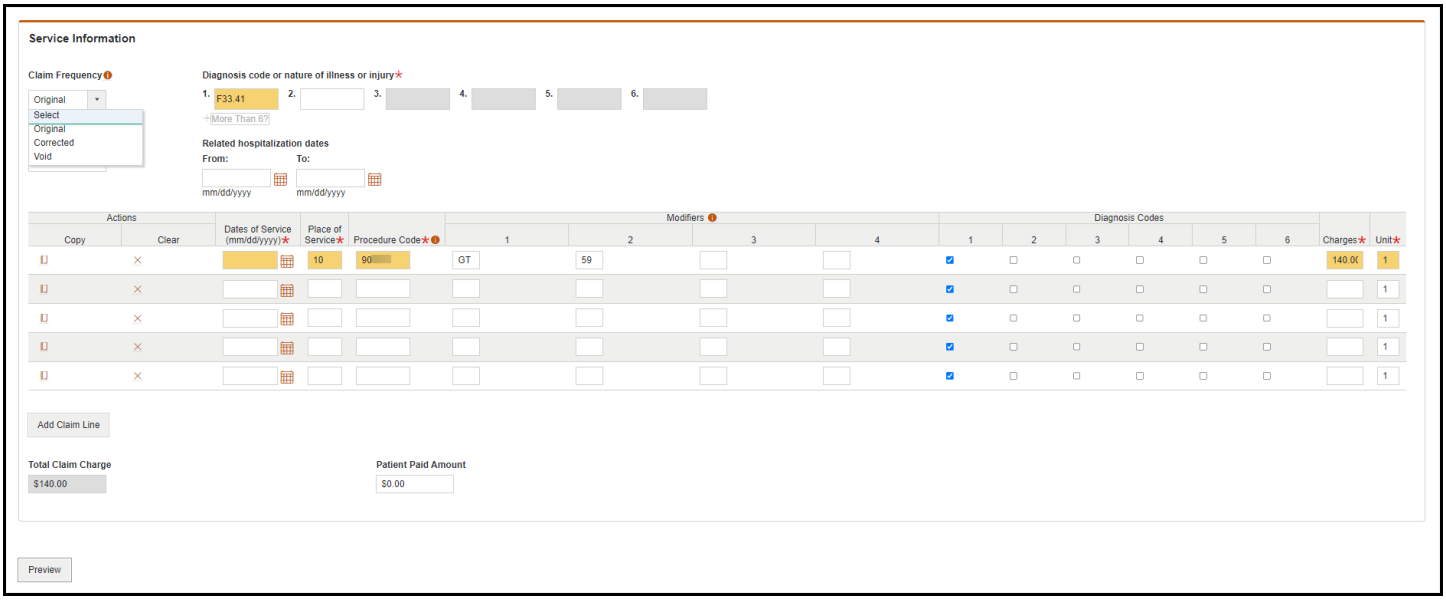
A processed void request will result in a refund to Alaska Medical Assistance of the entire payment, reduction in the year-to-date dollar amount of claims paid to the provider appearing on the remittance advice and a provider's 1099 tax report, and deletion of the paid claim/claim line information from the participant and provider history files. Optum keeps historical records of all voided claims.

## Void a Claim in Provider Express

In the Service info section at Provider Express, the “Claim frequency” code is what is used to determine the type of claim you are filing. Provider Express defaults to “Original” but you can change it to “7 - Corrected” or “8 - Void.”

As the help icon next to Claim frequency indicates, to submit a Corrected or Void claim, you must enter the Claim Number (Payer control number) found on the claim record in Claim Inquiry. The claim number will also be reported on the paper remittance advice or electronic 835 file. You cannot submit a Corrected or Void claim until a claim number has been assigned.

Service Information on Claim Entry:



# 7. Appeals and Complaints

An appeal is a request made for re-review of a previous medical necessity determination that resulted in:

- non-coverage determination of a service request
- denied, reduced, or recouped claim payment.

A provider, participant, or a provider/advocate, with participant's consent, may request an appeal. This section outlines the appeals and complaints processes for Behavioral Health Services.

The ASO provides for an internal level of an appeal following an initial medical necessity review that resulted in a non-coverage determination of a service request. For Medicaid, the Department is the final authority, and may review the decision for Medicaid services at any stage. The timeframes for making the initial determination by the ASO is one hour for an urgent request and 24 hours for a non-urgent request. The timeframes for making reconsideration and appeal determinations are listed in the applicable sections below.

## 7.1 Appeals

### 7.1.1 Appeal Review – Authorization Request

The initial review of an authorization request submitted by a provider on behalf of a participant is completed by an Optum Care Advocate. A Care Advocate may only authorize service requests. When a Care Advocate is not able to authorize benefits based on the information provided via the Optum Alaska website, Provider Express, or telephonically, the Care Advocate may ask the provider for additional information. Upon receipt of the additional information, the Care Advocate will authorize the services requested or suggest an alternative level of care. If the Care Advocate is not able to authorize benefits for services as requested or negotiate an alternative, the Care Advocate will refer the case to the Optum Alaska Medical Director or Physician Reviewer.

A non-coverage determination of services results when the Optum Medical Director or Physician Reviewer reviews a service request and cannot approve the request because it does not meet the medical necessity criteria established for that level of service. The participant may request a fair hearing for non-approved services.

**Reconsideration**

A participant, provider, or participant advocate (with the participant's consent) may request a reconsideration following a non-coverage determination that is completed without the benefit of a peer-to-peer review.

The reconsideration is a request for a peer-to-peer review between the provider and Optum Alaska. The reconsideration must be requested within 24 hours from the notification of initial denial. Optum will make the reconsideration decision within 24 hours or by close of next business day from when the reconsideration request was received. If the decision non- coverage decision for the service is affirmed, then Optum sends a non-coverage notification letter to the participant and provider. If the participant or provider continues to disagree with the non-coverage decision, then a request can be made to have the

service request reviewed by another Optum Physician Reviewer as an Appeal Review 1. If the non-coverage determination of the service request is upheld, Optum will send a non-coverage determination notification letter to the participant and provider.

### 7.1.2 Appeals of Administrative Denials – First Level Appeal

An administrative non-coverage determination occurs when a claim is denied due to one of the following reasons:

- The provider fails to obtain a pre-authorization when required
- The timely filing requirements are not met
- The participant is not a Medicaid participant

A provider may request a first level appeal if payment of an original claim was denied or reduced, or if payment was reduced due to a recoupment action.

Providers may file first level appeals with ASO.

Providers must appeal for individual claim denials resulting from National Correct Coding Initiative (NCCI) edits, including:

- Procedure-to-procedure edits
- Medically unlikely edits
- Units of service edits

For additional information about NCCI regulations, refer to National Correct Coding Initiative (NCCI) in this section or visit the Centers for Medicare and Medicaid Services (CMS) website.

**Follow these guidelines to file a first level appeal:**

1. First level appeals must be in writing and received within 180 days of the claim disposition date (the date of the remittance advice. Any appeal submitted past 180 days will not be considered.

**NOTE:**

2. Include a copy of the claim denial or payment notice from the RA, a copy of the original claim that was denied or reduced, and any supporting documentation considered relevant (e.g., chart notes, claim check audit report, etc.).
3. Optum will notify providers in writing of the first level appeal decision.

To contact the Optum Appeals Department, call **1.866.245.3040**.

Fax: **1.855.508.9353**

Mail: **Optum Alaska**
**Attn: 1st Level Appeals**
**911 W. 8th Ave., Suite 101**
**Anchorage, Alaska 99501**

If the reviewer upholds the initial decision, the provider may file a second level appeal to the Division.

## 7.2 Second Level Appeal

A provider may request a second level appeal when:

- The provider does not agree with the decision of the first level appeal
- The provider does not agree with a denied enrollment or disenrollment
- The provider does not agree with a service authorization decision
- A second level appeal for National Correct Coding Initiative (NCCI) edits is permissible.

A second level appeal must be requested in writing to the Division.

**To submit a second level appeal, please follow these guidelines:**

1. Second level appeals must be in writing and postmarked within 60 days of the date of the first level appeal decision by Optum or within 60 days of the adverse enrollment or service authorization decision.

**NOTE:** Second level appeals are not accepted by telephone or any other oral communication.

2. Include a copy of the Optum first level appeal decision, or a copy of adverse enrollment or service authorization decision, a copy of the claim denial or payment notice, a copy of the submitted claim, and supporting documentation considered relevant.

Providers should submit their appeal to:

**State of Alaska \ Division of Behavioral Health**
**Attn: 2nd Level Appeals**
**3601 C Street, Suite 878**
**Anchorage Alaska 99503**

Providers will be notified in writing of the final decision.

## 7.3 Final Level Appeal

Providers may appeal a previous decision to the Commissioner of the Department when they do not agree with the decision of the second level appeal, only when the denial of the claims relates to **not meeting the timely filing requirement**.

Final level appeal steps are as follows:

1. An appeal to the Commissioner of the Department must be in writing and postmarked no later than 60 days after the date of the second-level appeal decision by the Division. Include a clear description of the issue or decision being appealed and the reason for the appeal.

Providers should submit their appeal to:

**State of Alaska \ Department of Health**
**Attn: Commissioners Office**
**3601 C Street, Suite 902**
**Anchorage Alaska 99503**

## 7.4 Complaints

Anyone may file a complaint. Examples of complaints include concerns about quality of care, rudeness of a provider, a provider not respecting Participant rights, a concern about Optum or suspicious behavior. Complaints received are strictly confidential. If you have questions, please call the Optum Alaska Medicaid helpline at **1.800.225.8764** for assistance. Please ensure that the Complaint Form is included with your submission.

Complaints can be submitted one of three ways:

Email: ak_appeals_complaints@optum.com

Fax: **1.855.508.9353**

Mail: **Optum Alaska**
**Attn: Complaints**
**911 W. 8th Ave., Suite 101**
**Anchorage, Alaska 99501**

# Appendix 1: Participant Eligibility

## 1. Overview

Individuals in need of medical or other assistance may contact the Division of Public Assistance or consult the Alaska Medicaid Participant Handbook. In additional the Optum Alaska Participant Handbook is also available.

Providers should ask for the State of Alaska Medicaid Identification Card, this card will have a Medicaid Eligibility Identification number starting with either “06” or “20”. The Medicaid Card will either say “DenaliCare” or “Denali KidCare.” If the individual has a large paper coupon, this is not full Medicaid coverage and either indicates that the individual has their Medicare Part A and B paid for by State of Alaska Medicaid, or the individuals is in the Care Management program. When someone shows a large paper coupon, the provider should always check eligibility using the link on the Optum Alaska Website.

### Medical Assistance ID Cards and Coupons

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

Temporary Medical Assistance 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 participant is enrolled in the care management program. Temporary coupons may be computer-generated, typed, or handwritten.

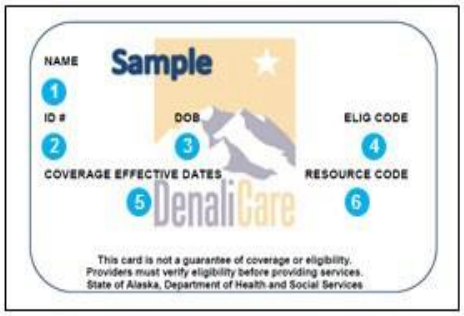
The medical identification card is not an authorization for payment of services that require a service authorization.

### Codes on Participant’s Card or Coupon

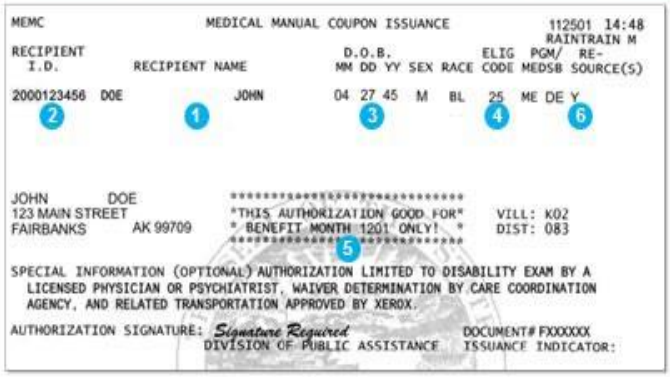
When referring to the medical assistance identification card or coupon, providers should be aware of the following items:

- Client (Participant) ID Number: This is a 10-digit number that begins “0600XXXXXX” or "200XXXXXXX"
- Month and Year of Eligibility
- Program Eligibility Codes
- Resource Codes (other insurance, also called Carrier IDs)
- Special Information or Authorization Statements

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






Providers must check all medical manual coupons for any special information or authorization statements. The coupons specify what services are eligible for Medical Assistance reimbursement. Special information statements most 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 HMS, a Gainwell Technologies Company”
- “Authorization Limited to Pregnancy Determination Only and Related Transportation as Approved by HMS, a Gainwell Technologies Company”
- “Authorization Limited to Incapacity Determination Only and Related Transportation as Approved by HMS, a Gainwell Technologies Company”
- “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 may provide medical services to a participant whose identification card or medical coupon has this wording
- “Authorization is Limited to a Non-Disability Waiver Determination Rendered by a Care Coordination Agency and Related Transportation Approved by HMS, a Gainwell Technologies Company”

# Appendix 2: Services for Participants who are Deaf or Hard of Hearing

## 1. Services for the Deaf and Hard of Hearing

Services under Alaska Medicaid Behavioral Health Services are provided to individuals who are deaf or hard of hearing and who meet the eligibility for public behavioral health services. Optum can be reached through the TTY number at **1.866.835.2755**.

# Appendix 3: Additional Resources

## 1. Alaska Partnership Access Line (PAL- PAK)

### Alaska Partnership Access Line (PAL-PAK)

The Partnership Access Line – Pediatric Alaska (PAL-PAK) offers immediate support to pediatric care providers (doctors, nurse practitioners and physician assistants) in Alaska who have questions about child and adolescent mental healthcare, such as diagnostic clarification, medication adjustment or treatment planning.

PAL-PAK is available to any prescriber caring for children or teens in Alaska. The consultation service is state and grant funded, so there is no charge for calling the consultation line. Providers may call about any patient, regardless of the patient's insurance type.

Consultations can be patient specific or can be general questions related to child psychiatry. The phone consultation is covered by HIPAA, section 45 CFR 164.506; no additional release of patient information is required to consult by phone.

Call **1.855.599.7257** (toll-free) Monday through Friday, 7 a.m. to 4 p.m. Alaska Time, to be directly connected to a child and adolescent psychiatrist.

For more information, visit the Alaska Partnership Access Line (PAL-PAK) website.

## 2. Additional Provider Resources

### Optum Supports and Services Manager

Optum Supports and Services Manager (OSSM) has a portal which is an access point to the OSSM Plan of Care for the Individual and the Support Team Members, including providers. Optum staff does not have access to the portal. Third party access to the portal is dependent upon receipt of a valid Release of Information (ROI) with detail on portal access views. Individuals have access to their own information on the portal. For more information, visit the Optum Alaska website.

### Health Care Services

Our mission is to provide to all eligible Alaskans access and oversight to the full range of appropriate Medicaid services. We also protect Alaska's most vulnerable populations through our certification and licensing sections. For more information, visit the Division of Health Care Services website.

### Office of Children's Services

The Office of Children's Services works in partnership with families and communities to support the well-being of Alaska's children and youth. Services will enhance families' capacities to give their children a healthy start, to provide them with safe and permanent homes, to maintain cultural connections and to help them realize their potential. For more information, visit the Office of Children's Services website.

### Senior and Disability Services

Our mission is to promote health, well-being, and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity. For more information, visit the Senior and Disabilities Services website.

### Office of Substance Misuse and Addiction Prevention

Implements public health approaches to prevent and reduce substance use disorders and support community-based activities across Alaska. For more information, visit the Division of Public Health website.

### Alaska Commission for Behavioral Health Certification

The Alaska Commission for Behavioral Health Certification is an entity that certifies counselors within the state of Alaska in the fields of behavioral health and addiction. For more information, visit the Alaska Commission for Behavioral Health Certification website.

https://akcertification.org/**Division of Public Assistance – Medicaid Eligibility**

All offices provide full-service statewide and are open weekdays from 8 a.m. to 5 p.m. Interviews are conducted on a walk-in basis or by telephone during the following times: Monday- Friday from 8 a.m. to 3 p.m. For more information, visit the Division of Public Assistance website.

### Alaska Native Tribal Health Consortium (ANTHC)

ANTHC's Behavioral Health department works with Tribal health organizations throughout the state to help build stronger Alaskans and healthier communities. Through training, education, and coordination with our partners, we collaborate to address community health priorities in many areas. For more information, visit the Alaska Native Tribal Health Consortium website.

### Division of Public Health – Alaska Longitudinal Child Abuse and Neglect Linkage Project (ALCANLink)

The ALCANLink project started with a group of Alaskan children whose mothers responded to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey over a three-year period shortly after they were born. Every year, project analysts check to see whether any of the children have been reported to child welfare or receive services from other public programs. As the children get older, we can calculate the percentage of children in each age group who have ever been involved with child welfare during their lifetime ("cumulative incidence").

Using these data, we can explore information on pre-birth factors from their mothers' PRAMS responses that increase or decrease the chance a child is reported to child welfare, as well as the early childhood family context of Adverse Childhood Experiences. This work has provided clear evidence for the need for early and continued efforts to prevent child maltreatment before birth and throughout childhood. For more information, visit the Alaska Longitudinal Child Abuse and Neglect Linkage Project website.