AHCCCS
Arizona Health Care Cost Containment System

IHS/638 Quarterly Forum

Behavioral Health Residential Facility

AMPM 320-V

Notifications

Behavioral Health Residential Facility (BHRF) Providers shall ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA upon intake to and discharge from the BHRF.

Admission Requirements

Member has a diagnosed Behavioral Health Condition which reflects the symptoms and behaviors necessary for a request for residential treatment. The Behavioral Health Condition causing the significant functional and/or psychosocial impairment shall be evidenced in the assessment by the following:

a. At least one area of significant risk of harm within the past three months as a result of:
    i. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent,
    ii. Impulsivity with poor judgment/insight,
    iii. Maladaptive physical or sexual behavior,
    iv. Member's inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports), or
    v. Medication side effects due to toxicity or contraindications.

Continued…

b. At least one area of serious functional impairment as evidenced by:
    i. Inability to complete developmentally appropriate self-care or self-regulation due to member's Behavioral Health Condition(s),
    ii. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care,
    iii. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders,
    iv. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications, or
    v. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem,

Continued…

c. A need for 24 hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community,

d. Anticipated stabilization cannot be achieved in a less restrictive setting,

e. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care, and

f. Member agrees to participate in treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

Criteria for Continued Stay

Continued stay shall be assessed by the BHRF staff and as applicable by the CFT/ART/TRBHA during Treatment Plan review and update. Progress towards the treatment goals and continued display of risk and functional impairment shall also be assessed. Treatment interventions, frequency, crisis/safety planning, and targeted discharge shall be adjusted accordingly to support the need for continued stay. The following criteria shall be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

Discharge Readiness

Discharge readiness shall be assessed by the BHRF staff and as applicable by the CFT/ART/TRBHA during each Treatment Plan review and update. The following criteria shall be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.
2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.
3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.
4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

Thank You.

American Indian Medical Home

American Indian Medical Home (AIMH) Program

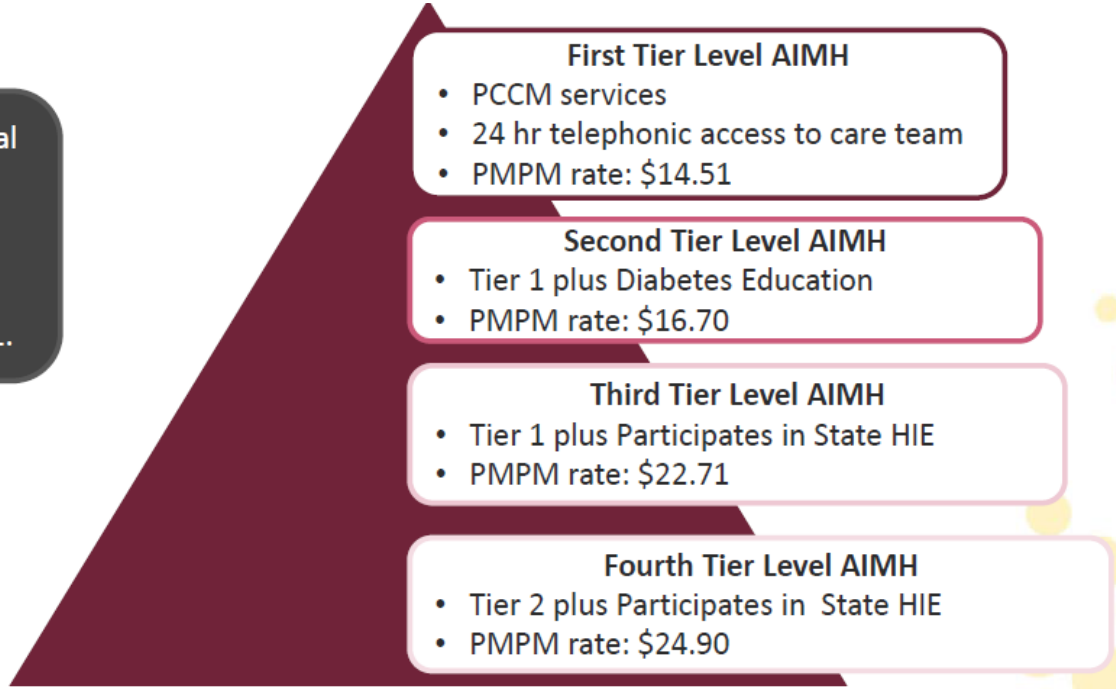
- AIMH initiative aligns with:
  - National IHS efforts to advance Patient Centered Medical Homes through the IHS Improving Patient Care (IPC) program
  - Coordinating care with IHS/Tribal 638 facilities
  - State-wide focus on integrated care, health information exchange, and care coordination
- Concept of PCCM and PMPM strategy as an AIMH brought to fruition thru efforts of a Tribal Workgroup

AIMH Eligible Provider Types

- Eligible IHS/638 Provider Types:
  - 02 – Hospital
  - 05 – Clinic (excluding Dental Providers)
  - IC – Integrated Clinic
  - C2 – Federally Qualified Health Center (FQHC)
  - C5 – 638 Federally Qualified Health Center (FQHC)
  - 29 – Community/Rural Health Center (RHC)

AIHP Service Tier and Reimbursement Levels

Note: There will be an annual renewal process every October at which time the medical home can select a new tier level. Annual rate increase occurs on January 1.



AIMH Provider Packet Submission Documents

- AIMH signed IGA
- AIMH Provider Registration Form with supporting documentation
- Electronic Data Interchange (EDI) Checklist
- IRS Form W-9
- AIMH Application Fax Request Form

AIMH Member Requirements

- Title XIX only; not for KidsCare
- Tribal ALTCS not included
- AIHP enrolled member only
- Participation is voluntary
- Member may discontinue at any time
- Member may switch AIMHs at any time
- Facility must keep signed AIMH form on file

Active American Indian Medical Homes

Phoenix Indian Medical Center (PIMC) – Tier 2

- 2,003 members; monthly payment $33,450
- Annual payment based on current membership $401,404

Chinle Comprehensive Health Care Facility – Tier 4

- 9,464 members; monthly payment $235,654
- Annual payment based on current membership $2,827,842

Winslow Indian Health Care Center – Tier 3

- 399 members; monthly payment $9,061
- Annual payment based on current membership $108,735

Whiteriver Indian Hospital – Tier 2

- Established 12/1/18

AIMH Web Page & AIMH email

- IHS/638 Facilities can send questions to AIMH@azahcccs.gov
- Review AIMH information at https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/
- State Plan Amendment (SPA) https://www.azahcccs.gov/Resources/StatePlans/StatePlanAmendments.html

Thank You.

Pharmacy Update

OptumRx

AHCCCS Fee-For-Service Pharmacy

- April 1, 2019 OptumRx PBM Changes:
  - PBM Claims Adjudication for Reimbursement of:
    - The All Inclusive Rate; and
    - Specialty Medications.
  - OptumRx will have online eligibility for all Native Americans enrolled in AHCCCS, which includes those enrolled in FFS or an MCO.
    - Native Americans enrolled in FFS KidsCare will continue to adjudicate prescription claims through current PBM process.
    - KidsCare claims will not be adjudicated under the All Inclusive Rate or Specialty Medication plans.

All Inclusive Rate Plan PBM Set-Up

- One pharmacy AIR per day per member per IHS/638 pharmacy.
  - Additional pharmacy claims submitted on the same day after the first claim has been paid at the AIR will pay at zero dollars.
- 5 AIR maximum per day per member per facility remains the same.
- Prescriptions for members eligible for Medicare:
  - Prescriptions medications must be billed to the member's Medicare Part D plan.
  - Prescriptions for Over-the-Counter products may be submitted to OptumRx for AIR reimbursement, with a maximum of one AIR per day per member per IHS/638 pharmacy and the 5 AIR daily maximum applies.
- Other plan parameters will be discussed with the pharmacy workgroup.

All Inclusive Rate Plan PBM Set-Up

- OptumRx will load the AHCCCS Fee-For-Service Drug List for claims adjudication.
- CMS Covered Outpatient Drugs not listed on the AHCCCS FFS Drug List are available through the prior authorization process.
- All Long-acting opioids medications currently require prior authorization which will be in effect on April 1, 2019.
- The Short-acting opioids limits for adults and children will be implemented on June 1, 2019.

All Inclusive Rate Plan PBM Set-Up

- Pharmacies will need OptumRx's BIN and PCN for claims adjudication of the AIR.
  - BIN = 001553
  - PCN = AIRAZM
  - OPTUM RX Help Desk Phone Number;
  - Toll Free: 1 (855) 577-6310

Specialty Medication Plan PBM Set-Up

- Most specialty medications require prior authorization (PA).
- All submitted PAs are reviewed and responded to within 24 hours of receipt of the PA.
- A decision is rendered within the 24 hour timeline unless there is missing information on the PA. A request will be sent to the prescribing clinician for the missing information within 24 hours of receipt of the PA.
- We are working with OptumRx to grandfather members' prescriptions, as they are submitted to OptumRx, up to a specific financial threshold with the exception of long-acting opioids.

Specialty Medication Plan PBM Set-Up

- Pharmacies will need OptumRx's BIN and PCN for claims adjudication of the AIR.
  - BIN = 001553
  - PCN = SPCAZM
  - OPTUM RX Help Desk Phone Number;
  - Toll Free: 1 (855) 577-6310
- OptumRx will have system testing available for both plans at the end of February or early March.

Thank You.

Rendering and Ordering Providers

- **Effective January 01, 2012, Rendering and Ordering providers must be registered with AHCCCS.**
- **Referring/Ordering Provider must have an active enrollment status with AHCCCS on the date of service.**
- **Claims submitted without the Referring/Ordering provider or the provider does not have an active status will result in a denial of the claim.**

Services that Require an Ordering Provider

LABORATORY	RADIOLOGY	ORTHOTICS
MEDICAL and SURGICAL SUPPLIES	PROSTHETICS	ENTERAL & PARENTERAL
DURABLE MEDICAL EQUIPMENT (DME)	VISION CODES (V-CODES)	
DRUGS (J- CODES)	RESPIRATORY	
PHYSICAL / SPEECH / OCCUPATIONAL THERAPY SERVICES (97001 – 97546)		

Who can be a Referring/Ordering Provider?

The provider types listed below are approved as a Referring / Ordering provider.

Medical Doctor MD.	Doctor of Osteopath D.O.
Optometrist	Physician Assistant
Registered Nurse Practitioner	Dentist
Podiatrist	Psychologist
Certified Nurse Midwife	

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Policy & Billing Manual Updates

Covered Behavioral Health Services Guide (CBHSG) Update

Covered Behavioral Health Services Guide (CBHSG) Transition

- In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:
  - AMPM 310-B, Behavioral Health Services Benefit
  - AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit
    - Non-Title XIX/XXI service information will be transferred to AMPM 320-T.

Covered Behavioral Health Services Guide (CBHSG) Transition

- The Provider Billing Manuals
  - Billing information for Fee-For-Service providers will be transferred to the Provider Billing Manuals.
    - Chapter 19, Behavioral Heath Services, of the Fee-For-Service Provider Billing Manual
    - Chapter 12, Behavioral Heath Services, of the IHS/Tribal Provider Billing Manual

Covered Behavioral Health Services Guide (CBHSG) Transition

- Appropriate Policies as necessary.
  - i.e. Service benefit information, including transportation and transportation billing information pertinent to MCOs and FFS providers, will be transferred to AMPM 310-BB.

Billing Manual Updates

Integration – Chapter 2 Eligibility

- On October 1, 2018 AHCCCS integrated physical and behavioral health care for most members. This is referred to as AHCCCS Complete Care (ACC). These members will have all of their providers listed under one network, which will be managed and paid for by their single health care plan. The following members will see no change:
  - ALTCS members (EPD and DES/DD);
  - Foster care children receiving services through the Comprehensive Medical Dental Program (CMDP); and
  - Adults with a Serious Mental Illness (SMI) designation.

Integration – Chapter 2 Eligibility

- AHCCCS Complete Care (ACC) members, who maintain eligibility, may change plans once a year during their enrollment anniversary month. The enrollment anniversary is the month in which a member was first enrolled with an AHCCCS contractor.
- American Indian/Alsakan Native (AI/AN) members may choose to switch their enrollment between an AHCCCS Complete Care (ACC) health plan or the American Indian Health Program (AIHP) at any time. However, they may only change between different ACC plans once per year during annual enrollment.

Chapter 3 Provider Registration - PPA

- To become an AHCCCS provider, a provider must sign the Provider Participation Agreement (PPA).
- Per the PPA providers must follow all AHCCCS guidelines, policies and manuals, including but not limited to the following:
  - The AHCCCS Medical Policy Manual (AMPM),
  - The AHCCCS Fee-For-Service or IHS/Tribal Provider Billing Manual,
  - AHCCCS Claims Clues, and
  - Reporting Guides.
- These guidelines, policies and manuals are available on the AHCCCS website.

Chapter 10 Pharmacy - Billing

- Prescription medications may be reimbursed by the AHCCCS Administration or the Fee-For-Service (FFS) Pharmacy Benefit Manager (PBM), OptumRx, depending upon the member's enrollment and filling pharmacy, which are detailed in the next slide.

Chapter 10 Pharmacy - Billing

Program/Member Type	Enrollment in AIHP, AHCCCS Complete Care (ACC), Kidscare or TRBHA	Pharmacy Dispensing Medication	Claims Shall Be Submitted To
Title XIX Members	AIHP, ACC and TRBHA	IHS/638 Pharmacies	AHCCCS Administration
Title XIX & XXI Members	AIHP and TRBHA	Non-IHS/638 PBM Network Pharmacies	FFS PBM - OptumRx
Title XIX & XXI Members	ACC	Non-IHS/638 PBM Network Pharmacies	The ACC Plan's PBM
Title XIX Members	Kidscare members enrolled in AIHP & TRBHA	All IHS/638 and non-IHS/638 PBM Network Pharmacies	FFS PBM - OptumRx

Chapter 10 Pharmacy – Billing

- In a case where more than one prescription is prescribed and filled on the same day, at the same facility, for the same member, the NDC codes for all of the filled prescriptions must be included on that day's claim submission for the AIR, however, only one AIR shall be reimbursed.

Chapter 10 Pharmacy - Billing

- The AIR may be billed for adults 19 years of age and older, when a prescription is filled at an IHS/638 facility pharmacy. The AIR for prescription services may be billed once daily, per member, per facility pharmacy. Up to five AIRs may be billed daily, per member, per facility and they must be qualifying non-duplicative visits.

Chapter 10 Pharmacy - Billing

- Example: A member is seen at an IHS 638 facility and has a dental visit, a PCP visit, and is prescribed 1 medication during the dental visit for pain and 2 medications during the PCP visit. All visits occur at the same IHS 638 facility. The member has all 3 prescriptions filled on the same day.
- In this scenario three AIRs may be billed for reimbursement. One AIR may be billed for each of the following:
  - The dental visit;
  - The PCP visit; and
  - All 3 prescriptions.
- The claim submitted for the three prescriptions must include all 3 NDC codes.

Chapter 10 Pharmacy - Billing

- **IHS/638 pharmacies** dispensing and billing prescription claims at the All Inclusive Rate (AIR) for Title XIX members shall submit prescription claims to the AHCCCS Administration on the UB-04 claim form (or 837I for electronic claims) or shall submit via the AHCCCS website. The claim form shall:
  - Use revenue code 519 (Other Clinic).
  - Enter the outpatient All Inclusive Rate (AIR) on the first service line of the claim (0519).
  - Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).
  - Include the AIR in the Total Charges field (Field 47), on the 0001 line.

Chapter 10 Pharmacy - Billing

- **IHS/638 pharmacies** dispensing and billing prescription claims at the All Inclusive Rate (AIR) for Title XIX members shall submit prescription claims to the AHCCCS Administration on the UB-04 claim form (or 837I for electronic claims) or shall submit via the AHCCCS website. The claim form shall:
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  - Enter the outpatient All Inclusive Rate (AIR) on the first service line of the claim (0519).
  - Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).
  - Include the AIR in the Total Charges field (Field 47), on the 0001 line.

Chapter 10 Pharmacy – Pharmacist Administered Vaccines/Emergency Medications

- AHCCCS covers vaccines and emergency medication for adults without a prescription order when administered by a pharmacist, who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law A.R.S §32-1974.
- IHS and 638 Pharmacies may bill the outpatient AIR one time which includes the vaccine and the administration of the vaccine.
- For purposes of this section "Emergency Medication" means emergency epinephrine and diphenhydramine. "Vaccines" are limited to AHCCCS covered vaccines for adults as noted in the AHCCCS Medical Policy Manual (AMPM) Policy 310-M, Immunizations.

Chapter 10 Pharmacy – Pharmacist Administered Vaccines/Emergency Medications

- In addition to the requirements specified in A.R.S. § 32-1974, AHCCCS requires the following:
  1. The pharmacy providing the vaccine must be an AHCCCS registered provider;
  2. IHS and 638 Pharmacies must be registered with AHCCCS; and
  3. The AHCCCS member receiving the vaccine must be age 19 years or older.

Chapter 11 Transportation – Response No Transport

- A Fee-For-Service ground ambulance provider, who responds to an emergency call and provides medically necessary treatment at the scene, but does not transport the member, is eligible for reimbursement. This service is billed with HCPCS code A0998 (Response No Transport), and reimbursement can vary based on a provider's designation.
- **Note: IHS/638 transportation providers are not regulated by the Department of Health Services (ADHS) and do not operate under an ADHS-granted Certificate of Necessity (CON).**

Chapter 11 Transportation – CON Providers

- For ground ambulance providers operating under an ADHS Certificate of Necessity (CON):
  - For providers operating under a CON, ADHS does not set a rate specifically for A0998 Ambulance Response No Transport. The rate that applies for the CON provider is their ADHS-established ALS or BLS base rate.
  - Where ADHS has established a base rate for the CON provider that does not include supplies, the provider may bill the supplies separately and be reimbursed separately for them; this is true for any ambulance trip whether or not a transport resulted.

Chapter 11 Transportation – CON Providers

- Therefore, for some CON providers, A0998 includes reimbursement for supplies and they are not permitted to bill supplies separately; for other CON providers A0998 does not include supplies and they may bill and be reimbursed separately for the supplies. This is determined by ADHS, not AHCCCS.

Chapter 11 Transportation – Non-CON Providers

- For non-CON ambulance providers:
  - Distinct from the above, AHCCCS has established a FFS rate for A0998 for non-CON ambulance providers, and that rate is deemed to include reimbursement for any supplies used during the service. The provider may not bill supplies separately.

Chapter 11 Transportation – Dx Codes

- If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:
  - For physical health use ICD-10 code R68.89, or
  - For behavioral health use ICD-10 F99
- This holds true for emergency transportation, air ambulance, and NEMT.

Chapter 14 Home Health Services – Face-to-Face Requirements

- Effective date of service 10/1/17, in accordance with CFR § 440.70, the initiation of Home Health Services will be subject to face-to-face encounter requirements for the FFS population. It must be performed by one of the following:
  - The ordering physician,
  - A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the physician in accordance with state law,
  - A physician assistant under the supervision of the ordering physician, or
  - For member's admitted to home health immediately after an acute or post acute stay, the attending acute or post acute physician.

Chapter 14 Home Health Services – Face-to-Face Requirements

- A non-physician practitioner who performs the face-to-face encounter must communicate the findings of the face-to-face encounter to the ordering physician.
- The face-to-face encounter may occur through telehealth.
- Face-to-face encounter requirements apply to the initiation of services only.
- Face-to-face encounter requirements do apply to rehabilitative therapies in the home.
- Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice.

Chapter 16 – Claims Processing - CRN

- A *Claim Reference Number (CRN)* is assigned to all claims when they are initially submitted to AHCCCS. The first five characters of the CRN represent the Julian date that the claim was initially received on by AHCCCS. The remaining numbers make up the claim document number that is assigned by AHCCCS.

Chapter 16 – Claims Processing - CRN

- When submitting documentation (e.g., Medicare EOB) following the initial submission of a claim, the CRN assigned when the claim was first submitted should be provided. This is required so that AHCCCS is able to link the documentation to the claim.
- Providers also must provide the initial CRN when replacing (resubmitting/adjusting) or voiding a claim.

Chapter 16 – Claims Processing - CRN

- For IHS facilities and providers, if your claim is replaced without the CRN, the claim will be treated as a first-time submission and may not pass the 12-month initial claim filing deadline or the 12-month clean claim filing deadline.
- If the initial CRN is not provided, the claim also may be incorrectly identified as a duplicate of an existing claim and denied.

Chapter 16 – Claims Processing Cycle

- Extensive revisions were done to the Claims Processing chapter. There have been no process changes, however clarifications were added.
- So what is the editing process?
  - It is when the claims system reviews submitted claims. The system then attempts to apply all our business rules to the claims (in what are called edits). It attempts to apply all edits during a single processing cycle.

Chapter 16 – Claims Processing Cycle

- The editing process begins when the system checks the claim form to ensure that all required fields have been filled in and that no completed fields are filled out incorrectly. Incorrectly filled out fields include, but are not limited to, the following:
  - The use of letters instead of numbers when numbers are required (and vice versa); and/or
  - Not entering a valid 9-digit AHCCCS ID, beginning with an A; and/or
  - Not including the entire required data set, such as when a provider uses 6 digits for an NPI instead of 10; and/or
  - Invalid diagnosis code.

Chapter 16 – Claims Processing Cycle

- When claims are processed in the system they are run through the editor, where the business rules are applied. The system will try to run through all the business rules and list all denial edits.
- However, if a crucial edit is encountered (such as a **required** field being found blank) the editing process for the rest of the claim will be **stopped**.
- The review of the claim does not proceed past the field that failed the editing process, and only the crucial edit that failed will be listed on the remit.
- This includes, but is not limited to, missing, incorrect or invalid data.

Chapter 16 – Claims Processing Cycle

- This means that if there are other fields that are blank, filled out incorrectly, or invalid appearing after the field that failed the initial editing process, these will not be caught by the system until after the provider makes the initial field correction and sends the **replacement** claim back in for review.
- Once the edit has been corrected and resubmitted by the provider the editing process may continue. Once the claim begins to reprocess, the claims processing cycle may encounter other critical edits. This may cause the claim to deny for a second time, and another remit may be sent out.

Chapter 19 – Claim Disputes

- Providers registered with AHCCCS Online also may submit a claim dispute via the AHCCCS Online Provider Portal as of August 16th, 2018. There are no changes to the claim dispute requirements when submitting online.
- A claim dispute should otherwise be submitted in writing. It should be mailed to:

  AHCCCS Office of Administrative Legal Services
  Mail Drop 6200
  P.O. Box 25520
  Phoenix, AZ 85002

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Chapter 19 – Claim Disputes

- The claim dispute also may be hand delivered to:
  - AHCCCS Office of Administrative Legal Services701 E. Jefferson Street, 3rd Floor Phoenix, AZ 85034
- Providers also may submit a claim dispute via fax at (602) 253-9115.

UB-04 Claim Form Submission Updates

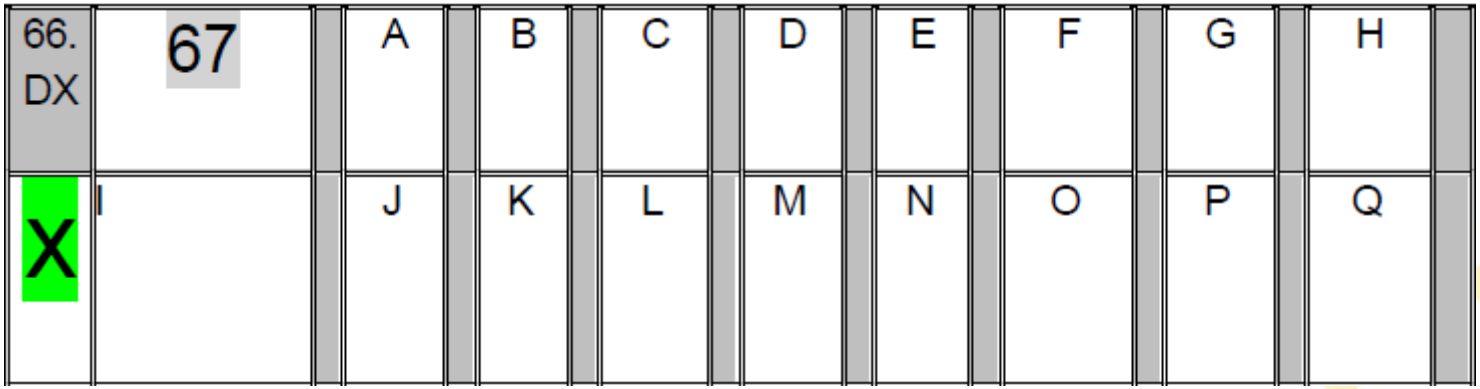
UB-04 Claim Form

- The **UB-04 claim form** is used to bill for:
  - IHS/638 Facility Inpatient and Outpatient Claims for Title XIX (Medicaid) for reimbursement at the AIR,
  - *Inpatient* Title XXI (KidsCare) members,
  - Nursing facility services,
  - Free-standing birthing centers,
  - Hospice services,
  - Residential treatment center services, and
  - Dialysis facility services.

UB-04 Claim Form

- Field 66 Reminders
  - The DX (Diagnosis and Procedure Code Qualifier) field is required.
  - Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
  - 0 = ICD-10-CM
  - 9 = ICD-9-CM (no longer accepted)

UB-04 Claim Form



66. DX	67	A	B	C	D	E	F	G	H
X	I	J	K	L	M	N	O	P	Q

UB-04 Claim Form

- Revenue Code Field – Field 42 is a required field.
- Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

UB-04 Claim Form

Example 1 (Billing for Clinic Visit):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0510		
2			
3			
4			

UB-04 Claim Form

Example 2 (Billing for Dental):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0512		
2			
3			
4			

UB-04 Claim Form

Example 3 (Billing for Urgent Clinic):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0516		
2			
3			
4			

UB-04 Claim Form

Example 4 (Billing for Pharmacy):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0519		
2			
3			
4			

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UB-04 Claim Form

- Please note that as of 7/1/2016, NDC information is required for outpatient pharmacy claims.
- To bill, enter the description of the revenue code billed in Field 42.

UB-04 Claim Form

- For outpatient pharmacy clinic claims report the NDC on the UB04 claim form, entering the following information into the Form Locator 43 (Revenue Code) field.
- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens or spaces.
- The NDC Unit of Measurement Qualifier*
  - UN = Unit
  - ML = Milliliters
  - GR = Gram
  - F2 = International Unit

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UB-04 Claim Form

- The NDC Unit Quantity is the amount of medication administered.
- **If** it includes a decimal point, a decimal point **must** be used and a blank space cannot be left in place of the decimal point. There is a **limit** of 3 characters to the right of the decimal point. (i.e. 1234.456). Any unused spaces are left blank.
- **IMPORTANT NOTE:** If the NDC Unit Quantity has a space in it, it can result in errors.

UB-04 Claim Form

- Examples of NDC Reporting
- **Example 1 (Incorrect Example):** A provider is attempting to bill for 20 milliliters, and enters the following on their claim:

N412345678901ML20 500

This would be read as **20500**.000 and not as **20.5**00

To correct the above example, the provider would enter:
N412345678901ML20.500

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UB-04 Claim Form

- Examples of NDC Reporting
- **Example 2 (Incorrect Example):** A provider is attempting to bill for 1 unit, and enters the following on their claim.

N412345678901ML1 000

This would be read as **1000**.000 and not as **1**.000

To correct the above example, the provider would enter:
N412345678901ML1.000 *or* **N412345678901ML1**

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UB-04 Claim Form

- Field 14 – Type (Priority of Admission/Visit) is a required field.
- Enter the code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.
  - 1 for Emergency
  - 2 for Urgent
  - 3 for Elective
  - 4 for Newborn
  - 5 for Trauma

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CC YY	08	1	

CMS 1500 Claim Form Submission Updates

CMS 1500 Claim Form Updates

- The **CMS 1500 claim form** is used to bill for:
  - IHS/638 tribal claims for individual provider services,
  - Emergency and non-emergency transportation services,
  - FQHC services,
  - Ambulatory surgical centers,
  - Independent laboratories,
  - Durable medical equipment, and
  - KidsCare *outpatient* services.

CMS 1500 Claim Form Updates

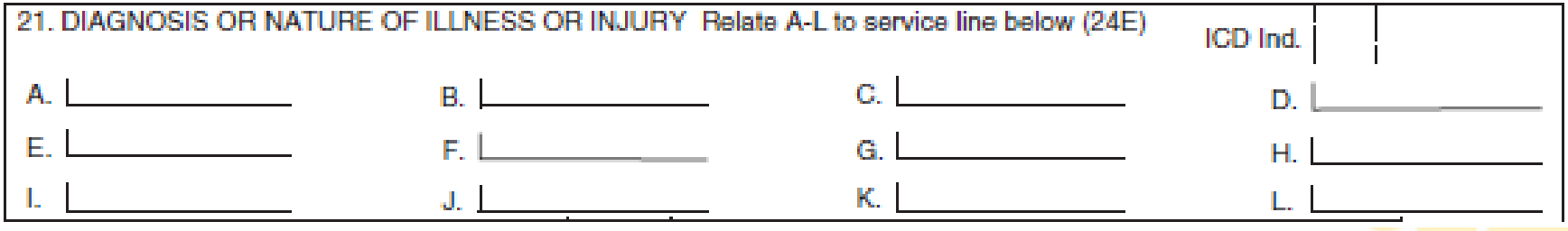
- CPT and HCPCS procedure codes must be used to identify all services.
- ICD-10 diagnosis codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied

CMS 1500 Claim Form Updates

- Field 21 Reminders – Diagnosis Codes
- Enter the applicable ICD indicator to identify which version of ICD codes is being reported.
  - 0 = ICD-10-CM
  - 9 = ICD-9-CM (no longer accepted)
- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

CMS 1500 Claim Form Updates

- Enter the ICD indicator between the vertical, dotted lines in the upper-right hand area of the field.
- Field A is the Principal Diagnosis.
- Relate diagnosis lines A – L to the lines of service in 24E by the letter.



CMS 1500 Claim Form Updates

- Fields 24I, 24J, 33a, and 33b – Clarifications
- Previously the shaded section of Field 24J was used to report Medicare and/or other insurance information.
- This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer's EOB to the claim. Please report the Rendering Provider's Taxonomy Code, if applicable, in this field.

CMS 1500 Claim Form Updates

- 24I
- Enter in the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. ZZ should be entered to indicate a Taxonomy Code.

DIAGNOSIS POINTER	$ CHARGES	OR UNITS	Family Plan	ID QUAL	RENDERING PROVIDER ID #
				ZZ	Taxonomy Code
					NPI Rendering Provider NPI ID #

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CMS 1500 Claim Form Updates

- 24J – Rendering Provider ID # - Required if Applicable
- (Shaded Area) Use for Taxonomy Code Reporting
- Use this SHADED field to report the provider's 10 digit alpha-numeric Taxonomy Number.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
					NPI Rendering Provider NPI ID #

AHCCCS
Arizona Health Care Cost Containment System

CMS 1500 Claim Form Updates

- 24J – Rendering Provider ID # - Required if Applicable
- (Non-Shaded Area) Rendering Provider ID #
- The Rendering Provider's 10 digit NPI is required for all providers that are mandated to maintain an NPI #.
- For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.

CMS 1500 Claim Form Updates

- 24J – Rendering Provider ID # - Required if Applicable
- (Non-Shaded Area) Rendering Provider ID #

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
				NPI	0000000000

CMS 1500 Claim Form Updates

- 33a – Billing Provider NPI # - Required if Applicable
- 33b – Other ID – AHCCCS ID # (Shaded Area) Required if Applicable

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
				NPI	0000000000

AHCCCS
Arizona Health Care Cost Containment System

Special Billing Topics

Global OB Billing for IHS/638 Facilities

- **Q: How do IHS/638 facilities bill for labor and delivery services?**
- A: The hospital bills the inpatient All Inclusive Rate (AIR), on a UB-04 claim form, for all inpatient services. The AHCCCS global obstetrical (OB) codes are billed on a CMS 1500 claim form.

Global OB Billing for IHS/638 Facilities

- **Q: How do IHS/638 facilities bill for labor and delivery services?**
- A: The hospital bills the inpatient All Inclusive Rate (AIR), on a UB-04 claim form, for all inpatient services. The AHCCCS global obstetrical (OB) codes are billed on a CMS 1500 claim form.
  - Evaluation and management (E/M) codes for office and/ or hospital/clinic visits may not be unbundled from the global OB code and billed separately. Claims for these services will be denied when billed in addition to the global code.

Global OB Billing for IHS/638 Facilities

- **Q: If a patient comes in and has a UTI, back pain, or other injuries not related to pregnancy, can the service be billed to AHCCCS?**
- Examples:

  If a patient comes in for an OB visit and also complains about a sore throat, the OB/G provider may examine and treat the sore throat during the OB visit. This is NOT billable as an AIR clinic visit.

Global OB Billing for IHS/638 Facilities

- If the OB/G prescribes a medication for the sore throat, AND/OR for the pregnancy, and the patient picks up the medication at the pharmacy on the same day, then this pharmacy encounter is billable as one (1) AIR.
- However, if the patient comes in for an OB visit, then goes to the walk-in clinic and is seen by another provider who examines and treats for the sore throat, then this clinic visit is billable as an AIR clinic visit.
- If the patient then goes to the pharmacy window and picks up medications prescribed by both the OB/G and walk-in clinic, then this pharmacy encounter visit is billable as one (1) AIR.

Global OB Billing for IHS/638 Facilities

- **Q: How should a provider bill the Global OB when delivery occurs at a different facility?**
- In this scenario the following apply:
  - A member is seen by a physician for all their antepartum and postpartum visits at the physician's office/clinic;
  - Due to complications or a lack of resources in the member's area of residence, delivery occurs at a separate hospital that the physician is not affiliated with; and
  - The same physician performed both the delivery and all antepartum and postpartum visits.

Global OB Billing for IHS/638 Facilities

- In this scenario (when delivery occurs at a different facility), the hospital where the delivery was performed at will need listed on the claim as POS 22, with the address and NPI of that facility.
  - This must be done since the facility will also be billing with their address, and if the addresses, date of service, and place of service do not match on the facility claim and professional claim, then unnecessary denials can occur. The other address on the professional claim would then be the office/clinic address.

Global OB Billing for IHS/638 Facilities

- Please note: In a scenario where delivery occurs at a different facility, AHCCCS would highly encourage the physician's office to contact the hospital's credentialing department where the delivery took place, to obtain temporary privileges during the time span the delivery occurred in. Doing so can prevent unnecessary denials for submitted claims.

Crisis Services

- A crisis is any situation in which a person's behaviors put them at risk of hurting themselves and/or others, and/or when they are not able to resolve the situation with the skills and resources available to them. Persons in a crisis present with sudden, unanticipated, or potentially dangerous behavioral health conditions, episodes or behaviors.

Crisis Services

- **There has been no change for crisis services or for crisis service billing for American Indian/Alaskan Native (AI/AN) members located on tribal lands.**
- Note: Integration began on 10/1/2018, and there was no change in crisis services for Title XIX and XXI members. RBHAs will continue to serve the same geographic service areas that they served prior to 10/1/2018.

Policy Reminders

Emergency Dental Services

- AHCCCS covers emergency dental services for adult members (21 years of age and older).
- This dental benefit applies to all Fee-For-Service members who are 21 years of age and older, and our ALTCS and Tribal ALTCS members who are 21 years of age and older.
- Emergency dental has the following requirements:
  - The benefit must be for emergency dental services only;
  - The benefit does not cover comprehensive dental services (such as cleanings); and
  - The annual benefit amount is not to exceed $1,000 per member, per contract year (October 1st to September 30th).

Emergency Dental Services

- Any unused benefits for Fee-For-Service members, 21 years of age and older, will not be permitted to "carry-over" into the next contract year.
- For instance, if a member used $400 of their $1,000 limit for emergency dental services, they would not have $600 carry over into the next year. On October 1st of the following contract year, the member would have a $1,000 benefit, and not a $1,600 benefit.
- It is the responsibility of the provider to check with the member, to determine the amount of dental benefit already used within each contract year.

Emergency Dental Services

- EPSDT and KidsCare members under the age of 21 receive dental services separate from this emergency dental benefit. For additional information please see AMPM 431, Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment Aged Members.

Thank you!