





IHS/638 Second Quarter Billing Forum 2022

May 11, 2022

2:00 p.m. – 3:30 p.m.

AHCCCS
Arizona Health Care Cost Containment System

IHS 638 Quarterly Billing Forum Agenda

- Upcoming Tribal Consultation Meetings
- CY 2022 AIR Rates and Recycle
- American Indian Medical Homes (AIMH)
- Participating Provider Requirements
- DD-Tribal Health Program
- Telehealth Modifier FQ (Audio Only)
- IHS/638 KidsCare Billing Reminders
- Medicare and Secondary Payer Claims
- Tribal Self-Funded Insurance Plans



Upcoming Tribal Consultation Meetings

Upcoming Tribal Consultation Meetings

All meeting materials for AHCCCS Tribal Consultation meetings, including relevant slide decks and meeting recordings and/or summaries, are available on the Tribal Consultation Meeting Materials webpage. Please check this website regularly for updated meeting materials.

May 12, 2022 1:00 PM (MST) Registration Link

August 11, 2022 1:00 PM (MST) Registration Link: TBA

November 03, 2022 1:00 PM (MST) Registration Link: TBA




CY 2022 All Inclusive Rates

CY 2022 All Inclusive Rates

- Reminder: The Federal Register published the **2022** All Inclusive Rates (AIR) on April 8, 2022. The 2022 rates are effective beginning with date of service **January 1, 2022**.
- The AHCCCS claims recycle project was completed the week of 5/2/2022. For additional payment information, providers may review their remittance or 835 payment notices.

- CY 2022 Inpatient AIR is $4,239.00
- CY 2022 Outpatient AIR is $640.00




American Indian Medical Home (AIMH)

What is an American Indian Medical Home

American Indian Medical Homes help address health disparities that exist between American Indians and other populations in Arizona by offering services and supports which improve access to critically needed care. Learn more about DFSM's efforts on the AIMH web page.

What is an American Indian Medical Home

The American Indian Medical Home (AIMH) is a care management model that puts AHCCCS American Indian Health Program (AIHP) members at the forefront of care.

AIMHs help address health disparities between American Indians and Alaskan Natives in Arizona by enhancing case management and care coordination through the use of Primary Care Case Managers (PCCM) and 24 hour access to the care team.

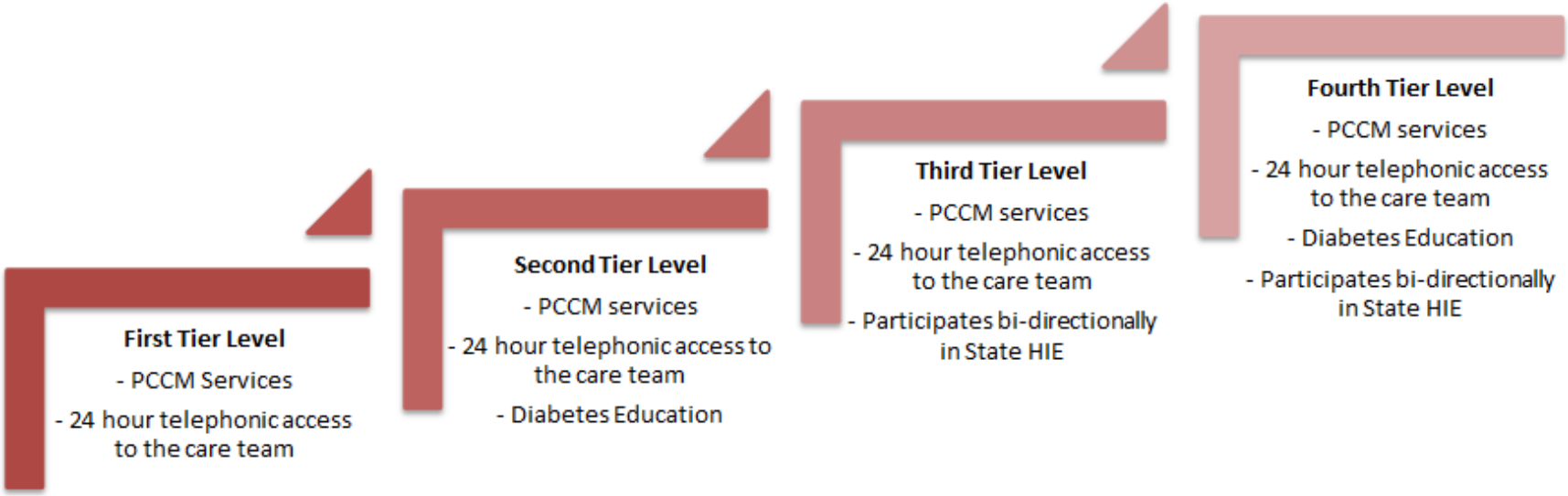
AIHM Medical Provider Types

Provider Type	Description
02	Hospital
05	Clinic (excluding Dental Providers)
29	Community / Rural Health Center
C2	Federally Qualified Health Clinic (FQHC)
C5	638 Federally Qualified Health Clinic (FQHC)
IC	Integrated Clinic

AIHM Provider Requirements

- Be an IHS or Tribal 638 facility
- Enter into an AIMH Intergovernmental Agreement (IGA)
- Primary Care Medical Home (PCMH) accreditation
- Provide 24-hour telephonic access to the care team
- Dependent on selected Tier Level
  - Provide diabetes education
  - Participate bi-directionally in the State Health Information Exchange (HIE)

American Indian Medical Homes Tier Levels



AIMH Reimbursement Rates 2022

AIMH 4.6% rate increase calculation – 10 year forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Level 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
Level 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
Level 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
Level 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

Active American Indian Medical Homes

Tier 1

Parker (280)

Fort Yuma Indian Med. Ctr. (11)

Tier 2

Phoenix Indian Med. Ctr. (5,630)

White River Indian Hospital (6,462)

Tier 4

Tuba City Regional Health	(2,726)
San Carlos Apache Healthcare	(4,520)
Winslow Indian Medical Center	(3,841)
Chinle Comprehensive Healthcare	(13,845)

AIMH Resources and General Information

IHS/638 Providers 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




Participating Provider Information

Participating Provider Information

- As of October 1, 2022, participating provider reporting requirements will apply to the following AHCCCS provider types:
  - 05 – Clinic
  - 77 - Outpatient Behavioral Health Clinic
  - IC – Integrated Clinic
- Participating Provider- The individual provider(s) who provided the service(s) on behalf of the member and is legally authorized to do so by the State in which they deliver the service(s), as specified in 42 CFR 457.10 and 42 CFR 438.2.
- A full list of AHCCCS provider types are available online:
  - AHCCCS Provider Types

Participating Provider Information

- In order to retain information related to the actual professional practitioner (provider) participating in/performing services associated with clinic visits reported with the IC, 77 or 05 provider type as the service/rendering provider, that professional practitioner (provider) participating in/performing services must also be reported on all claims.

Participating Provider Information Cont.

- The participating provider is only needed if the clinic is listed as both the servicing and billing provider on the claim.
- Participating provider reporting requirements do not apply to claims submitted on the UB-04 claim form.
- Billers will continue to report the servicing/rendering provider NPI information in fields 24J on the CMS 1500 and field 35 on the ADA dental claim forms as required by AHCCCS Medicaid claim submission billing guidelines.
  - For additional guidance- Exhibit 10-1

Participating Provider Information Cont.

- The DFSM training team will be offering training sessions beginning in May.
- Trainings cover billing guidance including:
  - Participating provider qualifier codes.
  - Claim fields to report participating provider claim information.
    - CMS 1500, ADA, 837P and 837D
  - How to report participating provider claim information via the AHCCCS Online Provider Portal.
  - How to report more than one participating provider.
  - How to report a provider who does not have an NPI.

Participating Provider Information Cont.

- For additional questions, please contact the DFSM Provider Training Team: providertrainingffs@azahcccs.gov
- To sign up and receive communication alerts via email please visit the FFS Training page:
  - https://www.azahcccs.gov/Resources/Training/DFSM_Training.html
    - DFSM Email Alerts




DD-Tribal Health Program (THP)

DFSM/DDD THP Interagency Subcontract

- Effective April 1, 2022 AHCCCS' Division of Fee-for-Service Management (DFSM) will manage acute physical and behavioral health service authorizations for enrolled DDD THP members via an inter-agency subcontract with the DDD THP.
- The DDD will retain full responsibility for:
- Care coordination,
- Case management functions for all DDD THP members, and
- Authorization of LTSS.
- The DFSM/DDD THP subcontract will improve THP member access to care.

American Indian/Alaska Native Options

AI/AN members who are eligible for both DDD and ALTCS have options for how they want to receive health care services:

Option	Physical Health Services	Behavioral Health Services	Children's Rehabilitative Services	Long Term Services and Supports	Support Coordination
1	DDD Health Plan	DDD Health Plan	DDD Health Plan	DDD ALTCS	DDD
2	DDD Health Plan	Tribal Regional Behavioral Health Authority (TRBHA)*	DDD Health Plan	DDD ALTCS	DDD
3	Tribal Health Program	Tribal Regional Behavioral Health Authority (TRBHA)*	Tribal Health Program	DDD ALTCS	DDD
4	Tribal Health Program	Tribal Health Program	Tribal Health Program	DDD ALTCS	DDD

How Will This Change Impact DDD THP Members?

- Members will continue to be eligible for all the same services and benefits.
- Members will continue to use the existing network of fee-for-service providers.
- Members should see improved access to care.

What is NOT Changing?

- DDD is currently responsible for the assessment and oversight of Long-Term Services and Supports through its Qualified Vendor Network. This will continue after April 1, 2022.
- DDD will continue providing Support Coordination (Case Management) for all DDD enrolled members.

Where Can I Find Information If I Have Questions?

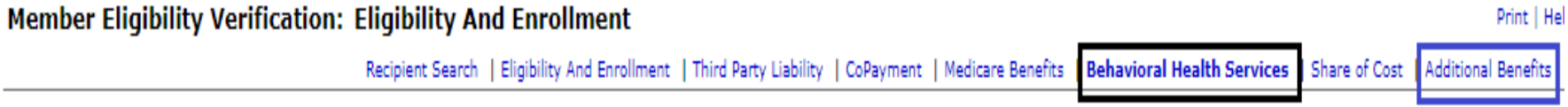
- DDD has published a website with information about this transition, https://bit.ly/ddd-ffs.
- Fee-for-Service providers are encouraged to sign-up to receive updates and information from the AHCCCS DFSM using this link, https://bit.ly/ahcccsdfsm.




How to Verify Member Eligibility and Enrollment in the DDD-THP Program

How to Verify Behavioral Health Services Enrollment

Click on the behavioral health services tab to view the BHS site information.



If Site 62 DDD-SUB is listed, click on the "Additional Benefits" tab

Behavioral Health Services

BHS Category	Begin Date	End Date	BHS Site	BHS Service Type
G GENERAL MENTAL HEALTH SERVICES	08/13/2021		62 DDD - SUB	CH MENTAL HEALTH FACILITY - OUTPATIENT

How to Verify Behavioral Health Services Enrollment

- AI SUB – DDD Tribal Health Program is present – Physical and Behavioral claims must be submitted to AHCCCS FFS for processing.

DDD Subcontractor Plan		
DDD Plan	Begin Date	End Date
AI SUB - DDD TRIBAL HEALTH PROGRAM	04/01/2022	

Training resources:

- https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2020/FALL2020_MemberEligibilityAndVerification.pdf




New Telehealth Modifier FQ (Audio Only)

Telehealth Billing Update
New Modifier to Report Audio Only (FQ) (cont.)

- Effective for dates of services beginning 01/01/2022, modifier FQ was added to identify a telehealth service was furnished using *real-time audio-only communication technology*.
- Audio only would include services conducted via telephone or secure video teleconferencing platform or the member did not consent to video and the (*video was turned off*).
- The place of service (pos) will continue to be reported as the "originating site" where the *member is physically located* at the time of the service.
- The place of service (POS) 02 and modifier "UD" (temporary code set) have been closed effective 12/31/2021.

Telehealth Update Billing
New Modifier to Report Audio Only (FQ)

- The 2022 Telehealth updates are posted on the Medical Coding Resources webpage and can be accessed at the link provided. Please make sure you review these updates when they are published. The columns will identify whether GT, GQ or FQ modifier is allowed.
- The POS or “originating site” is where the member is physically located at the time of service.
- For additional information regarding place of service codes and modifiers, refer to the Telehealth Code set resources webpage.
- https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

Reporting Telehealth Services
Medicare Claims

- The Centers for Medicare & Medicaid Services (CMS) has issued changes to POS codes for use when reporting telehealth services.
- Claims that are submitted directly to Medicare for processing, providers should follow Medicare billing guidelines.
  - POS code 02 description *changed* to “telehealth provided other than in patient’s home.”
  - POS code 10 *added* with description “telehealth provided in patient’s home.
- Medicare approved claims are automatically crossover to AHCCCS for consideration of the cost sharing amounts only.




Billing Dental Services

Billing Dental Services
Fee-For-Service or All-Inclusive Rate

- The AIR or OMB rate can be billed for dental services performed in the outpatient dental clinic.
- Professional services performed by a Dentist, Oral Surgeon or Affiliated Dental Hygienist must be billed on the ADA Dental claim form.




KidsCare Billing Reminders: Billing Dental Services

KidsCare Billing Reminders Dental Services

- Outpatient dental services for Title XXI (KidsCare) members are billed by the individual practitioner dentist on the ADA 2012 claim form with CDT-4 codes.
- Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Billing Reminders
Title XXI KidsCare

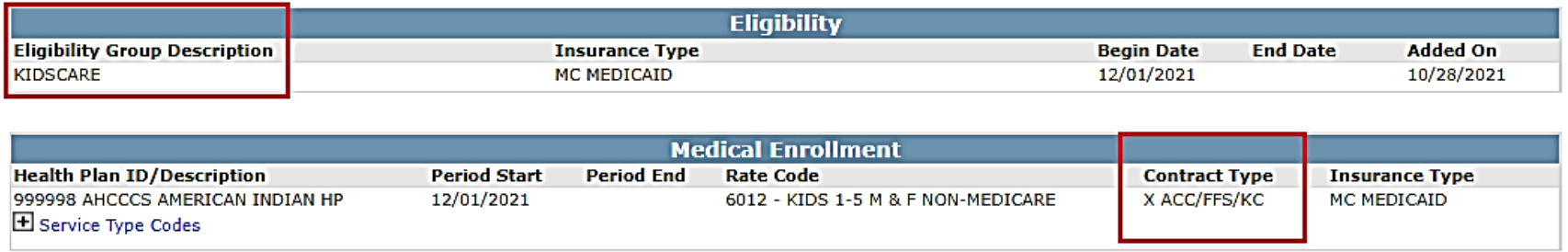
- KidsCare members that are enrolled in an ACC plan, IHS/638 providers must submit the claim to the ACC plan.
- KidsCare members that are enrolled in Fee-for-Service or AIHP, the claims are submitted to AHCCCS.

Billing example: A claim is submitted for a KidsCare member and is billed on the UB-04 claim form:

- The claim will deny with the remark code “AD102” - “IHS/638 KidsCare must bill on the CMS 1500, Dental (ADA) or Point of Sale for (pharmacy service) to AHCCCS”.

How to Verify KidsCare Eligibility

Providers can verify eligibility and enrollment for any member enrolled with AHCCCS Medicaid using the AHCCCS Online Provider Portal. On the member verification screen, under the heading Eligibility Group Description this field will show KidsCare and the Contract Type field will show FFS/KC (KidsCare) enrolled member.



Eligibility

Eligibility Group Description	Insurance Type	Begin Date	End Date	Added On
KIDSCARE	MC MEDICAID	12/01/2021		10/28/2021

Medical Enrollment

Health Plan ID/Description	Period Start	Period End	Rate Code	Contract Type	Insurance Type
999998 AHCCCS AMERICAN INDIAN HP	12/01/2021		6012 - KIDS 1-5 M & F NON-MEDICARE	X ACC/FFS/KC	MC MEDICAID
⊞ Service Type Codes					




IHS/638 Billing
Medicare and Secondary Payer Claims

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Adjusting Medicare Previously Paid Claims

- Medicare will automatically crossover approved claims to AHCCCS.
- Medicare does not transmit denied or adjusted Medicare claims.
- If Medicare adjusts a previously paid claim and there are no changes to the claim data, i.e., billed charges, dates of services or coding and the only correction by Medicare is either the paid amount, deductible or coinsurance amount due, a replacement claim is not required.
- Billers can easily adjust the prior payment by submitting a copy of the adjusted MEOB to AHCCCS via the Transaction Insight Portal and reference the 12-digit AHCCCS claim number.
- Timely filing rules will apply.

Adjusting Medicare Previously Paid Claims (cont.)

- Example #2, if there is a change with the total charges, coding, units, dates of services, etc., then a replacement or correction claim is required, providers must include a copy of the adjusted MEOB for processing.

Responsibility to Appeal

Appealing the Primary Payer is the Provider's Responsibility

If the first-or third-party payer (such as a health plan) denies a claim for a covered service, then the provider must follow that health plan's appeal process.

The provider **must** exhaust all remedies before the claim can be submitted to AHCCCS, and before AHCCCS can consider the covered service.

Once all other payer sources have been utilized, then the provider **must** submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission. If this is not done, then the claim submitted to AHCCCS may deny.




Medicare Inpatient Claims
Members with Part B Benefits Only

Inpatient Facility Claims – Members with Medicare Part B Coverage Only

- The facility will submit all Part B charges to Medicare.
- Medicare will process the Part B claim and transmit the claim to AHCCCS. The crossover claim will show only the Medicare Part B charges and coinsurance amount that is due for the Part B charges.
- In this example an adjustment claim is required for processing. The biller must submit a claim for the total charges for the full stay, reference the claim number of the paid Part B claim and include a copy of the Medicare Part B Explanation of Benefits for review.
- The facility NPI number on the replacement/correction claim must match the NPI on the MEOB.
- Correction claims can be submitted via the AHCCCS Online Provider Portal.


Tribal Self-Funded Plans
AHCCCS As The Primary Payer

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Payer of Last Resort

AHCCCS is considered the “Payer of Last Resort” (per A.A.C. R9-22-1003), unless specifically prohibited by federal or state law. AHCCCS shall be used as a source of payment for covered services ***only after all other sources of payment for covered services have been exhausted per A.R.S. 36-2946.***

- NOTE: This means that AHCCCS has liability for payment of benefits ***after*** other first and third-party payer benefits have paid on the claim.

Providers must determine the extent of the first and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

IMPORTANT: The claims submitted to AHCCCS **must** exactly match the original claims submitted to the primary payer source.

Payer of Last Resort (cont.)

- If a member's record indicates the existence of first or third-party coverage, but no insurance payment is indicated on the claim (EOB for example) from that first or third-party coverage source, then the claim submitted to AHCCCS Medicaid will deny.
- When a member has Medicare, first or third-party coverage, and EOB will be required by AHCCCS to process the claim.
    - This information is required even if the provider knows in advance that the service is not covered by the other payer source and that no payment will be made. The provider must still submit to the other payer source first to obtain documentation of the valid denial (such as an EOB).

Tribal Self-Funded Insurance Plans

Tribal Self-Insured Plan

If the member has primary coverage with a tribal self-funded insurance plan, then AHCCCS Medicaid assumes primary responsibility over the Tribal Self-insured plan.

- Tribal Self-Insurance- A health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator.

Medicaid Primary Over Tribal Self-Funded Plans

For the purposes of this presentation, the focus is on tribal self-funded plans.

Per R9-22-1002, AHCCCS is not the payer of last resort when the payer is an Indian Health Services contract health (IHS/638 tribal plan)

- AI/AN members that are enrolled in Medicaid and are also enrolled in a Tribal-funded self-insurance plan, AHCCCS is the primary payer, and the tribal funded plan is the “secondary payer”.
- Billers must verify the private/tribal insurance plan prior to submitting claims to the payer. If the tribal self-funded plan paid as primary in error, it is the responsibility of the provider to correct the payment error.

Medicaid Primary
Tribal Self-Funded Plans (cont.)

Suggestions for claim submissions when the member has a tribal self-funded plan:

- Electronically attach a letter from the tribal self-funded plan that states the insurance is tribal funded self-insurance (Transaction Insight Portal).
- The document must contain the member's name, Medicaid ID., etc.
- Include a document for each claim submission.
- This information can be submitted with the claim to allow processing.


Division of Fee-for-Service Management (DFSM) Provider Education and Training Unit

AHCCCS
Arizona Health Care Cost Containment System

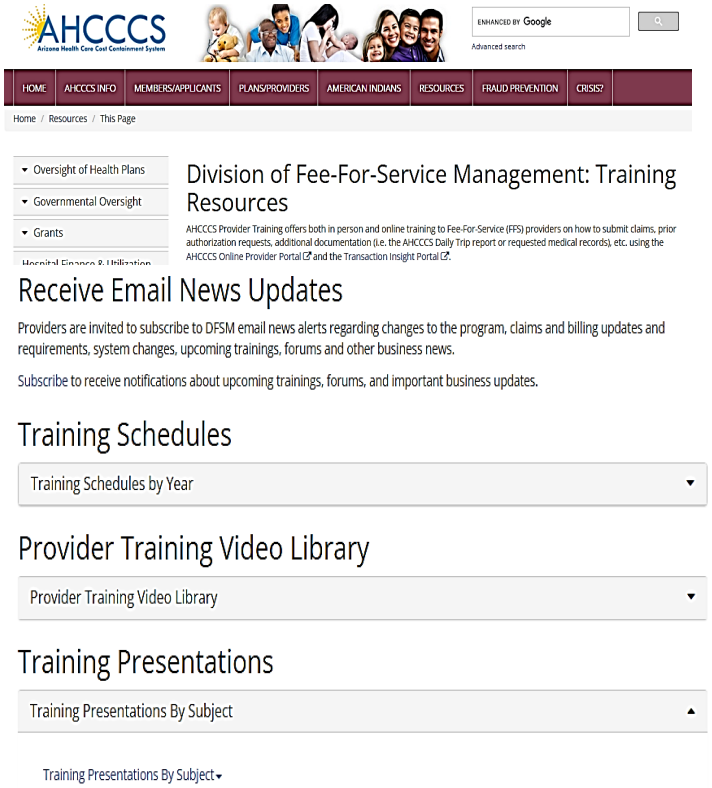
Provider Education And Training

- The DFSM Provider Training team offers training webinars and videos on many topics including how to submit and status claims and prior authorization requests, using the AHCCCS Online Provider Portal for the FFS programs including AIHP, TRBHAs and Tribal ALTCS.
- The training team also provides training on the Transaction Insight Portal application that is used to submit supporting claims documentation i.e., the AHCCCS Daily Trip report, explanations of benefits, Medical records and more.
- We also offer updates to program changes, system updates, and changes to the AHCCCS policy, guides and manuals.

Provider Education And Training Schedule

- The quarterly provider training schedules are posted to the provider training webpage. Registration is required to attend the scheduled trainings.
- To register, click the link below, select Training Schedule by Year, select the current quarter, and then select the training of your choice and complete the required information fields and submit.
- In addition to the training webinars the Provider Education team is available to assist providers with additional one-one training needs.

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html



Education And Training Questions

- **Rates** - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- **Coding** - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
- **ACC Plan Claims** - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.
- Note: The Provider Training and the Coding teams cannot instruct providers on how to code or bill for a particular service. Providers should direct coding questions to your professional coder or biller.

- Providers can email the provider training team at: providertrainingffs@azahcccs.gov

Additional Resources

- How to Use the AHCCCS Online Provider Portal to Verify Member Eligibility and Enrollment
- How to Register for an AHCCCS Online Provider Portal Account
- Transaction Insight Portal

Questions?

Thank You.