IHS /638 Tribal Provider Quarterly Billing Forum

Fourth Quarter 2021

Provider Training Unit

November 17, 2021

IHS/638 Quarterly Forum Agenda

- American Indian Medical Homes – AIMH
- CMS Extension of "Four Walls" Grace Period for IHS and Tribal Providers
- COVID-19 Vaccinations for Children
- COVID-19 Booster Shots IHS/638 Facilities Billing DME
- AIHP Transportation Request Process
- Transportation Requests
- Transportation Passes/Bus Passes
- Emergency Triage, Treat and Transport (ET3)
- Tribal ALTCS Digital Toolbox
- Transaction Insight Portal – Important Information for Users who select Non-Person Entity

American Indian Medical Homes

Presented by:

American Indian Medical Home

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.

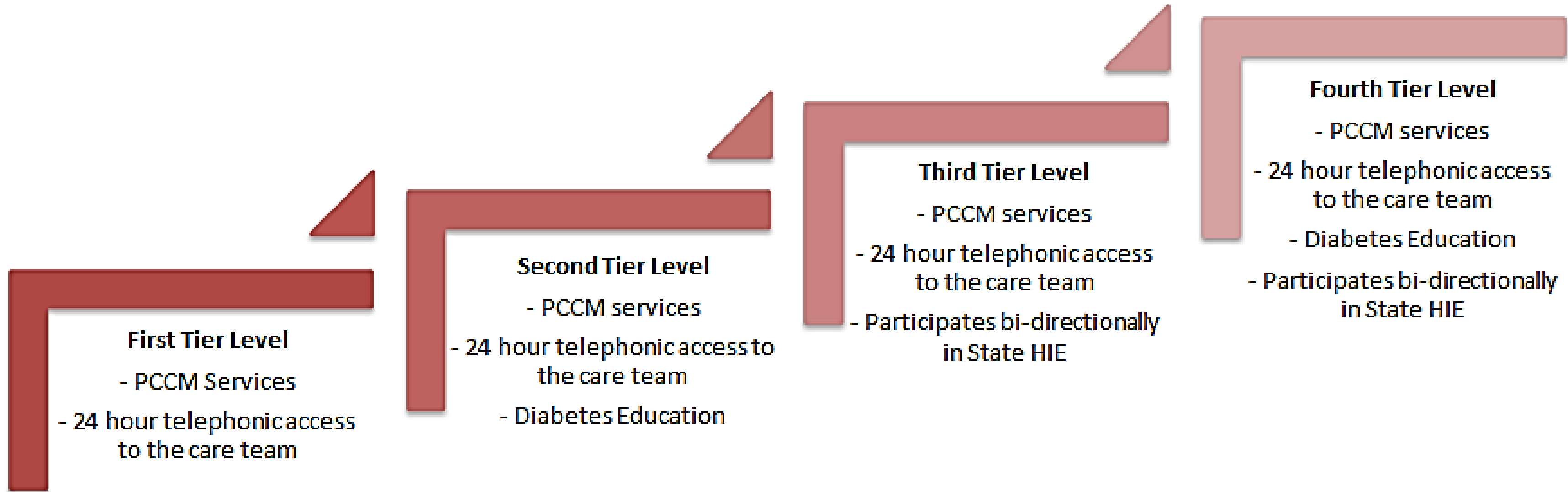
AHCCCS Provider Types that may elect to become an AIMH

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

AIMH Per Tier Levels



AIHM Reimbursement Rates 2021

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

First Tier Level (1)

- PCCM Services.
- 24-hour telephonic access to the care team.

Fort Yuma Indian Health Center

12 members

Active American Indian Medical Homes

Second Tier Level (2)

- PCCM Services.
- 24-hour telephonic access to the care team.
- Diabetes Education.

Phoenix Indian Med. Center
5,449 members

WhiteRiver Indian Hospital
6,149 members

Active American Indian Medical Homes

Third Tier Level (3)

- PCCM Services.
- 24-hour telephonic access to the care team.
- Participates Bi-directionally in State HIE.

Winslow Indian Medical Center

3,602 Members

Active American Indian Medical Homes

Fourth Tier Level (4)

- PCCM Services.
- 24-hour telephonic access to the care team.
- Diabetes Education.
- Participates Bi-directionally in State HIE.

Chinle Comprehensive Health Care
13,510 members

San Carlos Apache Healthcare
3,927 members

Tuba City Regional Healthcare
2,581 members

- Approximately 25% of AIHP members are empaneled with an AIMH

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AIHM 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

Extension of Four Walls CMS Grace Period

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Extension Grace Period for "Four Walls"

On October 04, 2021, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin that extends the grace period previously granted to Indian Health Service (IHS) facilities, and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), which permits IHS/Tribal facilities to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate (AIR) for services provided outside of the ***"Four Walls"*** of the facility.

Extension of the Grace Period "Four Walls"

Extension of the grace period will allow states and Tribes to continue the work needed to make an informed decision about the Tribal FQHC option described in a January 15, 2021 *Informational Bulletin* and take steps to effectuate that option.

- On October 04, 2021 an updated *Informational Bulletin* was released which extends the grace period to end *nine months* after the end of the COVID-19 Public Health Emergency.
- Learn more here: Further Extension of Grace Period Related to the “Four Walls” Requirement under 42 C.F.R. § 440.90 for Indian Health Service and Tribal Facilities to Nine Months after the COVID-19 PHE Ends

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COVID-19 Booster Shots Updates

Center of Disease Control
Vaccine recommendations ages 5 and older

Authorized For	Pfizer-BioNTech	Moderna	J&J / Janssen
4 years and under	No	No	No
5–11 years old	**Yes**	No	No
12–17 years old	**Yes**	No	No
18 years and older	**Yes**	**Yes**	**Yes**

Who is eligible to receive the COVID vaccine?

Currently, members who are 18 years of age or older are eligible to receive the Pfizer, Moderna, or Janssen vaccine.

Members who are between 12 and 18 years of age are only eligible for the Pfizer vaccine.

Vaccine Boosters Billing

Presenter:

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EUA for Use of Moderna COVID-19 Vaccine as a Booster FDA authorized, Oct 20, 2021

A single Moderna COVID-19 Vaccine booster dose may be administered intramuscularly at least 6 months after completing a primary series of the Moderna COVID-19 Vaccine to individuals:

- 65 years of age and older
- 18 through 64 years of age at high risk of severe COVID-19
- 18 through 64 years of age with frequent institutional or occupational exposure to SARS-CoV-2
- https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-10-20-21/02-COVID-Miller-508.pdf

COVID-19 Booster Shots (Pfizer)

CPT Vaccine Codes for Medical Claims	Vaccine - Procedure Name	Vaccine Descriptor	Vaccine NDC Codes for Pharmacy POS Claims	Minimum Dosing Interval (general guidelines)	AHCCCS Payment
0003A	**Pfizer-Biontech Covid19 Vaccine Administration** **Third Dose**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; third dose.	59267-1000- 01 vial 59267-1000- 02 carton 59267-1000- 03 diluent		**$83.00** DOS on and after **08/12/2021**

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COVID-19 Booster Shots Moderna

CPT Vaccine Codes for Medical Claims	Vaccine - Procedure Name	Vaccine Descriptor	Vaccine NDC Codes for Pharmacy POS Claims	Minimum Dosing Interval (general guidelines)	AHCCCS Payment
0013A	**Moderna Covid-19 Vaccine Administration** **Third Dose**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage; third dose	80777-0273- 10 vial 80777-0273-99 carton		**$83.00** DOS on and after **08/12/2021**

Durable Medical Equipment
Prior Authorization and Billing Reminders

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DME Billing Reminders

- DME is not reimbursed at the AIR and ***cannot be billed to AHCCCS on the UB-04 claim form.***
- DME services must be billed on the CMS 1500 claim form.
- DME claims must include the HCPCS code and billing units.

All claims for DME/supplies must include the ***appropriate modifiers:***

- LL lease/rental
- NR new when rented
- NU new equipment
- RA replacement of medical equipment and appliance item
- RB replacement of part of a medical equipment and appliance

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DME Referrals to a Non-IHS DME Provider

Prior Authorization Guidelines:

- If a Member is referred to a non-IHS DME provider or supplier for Durable Medical Equipment or Medical Supplies, the Non-IHS DME provider may be required to obtain a prior authorization from AHCCCS FFS.

Prior authorization Guidelines for Non- IHS DME Providers

Prior authorization from AHCCCS FFS is required for:

- All medical equipment and appliance rentals;
- All medical equipment and appliance repairs;
- All consumable medical supplies (supplies that have limited potential for re-use) in **excess of $100.00;**
- All medical equipment and appliances, and prosthetic devices when the purchase price **exceeds $300.00 for acute members and $500.00 for ALTCS members;** and
- All orthotics when the purchase price **exceeds $300.00 for members aged 21 years and older.**

Billing Secondary DME claims to AHCCCS FFS

- Providers must verify if a member has other insurance prior to services rendered.
- Medicare Part B may cover durable medical equipment and medical supplies.
- The primary EOB must be attached to the claim.

Non-Medicare Secondary DME Claims

- DME must be billed to AHCCCS on the CMS 1500 claim form.
- Provider Identifiers (NPI) must match the NPI billed to the primary payer (*PP*)listed on the PPs Explanation of Benefits (EOB)
- Mismatch of the provider ID numbers will result in a denial of the claim. It will be the biller's responsibility to submit a correction claim with matching information.

AIHP Transportation Request Process
Transportation Requests

Presented by:

AIHP Transportation Request Process

AHCCCS American Indian Health Program Transportation Referral Request Process

Referral from treating or referring facility will submit supporting documentation to support the member going beyond what is reasonably be expected to be the nearest provider for care.

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How the Transportation Request Process Works

Submit referral to AHCCCS Transportation

Complete mandatory fields in the prior Authorization Medical Documentation Form.

Select Transportation BH NEMT or Medical NEMT and fax to Transportation (602) 254-2451

How the Transportation Request Process Works

Schedule Transportation

The member and or the treating or referring facility should arrange transportation with an AHCCCS registered transport provider prior to the referral being submitted to AHCCCS. Transportation should be arranged as soon as the scheduled appointment has been made.
A list of AHCCCS registered transport providers is provided below.

Submit Transportation Prior Authorization Request

A Transportation Prior Authorization is submitted to AHCCCS directly from an AHCCCS Registered Transportation Provider using the online submission service.

https://www.azahcccs.gov/PlansProviders/Downloads/NEMTList.pdf

Non-Emergency Medical Transportation (NEMT)
Bus Passes

Presented by:

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Public Transportation Coverage

Effective 10/1/2021, providers with a Category of Service (COS) 31 may offer Public Transportation options to FFS members (such as a bus pass) when they travel to and from an AHCCCS approved service, in accordance with AMPM 310-BB.

The following shall be considered when offering public transportation to a member:

1. Location of the member to a transportation stop.
2. Location of the provider of services to a transportation stop.
3. The public transportation schedule in coordination with the member's appointment.
4. The ability of the member to travel alone on public transportation.
5. Member preference

Provider types that are eligible to claim reimbursement for public transportation passes include 02, 05, 13, 14, 25, 27, 29, 41, 77, 81, 85, 86, 87, A3, A4, A6, B7, BC, C2, and C5.

Public Transportation Requirements

- Transportation passes may be up to 1 month in duration
- Replacement or duplicate transportation passes are not eligible for Medicaid reimbursement
- There shall be a continuous need for transportation to Medicaid reimbursable services consistent with the length of the purchased transportation pass
- Providers shall determine the appropriate type/duration of public transportation pass to issue to members in accordance with the member's treatment plan and existing future appointment dates.

Claim Submission

- Bill using code A0110 for the net cost of the transportation pass, not to exceed the cost of a 30-day pass.
- Submitted Claims must include the following documentation.
  - Copy of public transportation pass,
  - Itemized receipt specifying cost of public transportation pass,
  - Pricing that corresponds with the price of the pass in the geographic areas of issuance, and
  - Completed Public Transportation Pass form to include the following:
    - Provider's name and ID#,
    - Public Transportation pass type (daily, weekly, or monthly),
    - Price of the Public Transportation pass,
    - Date of issuance,
    - Name, title, signature, and signature date of person issuing Public Transportation pass to the member,
    - Member name, AHCCCS ID#, signature and signature date.

Submitting Claims for Transportation/Bus Passes

Submitting claims via the AHCCCS Online Provider Portal is the preferred method. Providers may also attach the Public Transportation Pass Form using the Transaction Insight Portal.

- **Claim Form Type: CMS 1500 or 837P (*edi format*)**
- **The Public Transportation Pass Form must be submitted with each claim.**

AHCCCS Public Transportation Pass Form

Emergency Triage, Treat and Transport (ET3)

Presented by:

AHCCCS
Arizona Health Care Cost Containment System

What is ET3?

ET3 stands for Emergency Triage, Treat, and Transport.

Typically, reimbursement models for emergency transportation services encourage transport to a high acuity, high cost setting following a 911 call, even when a lower acuity setting would be more appropriate.

When EMS personnel respond to a 911 call, they *typically* must transport the member to the nearest, most appropriate ER. If a member refuses transport to an ER, then the member must sign a form (when possible) indicating refusal to transport against medical advice.

EMS personnel are left with few “in between” options for the member.

What is ET3?

ET3 seeks to remedy the challenges currently faced by EMS providers, by providing greater flexibility to ambulance care teams following a 911 call.

ET3 has the goals of:

- **Increasing Quality of Care** by:
  - **Providing person-centered care**, such that beneficiaries receive the appropriate level of care delivered safely at the right time and place, while having greater control of their healthcare through the availability of more options; and
  - **Encouraging appropriate utilization of services** to meet health care needs effectively; and
- **Increasing efficiency in the EMS system** to more readily respond to and focus on high-acuity cases, such as heart attacks and strokes; and
- **Cost reduction.**

What is ET3?

The three components of ET3 are:

1. **Transport of the Member to an Alternate Destination** (i.e. an urgent care center or PCP's office)
2. **Treatment in Place by a Qualified Health Care Practitioner** (i.e. medical triage of the member via telehealth, with the EMS personnel assisting as needed)
3. **Treatment in Place by a Qualified Health Care Practitioner *In Person*** (i.e. the EMS personnel provide treatment at the member's existing location, using standing orders)

Potential Benefits of ET3

- Allows all members access to the most appropriate level of care at the right time and in the right place;
- Enables an increased quality of care for all patients, regardless of health plan enrollment;
- Allows EMS personnel the time and resources to more readily respond to and focus on high-acuity cases;
- Allows commercial plan and Medicare members to incur fewer out-of-pocket costs by facilitating lower-cost treatment in lower-acuity settings; and
- Assists in overall cost reduction for all participating health plans.

CMS and ET3

ET3 was originally "kicked off" by the CMS Innovation Center for Medicare Fee-for-Service (FFS) Providers.

It released a Request for Applications (RFA) in early August 2019 for ambulance providers and suppliers who wished to participate in ET3 when serving Medicare FFS members, and 14 applicants were chosen within Arizona.

- The list of all selected applicants for participation in the Medicare FFS model can be found here: https://innovation.cms.gov/files/x/et3-selected-applicants.pdf
- AHCCCS registered providers who were not selected for the Medicare FFS Model, may still participate in the AHCCCS ET3 model.

ET3 and the Public Health Emergency

Due to the ongoing COVID-19 Public Health Emergency, implementation of ET3 for Medicare FFS providers and members was postponed until January 1, 2021.

Stay up to date on the latest CMS Medicare FFS ET3 Model news and updates by subscribing to the ET3 Model listserv.

- Please note that AHCCCS has its own ET3 Model email list for Medicaid providers interested in participating in the AHCCCS Model.

ET3 and Long-Term Sustainability

CMS and AHCCCS recognize that the long-term sustainability of the ET3 model program will depend upon the participation of multiple payer sources.

Accordingly, the Request for Applications (RFA) by CMS gave preference to providers who had partnered with multiple payer sources, including their State Medicaid Program, as this would increase their likelihood of creating a long term, sustainable, ET3 program.

- Applicants for the RFA were encouraged to submit Letters of Intent (LOI) for these additional payer sources. To provide support to our EMS providers, AHCCCS issued a Letter of Intent for their use in the RFA.
- AHCCCS Letter of Intent for the ET3 Program

What is the AHCCCS Role in ET3?

Per our Letter of Intent, AHCCCS intends to pursue an ET3 model so as to allow this greater flexibility for providers, and the quality of care benefits for members. This model will be separate from the Medicare model.

Interested providers are encouraged to subscribe to the ET3 email alerts.

- Please fill out the contact information in the form and select “ET3 Updates” under the “Email Lists” section.
- You may unsubscribe at any time by clicking the “unsubscribe” link at the bottom of every email.

For questions about the agency’s ET3 implementation plans, please contact Alexa Kaumaya.

AHCCCS ET3 Timeline and Stakeholder Input

AHCCCS has concluded a detailed review and analysis of the Emergency Triage, Treat, and Transport (ET3) model and has approved the implementation of a model based on ET3 in Arizona. The anticipated effective date is Fall 2021.

More details regarding the initiative will be released throughout 2021, prior to the effective date.

AHCCCS anticipates ample opportunity for stakeholder input related to the implementation of ET3.

Who Can Participate in AHCCCS ET3?

AHCCCS' intent is for any AHCCCS Registered Emergency Transportation Provider (Provider Type 06) to have the opportunity to participate in ET3.

Additional details shall be released in regards to any additional requirements for participation, as decisions are made.

ET3 Billing Information

AHCCCS intends to publish formal billing guidance for providers in the FFS Provider Billing Manual, once final decisions have been made.

Currently the following 3 codes are looking to be opened up to ET3 billing, with the addition of a CG modifier.

- A0426 AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY
- A0428 AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TR
- A0998 AMBULANCE RESPONSE AND TREATMENT, NO TRANSPORT

Information on rates shall be released as decisions are made.

ET3 Resources

AHCCCS ET3 Updates Page

- https://www.azahcccs.gov/AHCCCS/Initiatives/ET3/

AHCCCS ET3 Email List Sign-Up

- DFSM Email Sign Up

ET3 CMS Model Page

- https://innovation.cms.gov/initiatives/et3/

ET3 CMS FAQs

- https://innovation.cms.gov/initiatives/et3/faq.html

ET3 CMS Model Listserv (Email Subscription for Updates)

- https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12521

Tribal ALTCS Digital Toolbox

Presented by:

Welcome to the AHCCCS DFSM Case Management Digital Tool Box (DTB). The AHCCCS DFSM Tribal ALTCS team has created this DTB to centralize the various ALTCS case management related resources into one location so Tribal ALTCS Program Supervisors and Case Managers can find them quickly and easily.

Simply click on the below icons to take you to a particular tool section and then explore!

Tribal Contacts

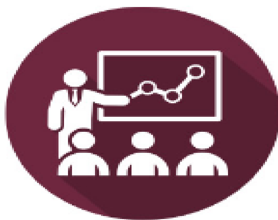
Deliverable Reports & Submission Portal

All About Forms

PMMIS System

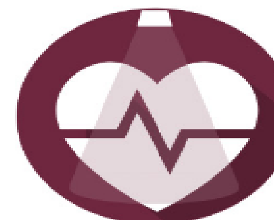
Rate Schedules

Training Resources



AHCCCS Policy & Procedures

Tribal Plan Spotlights



What Information is available Tool Kit?

- Tribal Contacts- contact information by Tribal Plan, ALTCS Program Manager and contact number and email address.
- Deliverable Reports and Submission Portal – view deliverables schedule, supervisory audit report template and more.
- Training Resources – PCSP Training Manual, Assessment Tool, Tribal ALTCS Quarterly Meeting
- AHCCCS Policy & Procedures and more

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Presented by:

AHCCCS
Arizona Health Care Cost Containment System

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Important Reminder: If a provider selects Non-Person Entity (2) and then enter in information into the Provider First Name field, this will cause an error and your attachments will not link to the claim. This will cause your claim to be denied for missing documentation.

To ensure that the attachment process is successful when Non-Person Entity (2) is selected, do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.

Transaction Insight Portal – Non-Person Entity

- Correct: (Provider First Name must be blank/empty)
- Provider Entity Type Qualifier: Person (1) **Non-Person Entity (2)**
- Provider Last or Organization Name: **Enter the name of the Organization**
- Provider First Name: **(This field must be blank when Non-Person Entity is selected).**

➢ **Important: The Provider First Name field must be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the portal.**

Example

Transaction Set Purpose Code: 02 - Add *

Submitter Last or Organization Name: EDI TEAM *

Provider Entity Type Qualifier: ○ Person (1) ◉ Non-Person Entity (2) *

Provider Last or Organization Name: COMPANY *

Provider First Name:

Providers can contact EDI Customer Support at servicedesk@azahcccs.gov

DFSM Provider Education and Training Unit

Division of Fee-for-Service Provider Education

The DFSM Provider Education and Training Unit can assist providers with the following:

- Upcoming webinar trainings
- Provider training materials by topics to include, Claims Submission and Status, Prior Authorization Submission and Status, how to include supporting claim documentation using the Transaction Insight Portal and general updates regarding AHCCCS Policies and changes.
- Provider Training Videos and Resources

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

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- 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
    - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- 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.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

Prior Authorization Questions?

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
  - https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/
- DFSM Prior Authorization Web Page:
  - https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548

NOTE: Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.

Policy Information

AHCCCS FFS Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual

- https://www.azahcccs.gov/shared/MedicalPolicyManual/

Questions?

Thank You.