





Documentation Requirements for Claim Submission and Concurrent Review

DFSM Provider Training Team
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AHCCCS
Arizona Health Care Cost Containment System

About This Training Module

These materials are designed for the AHCCCS Fee-For-Service programs, including American Indian Health Program (AIHP), DD Tribal Health Program (DD THP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

This training covers the responsibility of providers to submit required documentation with claims, and to respond to AHCCCS requests for documentation for concurrent review.

Note: To view the complete training presentation for submitting documentation using the Transaction Insight Portal visit the DFSM Training Resources webpage.

Why is Documentation Required?

Based on the services provided, AHCCCS may request supporting medical information for review. The clinical or behavioral health information may be required to substantiate the service or treatment rendered or the delivery of services that are noted within the claim(s) submission. Some examples of requested information or documentation may include, but is not limited to:

Itemized hospital summary for the UB-04	**Complete medical records when requested**
Surgery - Operative Report, History and Physical	**Physician Orders may include diagnostic testing, home health, therapy, etc.**
Office Notes to include history of present illness, diagnosis, past treatments, etc.	**Progress notes that document a patient's status**
Consent to treatment forms, surgery consent, assessment, treatment plan, etc.	**Diagnostic test results reports (xray/labs)**

Documentation Resources

For Fee-for-Service (FFS) Providers, AMPM 820, FFS Prior Authorization Requirements, contains information on the documentation requirements necessary to obtain prior authorization (and therefore needed to ensure successful payment of the claim).

For documentation requirements for individual services, please refer to that service's corresponding chapter in the AHCCCS Medical Policy Manual

General requirements, along with detailed billing instructions, can be found in the FFS Provider Billing Manual and the IHS/Tribal Provider Billing Manual.




DFSM Medical Review Process

Medical Review and Documentation

Medical review is performed by the AHCCCS CMSU. The medical review process helps ascertain that provider billings are accurate, reasonable and appropriate for the services provided are in accordance with AHCCCS policy as it relates to medicaid coverage, coding, appropriate billing, medical necessity and emergency services.

- Medical review and adjudication also are performed to audit appropriateness, utilization, and quality of the service provided.
- If documents needed to complete medical review are not on file, an automatic request for documentation may be initiated.
- If required documents are not received, a denial may be issued specifying what documentation is required for review.
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AHCCCS Requests for Documentation for Medical Review

Providers will not receive a letter requesting documentation because the denial codes are very specific as to what document(s) or information is needed.

Note: If there are no changes to the claim details and the only action step that is required is to submit the documentation, **DO NOT** resubmit the claim. Providers can upload the necessary documentation using TIBCO, the AHCCCS 12-digit claim number will be the attachment /control number.

Medical Review denials codes will have the prefix **"MD"** followed by the description details. The denial edits will vary based on the services rendered and the documentation required.

- We have provider some examples of requests for records on the next slide.

AHCCCS Requests for Documentation for Medical Review

This is not an all inclusive list. Providers can view the edits assigned to each claim in "real time" using the AHCCCS Online Provider Portal.

MD002	Deny/Sterilization. Consent Form Not Attached.
MD005	Resubmit with Operative Report
MD011	Resubmit with Physicians Orders
MD021	Resubmit with Observation Orders
MD023	Resubmit with H&P, OP, D/C, ER Records
MD024	Resubmit with MD Orders & Progress Notes
MD034	Emergency Criteria Not Met
MD036	Charges not Substantiated
MD037	Services Require a Prior Authorization
MD039	Medical Records Do Not Match DOS Billed

Documentation Requests For Post-Service and Prepayment Review

Claims may be identified for post-service, prepayment review for a variety of reasons, in addition to reviewing for medical necessity.

- **Post payment review** A.R.S. §36-2903.01 L. requires AHCCCS to conduct post-payment review of all claims and recoup any monies erroneously paid. Under certain circumstances, AHCCCS may find it necessary to recoup or require the repayment of money previously paid to a provider as an overpayment. Overpayments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

- **Pre-payment review** this entails the review of claim data, documentation and eligibility prior to the approval of the claim.

Documentation Requests For Post-Service and Prepayment Review (cont.)

Claims that may be subject to such requests may include, but are not limited to, the following:

- Unlisted procedure codes (By-Report).
- Claims for services that, due to their nature, require supporting clinical and/or other information/documentation to be submitted in order to determine whether they are payable.
- Claims where documentation may be required by other entities such as the Centers for Medicare and Medicaid Services (CMS) or under relevant state or federal regulations.

General Documentation Requirements

Not all documentation is required to be submitted with the claim.

- For a listing of documentation that should not be submitted unless specifically requested to do so, providers can review the Documentation Requirements list in Chapter 4, FFS Provider Billing Manual, General Billing Rules.

Near Duplicate Claim Message

Near Duplicate Claims

AHCCCS defines a “near duplicate claim” as a claim submitted with the same CPT/HCPCS code, performed on the same day, for the same member, however, the services may be rendered by a different provider.

“Near duplicate claim” denials will require medical review. Documentation is required to allow the AHCCCS Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service performed on the same day.

Near duplicate claims for certain codes, such as evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review.

- In order for medical review to take place, providers may be required to submit additional documentation for Fee-For-Service submitted on the CMS 1500 claim form.

Near Duplicate Claim Edit

If the system identifies a near duplicate claim, the processing system will place the claim in a **“Hold”** status for review.

Edit Reason Code **L081.1** will append to the claim.
“**Duplicate Check Failed; Near Duplicate Claim”**

If the services are substantiated by the documentation, the claim will be released for payment if the claim has not failed any additional edits.

Prior Authorization Documentation Requirements

FFS Prior Authorization Information

Prior Authorizations are only issued for an AHCCCS covered service that is on the FFS PA list; and are within certain limitations, based on the following:

- The member's AHCCCS eligibility;
- Provider status as an AHCCCS-registered FFS provider;
- The service requested is an AHCCCS covered service that requires a PA;
- Information received from the provider meets the requirements for issuing a PA number,
- Documentation requirements will vary based on the service.
- Timely submissions of PAs is critical to the timely review of the PA request.
- The service requested is not covered by another primary payer (e.g., commercial insurance, Medicare, other agency).

Fee-for-Service Prior Authorization

A key step in the PA process is to first verify if the service requires a prior authorization. The Fee-for-Service Authorization Guidelines is a list procedures that may require a prior authorization.

The Prior Authorization Requirements Web Page provides additional information for specific services, i.e. DME, home health and hospice services and services that may not require a PA i.e. emergency hospital admissions, diagnostic procedures. etc.,

Additional Resources:

The AHCCCS Medical Policy Manual and FFS Billing Manuals provide additional information regarding documentation requirements for PA and claim submissions.

AHCCCS Medical Policy 820 FFS Prior Authorization Requirements

FFS Provider Billing Manual and the IHS/Tribal Provider Billing Manual.

What Medical Documentation is Required?

Services that May Require Documentation

Some services that may require documentation (not an all inclusive list), include:

- By-Report Procedures
- Multiple Surgery Claims
- Federal Emergency Services
- Members with Retro Eligibility status
- Procedures billed with certain modifiers
- Non-emergent hospital admissions
- Dialysis Services
- Secondary Payer Claims

What Does This Section Cover?

This section provides a general overview of documentation requirements for common Medicaid-covered services.

Please note, that this is not a comprehensive list and that documentation requirements may change, or additional documentation may be requested for concurrent review.

It is the provider's responsibility to remain current on documentation requirements and to submit any documentation requested by AHCCCS. Additional documentation requirements can be found in the provider billing manuals.

What Does This Section Cover (cont.)

This section will help providers determine what documentation is required. This is not an exhaustive list. For additional details on each service type, please visit the AHCCCS Medical Policy Manual, the FFS and IHS/Tribal Provider Billing Manuals, and the AHCCCS website.

This training will cover documentation requirements for the following services:

- Non-Emergent Medical Transportation (NEMT)
- Sterilization and Hysterectomies
- Surgical Procedures
- Emergency Room Visits
- Federal Emergency Services Program coverage

Documentation Requirements Non-Emergency Medical Transportation (NEMT)

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Non-Emergency Medical Transportation Documentation Requirements

Any provider type that has been assigned COS 31 (NEMT) for example BHRFs, hospitals, home attendant care, behavioral health outpatient clinics, etc., **must** submit the AHCCCS Daily Trip Report with each NEMT claim submission.

- Exhibit 14-1, the AHCCCS Daily Trip Report (PDF)
  - AHCCCS will accept PDF files of the AHCCCS Daily Trip Report.
- Exhibit 14-1, the AHCCCS Daily Trip Report (Excel)
  - AHCCCS will not accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they must convert to a PDF before submission. The Excel file was included at provider request, so that they may fill it out on Excel and then convert to a PDF prior to submission.

Non-Emergency Medical Transportation Documentation Requirements (cont.)

AHCCCS offers a specific training on how to complete the AHCCCS Daily Trip Report for providers available on the AHCCCS DFSM Provider Training Web Page.

Detailed instructions for completing the Daily Trip Report can be found in Exhibit 14-2, Daily Trip Report Instructions .

Note: Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Report will be denied.

All trips for the same member, for the same date of service must be submitted on one claim form. A claim submitted with only the base code and a second claim submitted with only the mileage code will be denied, as split-billing.

Documentation Requirements
Federal Emergency Services Program (FESP)

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Federal Emergency Services Program (FES)

The FES program is set up to provide health care for *emergency services only* that meet the criteria set forth by the federal government.

Any services billed must meet the ***federal definition*** of emergency services as defined in ***federal law*** within section 1903(v)(3) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement. This includes services provided in any setting, ie. office, inpatient, outpatient, dialysis, etc.

Providers may refer to the FFS Billing Manual, Chapter 18 Emergency Services which contains coverage, billing, and reimbursement policies for the FES program.

FES Federal Definition Explained

"Emergency medical or behavioral health condition" for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including extreme pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Serious physical harm to self or another person (for behavioral health conditions).

Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be ***medically necessary,*** but may not meet this definition for Federal Emergency Services Program.

Federal Emergency Services Program

Examples of documentation may include but not limited to the following:

Emergency room records	Physician progress note(s)
Operative reports	OB triage records
Discharge summary	Itemized statement

- Providers should not attach the entire medical record.
- Claims submitted without medical documentation will deny.
- All FES claims will be reviewed on a per case basis. Medical documentation must be submitted with each claim and must support the emergent nature of the services provided or AHCCCS must have remote access to the medical records.

Documentation Requirements Sterilization & Hysterectomy

Sterilization

AHCCCS requires all claims related to sterilization procedures to be submitted with its consent form.

Sterilization services are covered for both male and female members when the requirements specified for sterilization services (including for hysteroscopic tubal sterilizations), in AMPM 420, Family Planning Services, are met.

Any member requesting sterilization shall sign an appropriate consent form (Attachment A, Consent to Sterilization) with a witness present when the consent is obtained. Consent forms *must* meet the requirements outlined in 42 CFR 441.250 et seq.

Hysterectomy

A Hysterectomy is a medically indicated procedure that is exempt from a 30 day waiting period. Coverage of Hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis.

AHCCCS requires all claims related to hysterectomy procedures to be submitted with the respective consent form.

- Attachment A, AHCCCS Hysterectomy Consent and Acknowledgment Form, must be filled out and submitted to AHCCCS, unless the physician determines that the member is:
  1. Already sterile prior to the procedure, or
  2. The hysterectomy is needed because of a life-threatening emergency situation.

  NOTE: These Exceptions are listed in full detail in AMPM 310-L, Hysterectomy.

Hysterectomy

Prior to performing a hysterectomy, unless the exceptions in AMPM 310-L, Hysterectomy are met, a provider shall comply with the following requirements. They shall:

1. Inform the member and member's representative, if any, both orally and in writing that the Hysterectomy will render the member incapable of reproducing (i.e. result in sterility); *and*

2. Obtain from the member or member's representative, if any, a signed and dated written acknowledgment stating that the information above has been received and that the member has been informed and understands that the Hysterectomy will result in sterility. This documentation shall be kept in the member's medical record.

It is the provider's responsibility to maintain any required documentation, such as what is described above, and provide it to AHCCCS if requested.

Documentation Requirements Emergency Department Visits

Emergency Department Visits

AHCCCS requires all claims related to an emergency room visit to be submitted with the complete emergency room record.

In accordance with the Balanced Budget Act, prior authorization is not required for emergency physical and behavioral health services.

The attending physician's signature **must** be on the emergency room record.

AHCCCS registered hospitals also have an option to allow AHCCCS "remote" access to hospital health records for clinical review.

Documentation Requirements
Surgery

Surgical Procedures

AHCCCS requires all claims related to surgical procedures to be submitted with the following items:

- History and physical,
- Operative report, and
- Emergency department report (if applicable).

Certain surgical claims require additional distinction, such as procedures that involve bilateral procedures, multiple procedures performed on the same date, secondary procedures, or procedures performed during the same operative session by the same physician.

- Please note, these are typically indicated through use of a modifier when billing, and any submitted documentation must support the use of the modifier(s).

Outpatient Dialysis Services
Federal Emergency Services (FES)

Outpatient Dialysis Services

Free-standing dialysis facilities are reimbursed a composite rate, and services included in the composite rate may not be billed separately.

Chapter 15, Dialysis Services, of the AHCCCS FFS Provider Billing Manual, provides a list of drugs and tests covered under the composite rate.

- Separately billable drugs and vaccines that are *not* included in the composite rate require medical documentation to be submitted with the claim.
- Tests performed more frequently than specified in policy may be covered by AHCCCS only if medically justified by supporting documentation.

Services that are billed separately from the composite rate, because they were provided more frequently than specified by policy, must be justified by supporting documentation. If no documentation is submitted with the claim, or if the documentation does not support the charges, then payment for those services will be disallowed.

FES and End Stage Renal Disease Dialysis Services

Emergency services under the FES Program also include outpatient dialysis services, if the FES Program Member has ***End Stage Renal Disease (ESRD),*** when the criteria specified in A.A.C. R9-22- 217(B) and Section B of AMPM 1100, Federal Emergency Services Program are satisfied.

Notification Requirements: There are two documentation items of note for dialysis providers which will be discussed on the following slides:

1. *Initial Dialysis Case Certification* and,
2. *Monthly Certification of Emergency Medical Condition*
3. Providers must also include the **Prior Authorization Request Form** and fax the forms to the PA team.

Initial Case Certification for ESRD Services

Initial Dialysis Certification: When a FES member requires dialysis services for ESRD for the first time, the treating physician must issue an initial certification in writing, that in his/her opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in any one of the following:

- Placing the member's health in serious jeopardy.
- Serious impairment of bodily function.
- Serious dysfunction of a bodily organ or part

The initial certification is created by having the physician complete the Initial Dialysis Case Creation Form , which certifies that the aforementioned criteria have been met. The treating physician shall complete and sign the "Initial Dialysis Case Creation" form and then submit the form to AHCCCS/DFSM PA for review.

Federal Emergency Services Program & Dialysis

2) **Monthly Certification of Emergency Medical Condition:** The member's treating physician must certify in writing, for each month in which the dialysis services are received, that in his/her opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in any one of the following:

   - Placing the member's health in serious jeopardy.
   - Serious impairment of bodily function.
   - Serious dysfunction of a bodily organ or part.

The provider certifies the athis information by completing the Attachment B ("Monthly Certification of Emergency Medical Condition").

ESRD Extended Services Authorization

For FES members only upon approval for ESRD services, AHCCCS PA will create an an **Extended Services Authorization** will be entered by the ***PA unit.***

Note: Providers must not initiate/create an authorization for Dialysis services via the PA submission portal for members enrolled in the FES program.

- An extended services authorization is not entered under a individual provider's NPI number and this is due to FES members may receive ESRD services at any AHCCCS registered dialysis facility of their choice.
- An initial ES authorization for ESRD services may be approved based on the dialysis certification.
- Eligibility requirements will apply to all services.

Secondary Payer Claims

Secondary Payer Claims

Federal law 42 USC 1396a (a)(25)(A) requires Medicaid to take all reasonable measures to determine the legal liability of third parties for health care items and services provided to Medicaid members.

AHCCCS has liability for payment of benefits after Medicare and all other first- and third party payer benefits have been paid. 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.

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted per A.R.S. §36-2946.

Secondary Payer Claims

AHCCCS maintains a record of each member's primary coverage by Medicare and Other primary insurance plans.

If a member's primary payer's record indicates a first-party coverage (such as Medicare or employer's health plan) or a third-party coverage (i.e. third party liability, or TPL) and the claim is filed **without** the primary payer's EOB the claim will be denied.

To view additional resources/ information:
Chapter 9, Medicare and Other Insurance Liability, of the FFS Provider Billing Manual
Chapter 7, Medicare and Other Insurance Liability, of the IHS Tribal Provider Billing Manual.

Secondary Payer Claims

Under state and federal law and R9-22-1003 (E), AHCCCS must pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement from the First- or Third-Party payer (Post-Payment Recovery) when the claim is for one of the following:

1. Preventive pediatric services, including EPSDT services and administration of vaccines under the *Vaccines For Children (VFC) Program;* or

2. The liability is from an absent parent whose obligation to pay support is being enforced by *Division of Child Support Enforcement.*

Secondary Payer Claims Exceptions

Per R9-22-1002, AHCCCS is not the payer of last resort which means AHCCCS will be the primary payer when the following entities are the **third-party:**

- The payer is Indian Health Services contract health (IHS/638); or
- Title IV-E Foster Care and Adoption Subsidy, or
- Arizona Early Intervention Program (AZEIP); or
- Local educational agencies (LEA) providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
- Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

Documentation Requirements for Medicare and Secondary Claims

Required Documents for Medicare Secondary Claims

Members that are eligible for Medicaid may also have Medicare coverage. AHCCCS Medicaid is always considered **“the payer of last resort”.**

What documents are required for processing when Medicare is primary?

- First submit the claim to Medicare to obtain payment, EOB or claim denial.
- The MEOB is required with each claim submission and AHCCCS cannot consider a Medicare primary claim without the MEOB.

Medicare Non-covered Services:

- For Medicare non-covered services, providers must submit the claim to Medicare even if it is for a service not covered by Medicare. This information is required for processing.

Note: AHCCCS FFS timely filing rules will apply to direct claim submissions and claims that were adjusted by Medicare.

Required Documents for Medicare Secondary Claims (cont.)

Members that are eligible for Medicaid may also have Medicare coverage.

- Medicare will automatically transmit claims that have been approved for payment to AHCCCS for consideration of the medicare cost sharing.

- Medicare does not transmit denied or adjusted claims to AHCCCS.
  - The provider must submit a copy of the original EOB, adjusted EOB and a copy of the appeal decision when applicable for consideration.

- **AHCCCS FFS timely filing rules will apply to direct claim submissions and claims that were adjusted by Medicare.**

Required Documents for TPL Secondary Claims

Members that are eligible for Medicaid may also have a **First-Party or Third-Party Liability** coverage for example group employer plan.

- AHCCCS Medicaid is considered **“the payer of last resort”.**
- A copy of the primary payer’s Explanation of Benefits (EOB) is required for AHCCCS to consider the claim.
- TPL payers do not transmit denied or adjusted claims to AHCCCS. This will be the provider’s responsibility and must include a copy of the original EOB, adjusted EOB and a copy of the appeal decision if applicable for consideration.
- **AHCCCS FFS timely filing rules will apply to direct claim submissions and claims that were adjusted by the TPL.**

Medicare Enrollment for Providers

Providers who qualify for Medicare payment, but have not applied to Medicare, must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

Submitting Claims for Medicare Denials

Medicare allows providers to bill for a claim denial, this includes billing Medicaid for a non-covered service, to obtain the Medicare denial notice to submit to Medicaid.

For example:

- Based upon the bill type code (i.e. this can be done with non-covered SNF claims)
- There are some diagnosis codes that Medicare does not cover for DME. Providers still must submit a claim to Medicare for Denial.
- There is a modifier that Medicare allows providers to bill Medicare, that indicates that it is a non-covered service. Providers still must bill Medicare to ensure a Denial is received.

Secondary Payer Claims – Dual Eligible Medicare/Medicaid Members

Providers who qualify for Medicare payment, but have not applied to Medicare, must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

- Medicare allows providers to bill for denials, even for non-covered services, to obtain an EOB for Medicaid. For example:
  - Based upon the bill type code (i.e. this can be done with non-covered SNF claims)
  - There are some diagnosis codes that Medicare does not cover for DME. Providers still must submit a claim to Medicare for Denial.
  - There is a modifier that Medicare allows providers to bill Medicare, that indicates that it is a non-covered service. Providers still must bill Medicare to ensure a Denial is received.

Receiving the denial is important, to ensure that the provider has the Explanation of Benefits (EOB) for when they submit their Medicaid claim.

Professional Services

Global OB Documentation

In addition to standard documentation requirements associated with billing for the Total Global OB code, medical complications of pregnancy may require additional resources outside the global OB care package as outlined in Chapter 10, Individual Practitioner Services, of the FFS Provider Billing Manual, and may be reported separately.

The medical complication(s) must be present as supported by the medical documentation, including but not limited to, maternal medical history & physical, lab results and imaging reports.

Rehabilitative Services Documentation

The following written documentation must be in the member's medical records and available upon request for audit, as it pertains to rehabilitative services (physical, occupational, speech and respiratory therapies):

- Nature, date, extent of injury/illness and initial therapy evaluation,
- Treatment plan, including specific services/modalities of each therapy, and
- Expected duration and outcome of each therapy provided.

NOTE: Outpatient rehabilitation services are NOT covered for FES members.

Attending/Teaching Physician Documentation

The attending/teaching physician may submit a claim for professional services if certain criteria outlined in Chapter 10, Individual Practitioner Services, of the FFS Provider Billing Manual have been met.

Documentation substantiating the outlined criteria must be available for audit purposes.

All claims are subject to post-payment review and recovery per A.R.S. §36-2903.01 L.

Nutritional Therapy for EPSDT Members

Per AMPM 430, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services AHCCCS must verify medical necessity of nutritional therapy through the receipt of supporting medical documentation dated within three months of the request for coverage, prior to giving initial or ongoing authorizations for nutritional therapy.

Documentation shall include clinical notes or other supporting documentation from the member's PCP, specialty provider, or registered dietitian, including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on Attachment B, AHCCCS Cert. of Medical Necessity for Comm. Oral Nutritional Supplements.

NOTE: Refer to AMPM 430 for additional information on all EPSDT services and their subsequent claims.

Inpatient Hospital Services Documentation Requirements

Inpatient Hospital Claims

Inpatient hospital claims require the following documentation:

- An admission face sheet;
- An itemized statement, submitted by the provider;
- An admission history and physical;
- A discharge summary or an interim summary if the claim is split;
- An emergency record, if admission was through the emergency room;
- Medication Administration Record (MAR);
- Operative report(s), if applicable;
- A labor and delivery room report, if applicable;
- Physician orders;
- Diagnostic test results;
- Progress notes; and/or
- Documentation listed in Exhibit 11-4, Outlier Records Request, for claims qualifying for outlier payments.

Periodically, retrospective review will be conducted by AHCCCS based upon a variety of criteria.

Outlier Claims

- Outlier claims means any claim which has total charges in excess of the outlier threshold, for cases incurring extraordinarily high costs as defined in the State Plan.
- To qualify for outlier payment, a case must have costs above a fixed-loss cost threshold amount (a dollar amount by which the costs of a case must exceed payments in order to qualify for outliers and after non covered charges are removed).
- Claims that qualify for Outlier payments require additional documentation for medical review to include a copy of the itemized statement which is the hospital's line-by-line breakdown of the procedures, dates of service, units, revenue codes, charges, etc.
- The Outlier Records Request Form, Exhibit 11-4, Outlier Records Request , in the FFS Provider Billing Manual, should be used by providers to submit this.

Outlier Claims

The Outlier Records Request Form lists the documentation required to perform a review of an Outlier Claim. Documentation required includes:

- Medication Administration Record (MAR)
- Operating room and anesthesia times. (Need the operative report and anesthesia records as they contain some of the charges/supplies/implants/medications that might not be listed elsewhere)
- All other minor procedures (bronchoscopy, laceration repair, lumbar puncture, PICC insertion, etc.)
- High dollar radiology (CT's, MRI's, MRA's, Nuclear Med scans, IR (Interventional Radiology).
- High dollar medical supplies
- Echocardiogram
- Cardiac Cath records

Outlier Claims (Continued)

- Ventilator days
- Nitric Oxide days
- Dialysis records and CRRT
- Blood administration (copy of the blood administration tag that has the date, start/stop times, and signature of administrator)
- PACU in/out times
- Perfusion
- Cardiac Arrest reports
- If Observation Days are billed then physicians' orders must be verified per policy
- Emergency Room records (procedures performed and meds given in ER may not be listed anywhere else), Other

Additional Documentation Requirements

Additional Documentation Requirements

The following slides show tables listing the required documentation that should be submitted when billing for certain services on the CMS 1500 or the UB-04 Claim Form.

- These tables have been created to give providers some *general* guidance regarding the submission of documentation.

Please note, that not all Fee-For-Service claims submitted to AHCCCS are subject to Medical Review.

CMS 1500 Claims		
Service	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report, and emergency room report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, & pathology report	Information must substantiate fetal demise.
Emergency room visits	Complete emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, & consult reports	Documentation should be specific to code(s) billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, & history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.

UB-04 Claims		
Billing for	**Documents Required**	**Comments**
Observation	Refer to FFS Chapter 11 Hospital Services for required documentation.	If labor and delivery, send labor and delivery records
Missed abortion / Incomplete abortion	All documents required by statute, ultrasound report, operative report, & pathology report.	Information must substantiate fetal demise
Outlier	Refer to FFS Chapter 11, Hospital Services, and to Exhibit 11-4, the Outlier Record Request, for information on the required documentation.	

Modifiers

Medical Coding, Modifiers and Documentation

It is the biller/provider's responsibility to follow national coding standards, in order to support accurate reporting of certain procedures/services including the use of modifiers.

- Modifiers provide more reporting specificity.
- Modifiers should be added to CPT codes when they are required to more accurately describe a procedure performed or service rendered.
- The documentation in the medical record must substantiate/satisfy the use of the modifier.

Modifier 25- Evaluation and Management (E/M)

- **Modifier 25 (Significant Separately Identifiable)** is used to identify E/M services as separate from another service performed on the same day by the same or provider.
- When a preventive medicine service is reported in combination with problem-oriented E/M service, the visit documentation must clearly indicate the separate history, exam, and medical decision-making components related to the problem or abnormality being addressed.
- Billers/Coders should refer to the AMA coding guidelines for specific coding instructions.

Modifier 26 - Professional Component

Evaluation and Management Service Modifier

- **Modifier 26 (Professional Component)** is generally billed by a physician/practitioner and is used to indicate that only the professional component of a service/procedure performed by a physician or interpretation of the services performed by a physician.

Surgical Modifiers

Surgical Procedure Modifiers

- **Modifier 50 (Bilateral Procedures)** is used to identify bilateral procedures during the same operative session.
- **Modifier 51 (Multiple Procedures)** is used to identify multiple procedures performed on the same date, secondary procedures, or procedures performed during the same operative session by the same physician.
- **Modifier 59 (Distinct Procedural Service)** is used to identify services or procedures performed on the same day due to special circumstances that are not normally reported together.

Foresight Transaction Insight Portal (TIBCO)

What is the Transaction Insight Portal?

The Transaction Insight Portal is a free platform that is available to providers to electronically attach required documents to a Fee-for-Service claim for medical review or processing.

How does this process work?

There are two easy ways to attach documentation to your claim via TIBCO.

- Submit the claim via the AHCCCS Online Provider Portal and create a Provider Work Number (PWK) attachment number, or,
- Submit the claim using your own software, billing or clearinghouse and use the AHCCCS 12 digit claim number as the attachment number.

For complete instructions refer to the DFSM Provider Training Web Page


DFSM Provider Education and Training Unit

AHCCCS
Arizona Health Care Cost Containment System

DFSM Provider Education and Training

The AHCCCS Provider Training Unit can assist providers with the following:

- AHCCCS Online Provider Portal Training:
  - How to submit and status claims and prior authorization using the AHCCCS Online Provider Portal;
- How to use the Transaction Insight Portal (for the submission of accompanying documentation);
- Provide clarification on AHCCCS policies and system updates;
- Changes to the program; and
- Other details.

For training requests please contact the DFSM Provider Training Team at **ProviderTrainingFFS@azahcccs.gov**

DFSM Provider Education and Training

Note: The provider training and medical coding teams cannot instruct providers on how to code or bill for a particular service. For example, questions regarding the use of modifiers, billing combination of codes, place of service etc., should be directed to your organization's coder/biller for guidance.

Note: Questions regarding the processing of claims by the AHCCCS Complete Care (ACC) Health Plans should be directed to the appropriate ACC Health Plan.

Who to contact?

- Questions on AHCCCS Fee-for-Service rates email **FFSRates@azahcccs.gov**
- Questions on AHCCCS Coding email: **CodingPolicyQuestions@azahcccs.gov**

Need Help!

If you need assistance with the following:

Questions about warrants, paper EOBs, or EFTs please contact the Division of Business & Finance (DBF) at ahcccswarrantinquiries@azahcccs.gov or call **(602) 417-5500. Hours: 10:00 AM – 4:00 PM Arizona Time.**

To check the status of your EFT, please email the Division of Business & Finance (DBF) at ahcccsfinanceeft@azahcccs.gov

Questions related to electronic transactions or to request an ERA transaction setup email servicedesk@azahcccs.gov or contact **(602) 417-4451. Hours: 7:00 AM – 5:00 PM Arizona Time.**

Providers should use the AHCCCS Online website as the first step in checking the status of the prior authorizations and claims. Our Provider Services representatives are skilled to provide help to many *basic* prior authorization and claims questions. To reach **Provider Services call (602) 417-7670.**

Provider Services Call Center Operation Hours: **Monday-Friday from 7:30 A.M. - 5:00 P.M.**

Providers should not call the Provider Services 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. Providers should refer to the AHCCCS Website Plans/Providers for more information.

Questions?

Thank You.