IHS/638 Tribal Providers Quarterly Billing Forum

First Quarter 2024

Wednesday, March 27, 2024
2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

Topics

- Upcoming Events:
  - IHS Tribal ALTCS Consultations
  - IHS/638 Tribal Billing Forums
- 2024 All Inclusive Rates
- Provider Moratorium
- Intensive Outpatient Program Billing Update
- Appropriate Use of Respite Services
- American Indian Medical Home (AIMH)
- Referring, Ordering, Attending (ROPA)
- Provider Revalidation
- Transaction Insight Portal Reminders
- Participating Provider Reporting Requirements
- Third Party Liability
- Medicare Billing
- Submitting a Non-Medicare Crossover Claim
- Behavioral Health Documentation




Upcoming Events

AHCCCS Tribal Consultations

AHCCCS Quarterly Tribal Consultation Events

Consultation Type	Date/Time	Time	Location	Zoom Registration
Quarterly Tribal Consultation Session	May 7, 2024 (Tuesday)	8:30am – 4:30pm	Hybrid (To be Determined)	Zoom Registration Link
Quarterly Tribal Consultation Session	August 5, 2024 (Monday)	8:30am – 4:30pm	Hybrid (To be Determined)	Zoom Registration Link
Quarterly Tribal Consultation Session	November 14, 2024 (Thursday)	8:30am – 4:30pm	Hybrid (To be Determined)	Zoom Registration Link

Please check AHCCCS Tribal Consultation web page for meeting information.

IHS/638 Tribal Providers Quarterly Billing Forum 2024

Quarterly Billing Forums	Date/Time	Time	Zoom Registration
IHS/638 Tribal Providers Quarterly Billing Forum	June 26, 2024 (Wednesday)	2:00pm – 3:30pm	Second Quarter Zoom Registration
IHS/638 Tribal Providers Quarterly Billing Forum	September 25, 2024 (Wednesday)	2:00pm – 3:30pm	Third Quarter Zoom Registration
IHS/638 Tribal Providers Quarterly Billing Forum	December 18, 2024 (Wednesday)	2:00pm – 3:30pm	Fourth Quarter Zoom Registration

To sign up to receive information directly via Constant Contacts regarding IHS/638 forums click on **Subscribe to DFSM News**




2024 All Inclusive Rates (AIR)

Reminder: 2024 All Inclusive Rates (AIR)

Inpatient AIR

- New CY 2024 Inpatient AIR is $5,083.00.
- The 2023 Inpatient AIR is $4,239.00.

Outpatient AIR

- New CY 2024 Outpatient AIR is $719.00.
- The 2023 Outpatient AIR is $640.00.

Questions? Email us at ProviderTrainingFFS@azahcccs.gov




Reminder: Provider Moratorium

Reminder: Provider Moratorium

- In accordance with Section 42 CFR 455.470, Arizona Health Care Cost Containment System (AHCCCS), implemented an additional 6 months statewide moratorium on the enrollment of the following provider types:
  - Behavioral Health Outpatient Clinic, (PT 77)
  - Integrated Clinic, (PT IC)
  - Non-Emergency Medical Transportation, (PT 28)
  - Community Service Agencies, (PT A3) and
  - Behavioral Health Residential Facility (PT B8).
- This moratorium extension will expire on *June 8, 2024.*

These moratoria were approved by the Centers for Medicare and Medicaid Services (CMS) and is effective on December 8, 2023. This action is necessary to safeguard AHCCCS members, public funds, and to maintain the fiscal integrity of the AHCCCS program.

Reminder: Provider Moratorium (cont.)

This moratorium allows provider enrollment applications to be considered for an exemption on a case-by-case basis, under any of the following circumstances:

1. Medically Underserved Service Area and access to care with review and approval by State Medicaid Agency,
2. Service expansion in support of a State Medicaid Agency initiative,
3. At the request of an AHCCCS contracted managed care plan to ensure that access to care standards (i.e., time and distance) are not out of compliance, or
4. Additional exemptions as appropriate and as needs are identified.




Behavioral Health
Intensive Outpatient Treatment Billing Update

AHCCCS
Arizona Health Care Cost Containment System

Intensive Outpatient Treatment (IOP) S9480

Providers billing **S9480** for intensive outpatient psychiatric services must meet the minimum requirements as described below:

A. Treatment shall consist of a minimum of 9 hours of service per week, a minimum of 3 hours per day, conducted on at least 2 days and shall include, but is not limited to the following;

i. 1 session with the members treating Psychiatric Provider (Behavioral Health Medical Practitioner-BHMP) per week, and

ii. 1-3 individual counseling sessions with a BHP, no less than 50 minutes in duration, per week, and

iii. 2 group counseling sessions, no less than 50 minutes in duration, per week.

B. A BHMP shall be available on-site at least 80% of the time during IOP Program operation.

Intensive Outpatient Treatment (IOP) H0015

Providers billing **H0015** for intensive outpatient *alcohol and/or drug* services provide substance use disorder and co-occurring treatment, in alignment with ASAM Criteria, 3rd Edition, level 2.1, must meet the minimum requirements as described below:

A. Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and peer support.

B. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan.

C. Treatment shall consist of a minimum of 9 hours of services a week, conducted for at least 3 hours a day and at least 3 days a week.




Appropriate Use of Respite Services

AMPM 310-B Title XIX/XXI Behavioral Health Service Benefit

And AMPM 1250-D Respite Care

AHCCCS
Arizona Health Care Cost Containment System

Clarification of Billing Respite Services AMPM 310B and 1250-D

In accordance with AMPM 310-B Title XIX/XXI Behavioral Health Service Benefit:

Unskilled respite care (respite) is short term behavioral health services or general supervision that provides *an interval of rest or relief to a family member or other individual caring for the member receiving behavioral health services as authorized under the Section 1115 Waiver Demonstration* and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

Appropriate Use of Respite Services
AMPM 310B and 1250-D (cont.)

In accordance with AMPM 1250-D Respite Care:

- Respite Care is provided as an interval of rest and/or relief to a family member or other individual caring for an ALTCS member.
- Respite Care may be provided by a respite provider coming to the member's home, or by admitting the member to a licensed institutional facility or an approved Alternative HCBS setting for the respite period.
- Respite care may only be delivered as *specified in the member's Person-Centered Service Plan and requires prior authorization by the case manager.*




American Indian Medical Homes (AIMH)

What is an American Indian Medical Home

The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP).

The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

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.

IHS/638 Qualifying Provider Types
American Indian Medical Home Provider

The following IHS/638 Tribal provider types may elect to become an AIMH.

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

AIMH Reimbursement Rates and Provider Requirements

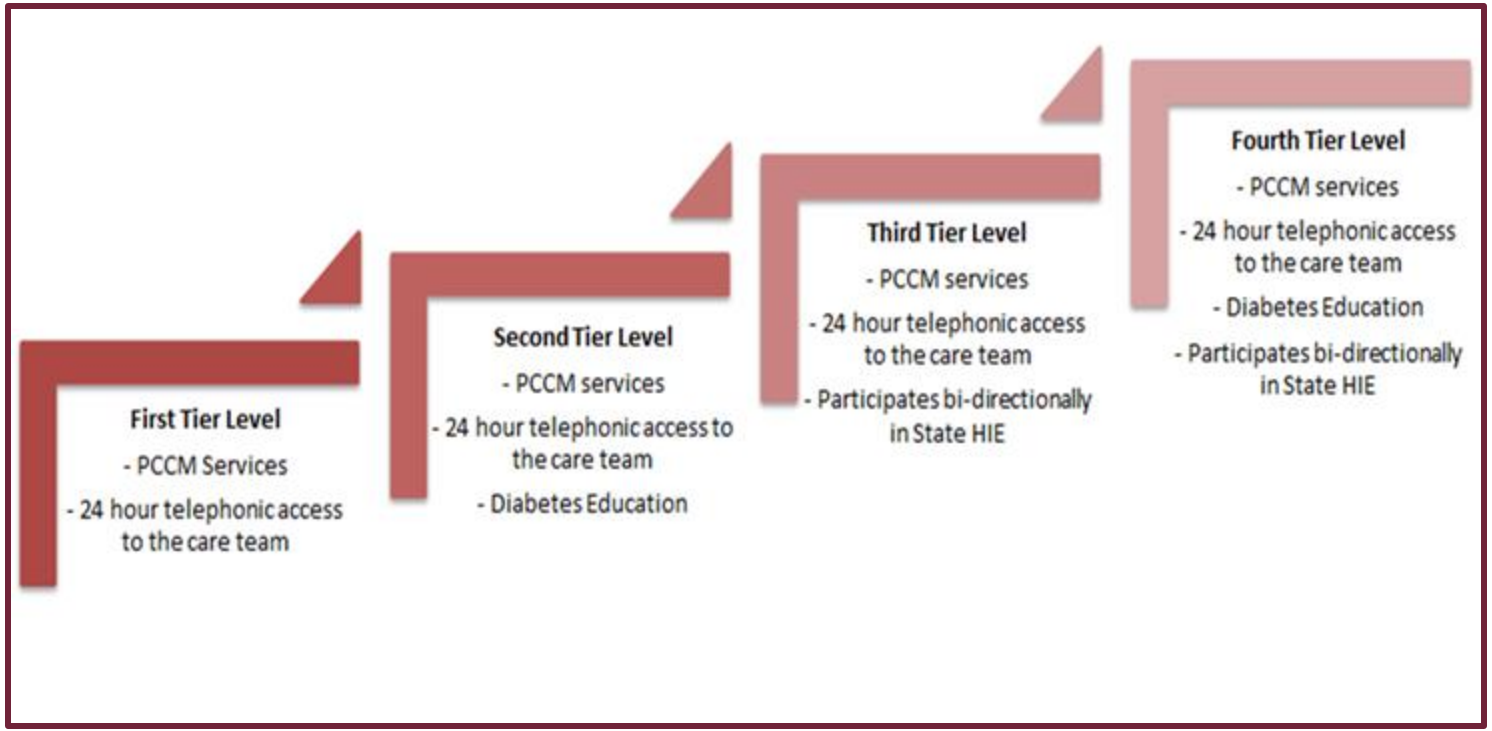
Facilities who choose to become an AIMH will receive a *Prospective Per Member Per Month (PMPM)* rate for services provided by their medical home.

- Payments are dependent upon the AIMH tier level selected.
- There are 4 Tier levels which includes annual rate increases.

AIMH Provider Requirements:

- Must be an IHS or Tribal 638 owned and operated facility,
- The provider must 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, or
  - Participate bi-directionally in the State Health Information Exchange (HIE).

American Indian Medical Home Reimbursement Tiers



AIMH Reimbursement Rates CY 2024

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

First Quarter AIMH Enrollments

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Chinle Comprehensive Healthcare	**4**	**13,295**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Fort Yuma Health Care	1	8

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Phoenix Indian Medical Center	2	4,667

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Parker Indian Health Center	1	927

Current AIMHs and Members

American Indian Medical Home	Tier Level	Member Enrollment
San Carlos Apache Healthcare	**4**	**5,529**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Tuba City Regional Healthcare Corporation	**4**	**2,846**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Whiteriver Indian Hospital	**2**	**6,106**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Winslow Indian Health Care	**4**	**3,768**




Reminders:
Referring, Ordering, Attending Providers (ROPA)

Reminder: Referring, Ordering, Attending Providers Registration Reminders

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA."

Referring, Ordering, Attending Providers Registration Requirements

Beginning ***July 1, 2024,***

claims submitted by fee-for-service providers that include a referring, ordering, or attending provider who is NOT registered with AHCCCS will be denied.

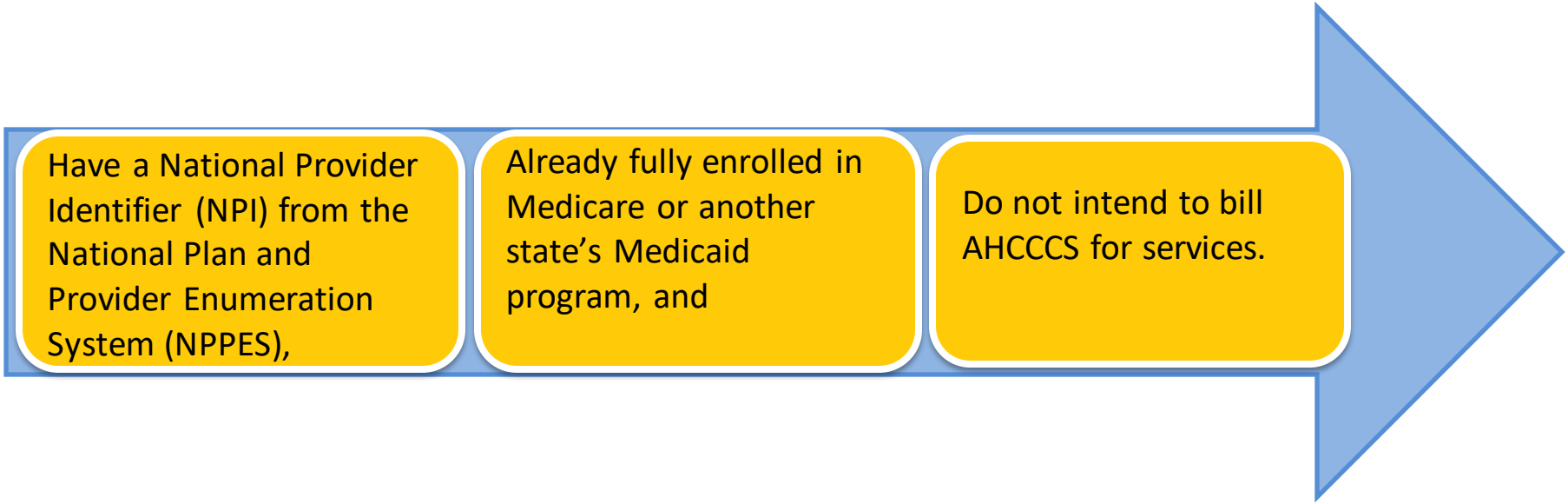
Fee-for-service claims that include an unregistered prescribing provider are not subject to this deadline Referring, Ordering, Prescribing Provider Information

To begin the enrollment process, visit AHCCCS Provider Enrollment

ROPA Provider Registration Requirements

Referring, Ordering, Attending Provider Registration Requirements

To make the ROPA registration process as simple as possible, AHCCCS developed a streamlined application for ROPA providers who meet all of the following criteria:



Steps To Comply With ROPA

- If you are a provider ***who refers*, orders, or acts as an attending provider** for AHCCCS members, and you are not represented on either of the lists, you must begin the registration or exception provider designation process.
- If you are a provider ***who receives* a referral or order** from a provider who is not on either of these lists (as appropriate), your fee-for-service claim will not be paid as of July 1, 2024.
- To validate providers who meet these requirements, AHCCCS publishes two listings as follows on a regular basis:
  - AHCCCS Active, Registered Providers by NPI who may Refer, Order, Prescribe, or Attend
  - ROPA Excepted Providers List (Residents, Interns, Pharmacists)
- ROPA enrollment can be initiated using the https://www.azahcccs.gov/PlansProviders/APEP/ProviderEnrollment.html

ROPA Provider Types

1. Providers who are already registered with AHCCCS and are attending, prescribing
2. All providers, including ROPA providers, must re-validate their AHCCCS enrollment every four (4) year
3. The ROPA requirement applies whether AHCCCS is a member's primary or secondary insurance.
4. Attending providers should be registered if they are a registerable provider type.
5. As required by the federal government, all medical providers (who are a registerable provider type) must be enrolled with the State Medicaid program in order for Medicaid to pay for services that they Attend, Prescribe, Order or Refer.
6. The rule applies even if the provider does not accept Medicaid payment for the provider's own services or wishes to otherwise participate as a Medicaid provider.

ROPA Provider Types

Additional information and questions concerning ROPA can be viewed here

https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

https://www.azahcccs.gov/PlansProviders/APEP/ProviderEnrollment.html




Reminder: AHCCCS Fee-for-Service Provider Revalidation

Completing the Revalidation Application Process

AHCCCS-Division of Member and Provider Services (DMPS) will begin notifying providers through the United States Postal Service mail who are required to revalidate their Medicaid id.

As part of the revalidation process the provider is subject to the same screening and disclosures captured during the initial enrollment. Additionally, based on provider type the process could include an enrollment fee, site visit, and fingerprint criminal background check required as a part of the screening requirements.

Additional information can be found on the Provider Revalidation webpage at:
https://www.azahcccs.gov/PlansProviders/CurrentProviders/providerrevalidation.html

Completing the Revalidation Application process is fast and easy!

- To begin your revalidation application, login to your Existing Provider account: To access APEP Direct
- Below are step-by-step instructions designed to teach providers how to complete a revalidation using a 14-digit Application ID APEP.
- For additional questions regarding how to troubleshoot through APEP to complete the revalidation application, contact APEPTrainingQuestions@azahcccs.gov or Provider Assistance 602-417-7670, include the provider's name, NPI and a brief description of the issue.




Transaction Insight Portal (TIBCO)
Uploading Claim Attachments

Uploading Claim Attachments using the Transaction Insight Portal

The Transaction Insight Portal is a tool that gives registered providers that are servicing members enrolled in the Fee-for-Service program including, American Indian Health Program (AIHP), ALTCS and Tribal Health Program (DD THP) access to attach required documentation to any type of claim form submission.

Need a User Account: How to Request a Transaction Insight Portal Account

Regardless of how the claim was initially submitted, Paper, EDI or on the AHCCCS Online portal, the Transaction Insight Portal is the most effective way to attach required documentation to a Fee-for-Service claim.

Important:

- Each team member must have an individual TIBCO account.
- Requesting an account is easy - send your request to Servicedesk@azahcccs.gov
- Provider Identification Number,

  Important Note: Providers that are assigned a NPI number this is your primary ID number used for claim submissions and TIBCO.
- The service desk will forward confirmation of your TIBCO access code to the email address that you provide.
- Sharing of account information is **prohibited.**

275 Transaction Insight Portal Trading Partner Agreement

- AHCCCS FFS providers are not limited to using the AHCCCS TIBCO application. Did you know that your billing company or clearing house can request to become a 275 Transaction Insight Portal Trading Partner with AHCCCS. The AHCCCS Information Services Division (ISD) Service Desk is the first point of contact for all questions related to submission of electronic transactions and data
- The preferred method of contact is email. All inquiries/requests will result in a Customer Support Ticket Number assignment.
- Contact information: Email: servicedesk@azahcccs.gov
- If you are interested in signing up to become a 275 Trading Partner, please review the guide below:

www.azahcccs. gov/Resources/Downloads/EDIchanges/CCICompanionGuide.pdf




Reminder:
Participating Provider Reporting Requirements

Participating Provider Reporting Requirements

As a reminder the following provider types must be report on each claim submission the participating provider qualifier details with each clinic visit.

The participating provider qualifier codes and details must be entered in the ***Additional Information field*** on the CMS 1500 and 837P EDI form.

- Provider Types (PT):
  - Integrated Care Clinic (IC),
  - Behavioral Health Outpatient Clinic (77) and,
  - Clinic (05)

Participating Provider Reporting Requirements (cont.)

- Providers must follow the requirements outlined in Exhibit 8-2 in the AHCCCS IHS/Tribal Provider Billing Manual for the participating provider reporting requirements and billing instructions for proper claims submissions.
- ***Effective July 1, 2023***, any claim filed without the participating provider information will be systematically denied.
- *Claims submitted with the organization's NPI listed as the participating provider in the Additional Information field will deny.*
- IHS/Tribal Provider Billing Manual, Exhibit 8-2 Participating Provider Information

Participating Provider Claim Denial Edits

Claims that do not include the required participating provider information will deny and the submitter must correct the data fields and submit a replacement claim.
The replacement claim must include all required documentation.

Common Claim Edit Denials for participating provider information

H482.1 NPI Missing or invalid; field is missing.

H482.7 NPI Missing or invalid; not valid for provider.

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/QuickGuideHowtoCompletetheParticipatingProviderReportingInformation.pdf

Participating Provider Reporting Errors

Example 1. XX123B456789Jones, Tom

The NPI number consist of 9 numbers only. When reporting the NPI number of the participating provider, Alpha characters should not be entered as part of the NPI.

Example 2. XX9999999999Jones,Tom

Non-registrable provider types are identified by (10) consecutive 9's. The XX qualifier code is not used to report services for a non-registrable provider type (i.e BHT).

Example 3. XX12345678900Jones,Tom

AHCCCS registered provider who have a NPI number, the XX qualifier code is entered first, followed by the provider's 10-digit NPI number, next the provider's last name, comma, space and first name.

Provider Work Number (PWK)

Provider Work Number (PWK)

1. The PWK Number is created during the initial submission of the claim and is populated on the Attachment tab.

2. The PWK number can also be created if the provider is using their own software, billing company or clearing house to submit the claims.

3. Did you know providers can submit a “trading partner agreement” request to set up the 275 Transaction Insight application using your software/app.

4. The PWK number (**A12345678032720**24) is unique to each claim submission including when a replacement claim is submitted.

5. If the same PWK number (**A12345678032720**24) is used for the replacement claim, the documents will link to the first claim. To link documents to the replacement claim, there must be a unique character at the end, for example (**A12345678032720**24**R1**). It is the provider's choice how to make the PWK number unique when submitting a replacement or correction claim.




Billing Reminders:
Third Party Liability Claims

Medicaid and Third-Party Liability

Medicaid enrolled members that have Third Party Liability (TPL) other than Medicare as their primary payer, AHCCCS Administration's reimbursement responsibility is limited to no more than the difference between the AHCCCS capped fee and the amount of the first- or third-party payers payment.

Third Party Liability (TPL) Secondary Claims

- **Filing a Reconsideration:**
  - Providers must follow the primary payer's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the primary payer's appeal decision for consideration of reimbursement of the FFS claim.
  - If the claim is reaching the timely filing period and has not been processed by the primary payer, providers may submit the claim to AHCCCS to meet the FFS timely filing timeframe, pending the finalization of the claim by the primary payer.
  - The processing of the claim by the primary payer does not extend the timely filing period with AHCCCS FFS.

Medicare Billing and Claims Processing

Medicaid and Medicare Cost Sharing

Medicaid enrolled members who have Medicare as their primary payer, AHCCCS may only be responsible for the *copay, coinsurance and deductible* amounts listed on the Medicare Remittance Advice.

To review the billing information for Medicare and TPL claims please visit:

IHS Tribal Provider Billing Manual Chapter 7 Medicare/TPL

Reminders: Billing Medicare Secondary Claims

- Medicare pays first for members enrolled in Medicare Parts *A ,B, C and D* coverage.
- Medicare secondary claims refers to any claim for which AHCCCS is the secondary payer after Medicare and any other third-party payers.
- The amount considered by AHCCCS Medicaid will be the copay, coinsurance or deductible as indicated on the MEOB.

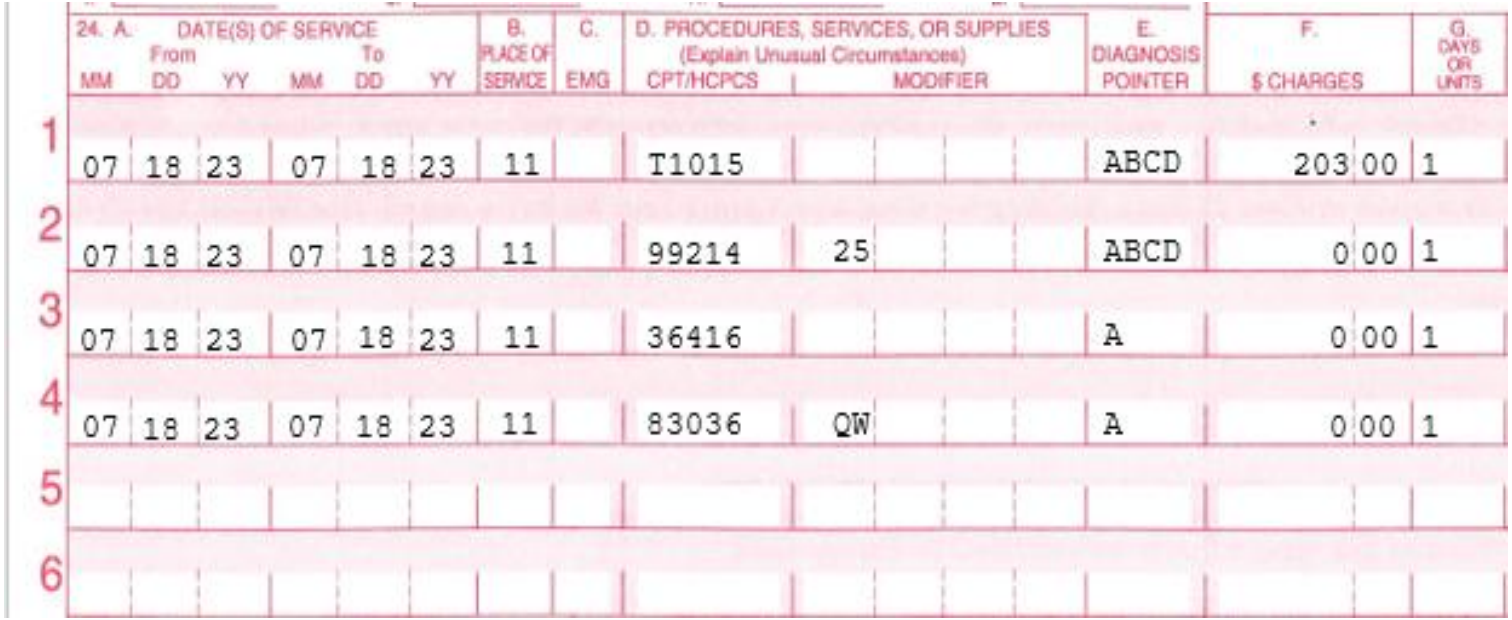
Reminders: Billing Medicare Secondary Claims (cont.)

- AHCCCS will consider Medicare secondary claims even if the claim includes procedures that were not covered by Medicare.
- Medicare claims that were not automatically crossover to AHCCCS, a copy of the MEOB is required with each claim submission.
- All services billed to AHCCCS are subject to Medicaid policy and are subject to review.

Example: Medicare Primary Claim Service Code T1015

In this example the provider submits a primary claim to Medicare Part B.

The claim was billed with the CPT codes T1015, 99214, 36416 and 83036.



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1	07	18	23	07	18	23	11		T1015		ABCD	203 00	1
2	07	18	23	07	18	23	11		99214	25	ABCD	0 00	1
3	07	18	23	07	18	23	11		36416		A	0 00	1
4	07	18	23	07	18	23	11		83036	QW	A	0 00	1
5													
6													

Example: Medicare Primary Claim Service Code T1015

In this example the provider submits a primary claim to Medicare Part B.

The claim was billed with the CPT codes T1015, 99214, 36416 and 83036.

- The Total billed amount $203.00,
- CO-45 Medicare contractual write off amount is $116.82 (this is the amount that exceeds Medicare's fee schedule for the CPT code(s),
- CO-253 $2.02 (Sequestration this is the reduction in federal payment and not included in the payment).
- Medicare total combined payment for each line of service is $98.78
- PR-2 Balance remaining or due is the **Medicare coinsurance amount $54.40**
- To verify the total amount approved by Medicare, add the Medicare paid amount, deductible and coinsurance amounts as shown on the MEOB.

How to Submit a Reconsideration Request for a Medicare Crossover Claim

- If Medicare adjusted a previously paid claim, and there is no change in the coding details a replacement claim is not needed.
- Providers will only need to submit a copy of the original MEOB and a copy of the adjusted MEOB with the reconsideration request.
- This information can be submitted with a cover letter indicating the details regarding the submission of the adjusted MEOB for reprocessing via the 275 Transaction Insight Portal (TIBCO).




Submitting a Non-Medicare Crossover Claim

Non-Medicare Crossover Claims

If the "**crossover**" **claim is not** automatically transmitted from **Medicare** and received by Medicaid, then the provider must **submit** a claim to Medicaid. The submission must include a copy of the Medicare EOB for processing.

- AHCCCS timely filing requirements will apply to secondary claims.

Submitting Medicare Secondary Claims

- When submitting a secondary claim, providers must include the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* information identifying why Medicare denied the claim, this may be due to exhausted benefits, medical necessity or eligibility, or another reason that may apply.
- **Reconsiderations:**
  - Providers must follow Medicare's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the Medicare appeal decision for consideration of reimbursement of the claim.

Reminders:
Required Documentation for Outpatient Behavioral Health Claims

BH Documentation Requirements

- The Arizona Health Care Cost Containment (AHCCCS) recommends that before you submit a claim or any medical records that have been requested, you ensure that the medical records for that specific service meet Medicaid's guidelines for signatures.
- Documentation must meet AHCCCS signature requirements. The AHCCCS clinical review team checks for signed and dated medical documentation that meets the signature requirements. If entries aren't correctly signed and dated, AHCCCS may deny the claim.
- Documentation must have enough information to show the date the service was performed and by what practitioner.
- Providers must make sure that all staff involved in the billing process including if you are using a billing service that they are trained to identify where signatures are necessary and understand the importance of obtaining them before the claim and documents are submitted for review.

Required Documentation for BH Outpatient Claims

As a reminder, the following documentation must be submitted with each outpatient behavioral health claim for all services billed on each date of service:

- Signed Consent to Treat form,
- Comprehensive Assessment,
- Treatment plan, and
- Medical record documentation.

This requirement is for but not limited to the following provider types:

- Integrated Clinic (IC),
- Behavioral Health Outpatient Clinic (77), and
- Clinic (05).

Reporting same day services on separate claim submissions can result in denial of services

Common Documentation Denial Errors

Common Denial Errors - Member Missing Information

- The submitted documentation does not identify the **member, date of birth and or AHCCCS ID** on every page of the documentation.
- Missing member signature – consent to treat form.
- The first page of the documentation must include the primary identifier which is the AHCCCS Medicaid member ID, first and last name and date of birth.
- Each subsequent page of the documentation must identify at a minimum two of the following elements, AHCCCS member ID, first and last name and date of birth.
- If this information is missing, corrective action is required by the provider to resolve the claim before the claim can be adjudicated.

Missing Provider Signature Denial

- The denial edit code AD282 Missing Provider Signature identifies the documentation submitted does not meet the necessary requirements for processing.
- It is the provider's responsibility to review each page of the documents that were uploaded to determine which document is in non-compliance.
- Providers must address these issues by reviewing and ensuring that all required documentation is properly signed by the authorized individual before claim submission.

Common Provider Signature Denials

- The provider's signature is not present on the required forms or documents that were submitted with the claim.
- The signature provided is illegible or does not match the signature on file.
- The documentation may have a signature, but it lacks the necessary credentials or titles.
- The provider must take corrective action by obtaining a signature that meets all necessary criteria and updating any relevant records.

Documentation Review for Behavioral Health Outpatient Claims

- The quickest and most efficient way to attach your documentation for review is to use the Transaction Insight Portal (TIBCO).
- For payment reviews, documentation is required and to help expedite the review process, we suggest that providers insert a “title sheet” identifying each document type that is uploaded followed by the documents.
- The documents should be attached as a single file upload.
- All combined services rendered on each day billed to FFS will require documentation to include physical services rendered and any services units billed.




DFSM Provider Education and Training Unit

DFSM Provider Education and Training

Our goal is to help providers understand billing policy and successful claim submission for the FFS program.

- The provider training team offers eLearning and video training presentations on specific topics which are in a self-paced format that allows providers to access trainings.
- We encourage the attendance of billing staff and agencies, practitioners and others.
- Let us know what you need.

DFSM Provider Education and Training

The provider training schedules are posted quarterly on the DFSM Provider Education Web page and registration is required to attend.

- DFSM Provider Training includes at any time and provide important information about how to use the AHCCCS Online Provider portal and the Transaction Insight Portal, recorded webinars and job aids for FFS providers.
- Courses can be attended remotely from any location via Zoom. To register for a session, click on the "Zoom Registration Link".
- For additional training videos, providers can visit the AHCCCS Medicaid YouTube Channel.

IHS 638 Provider Billing and Policy Resources

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/
- https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/MemoUnwindingFluandCovidAIRs.pdf

Thank You.