

## CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

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### Genetic Testing Requires Prior Authorization

AHCCCS Fee-For-Service has identified an increase in claim denials for laboratory providers billing for genetic testing.

The AHCCCS Medical Policy Manual (AMPM) Policy 310-N advises that:

“All genetic testing requires prior authorization. Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations.

Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such diagnoses would not definitely alter the medical treatments of the member.”

Refer to Policy 310-N for further coverage limitations, available online at:

<https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf>

***The ordering physician must request prior authorization.*** The laboratory provider's claim for the genetic testing will be denied unless the prior authorization is on file with AHCCCS.

### Tribal Regional Behavioral Health Authority Provider Notification

TRBHA Providers:

Effective 07/01/16 Behavioral Health providers submitting authorization requests for services rendered to Tribal Regional Behavioral Health Authority (TRBHA) members should submit Certification of Need documents and Recertification of Need documents directly to AHCCCS' Division of Fee-For-Service Management (DFSM). This change is being implemented in order to improve the efficiency and timeliness of the TRBHA authorization process.

All TRBHA authorization requests must be *faxed* to 602-364-4697 using the Fee-For-Service (FFS) Authorization Request form as the coversheet to the documentation being submitted. To avoid returned documents or delays in receipt of your requests please ensure that the completed FFS Authorization Request form is used as the cover

sheet to your faxed documentation and that you have selected BHS and TRBHA as your document type.

## Dental Review Process Change for Deep Sedation/General Anesthesia

AHCCCS Fee-For-Service (FFS) will be transitioning from prospective review to retrospective review of dental services performed under deep sedation/general anesthesia **beginning August 1<sup>st</sup> 2016**. The intent of this change is to improve the timeliness of service delivery to AHCCCS Fee-For-Service (FFS) plan members, and to reduce the administrative burden associated with an increased volume of service requests.

Beginning on **August 1<sup>st</sup> 2016** dental providers performing services under deep sedation/general anesthesia should submit their claims electronically to the FFS Claims area with the following documentation:

- Dentist's Substantiation of Necessity of Services Through Depiction of Dental Condition
- Dentist's Treatment Plan and Schedule
- Radiographic Images Fully Depicting Existing Teeth and Associated Structures by Standard Illumination When Appropriate.

*\*Please note that Fee-For-Service claims found to have been reimbursed incorrectly are subject to recoupment.*

**This change does not impact existing prior authorization requirements for other dental services.** Please continue to submit dental prior authorization requests using the completed Fee-For-Service Authorization Request form as the coversheet to your documents for the following dental services *at least 7 days in advance of the date of service*:

- Removable Dental Prosthetics (including complete and removable partial dentures)
- Cast Crowns
- Orthodontia Services
- Pre Transplant Dental Services

Services requiring Prior Authorization should be mailed to the AHCCCS FFS Prior Authorization area with the following documentation:

- Completed Fee-For-Service Authorization Request form
- Dentist's Substantiation of Necessity of Services Through Depiction of Dental Condition
- Dentist's Treatment Plan and Schedule

- Radiographic Images Fully Depicting Existing Teeth and Associated Structures by Standard Illumination When Appropriate. If radiographs are unavailable please document why.

Dental authorization requests should be mailed to:  
AHCCCS DFMS – Prior Authorization: Dental  
Mail Drop # 8900  
701 E. Jefferson Street  
Phoenix, AZ 85034

Fee-For-Service Authorization Request Forms Can be Found at:  
<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html>

Please direct Prior Authorization or Claims/Billing inquiries to:  
Fee-For-Service Prior Authorization Line: 602-417-4400  
Fee-For-Service Claims Customer Service: 602-417-7670

## Claims Customer Service Tips

### Understanding APR-DRG

All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems is used to categorize each inpatient stay based on the first 12 diagnosis codes billed. Each inpatient hospital claim will be assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category.

Reconsideration requests for DRG payment must include a copy of the actual 3M Version 31 calculation grouper detail sheet that indicates how the expected payment is calculated.

### Claim resubmission: reminder

Claim resubmissions must include the original claim reference number (crn):

- In field 22 of the CMS 1500 form
- In field 64 of the UB-04 form

Failure to include the original crn will result in a timely filing denial.

### Same day admit/discharge hospital claims

CPT/HCPCS coding must be billed for the Outpatient Fee Schedule (OPFS) payment methodology. Incorrect payment amount may result if the facility fails to include the required CPT/HCPCS coding.