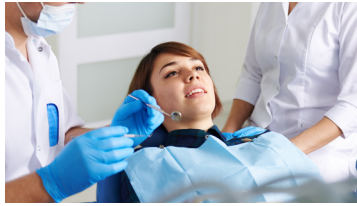


October 2017

Dental Benefits

Is dental a covered benefit?

Beginning on October 1st, 2017, AHCCCS Fee-For-Service members who are 21 years of age and older will receive a dental benefit of \$1,000 per member, per contract year (October 1st to September 30th). This benefit will cover emergency dental care and extractions, and is not applicable to routine diagnostic, therapeutic, or preventative care, such as routine cleanings. A dental emergency is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma. Any unused benefits will not be permitted to “carry-over” into the next contract year.



Previously ALTCS and Tribal ALTCS members received \$1,000 per contract year for medically necessary dental care. This benefit had been set up to cover diagnostic, therapeutic, and preventative care. With the addition of the emergency benefit, all ALTCS members will now have two dental benefits. They now have a \$1,000 fund per member, per contract year for their diagnostic, therapeutic, and preventative care, and they have another \$1,000 fund per member, per contract year to cover emergency dental care and extractions. Any unused benefits will not be permitted to “carry-over” into the next contract year. For further information, please see AHCCCS Medical Policy Manual (AMPM) 310-D1 and 310-D2.

This benefit will also affect AHCCCS ALTCS and Tribal ALTCS members.

DFSM BILLING TIPS

Common Occurrences Seen With Claim Submittals

Billing -59 Modifier

The FFS Provider Billing Manual Chapter 10 Professional and Technical Services, page 10-2 advises:

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service.

Claims submitted to AHCCCS utilizing modifier 59 will be subject to Medical Review. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499)

Claims billed with a 59 modifier incorrectly will be denied.

DID YOU KNOW?

The PWK number is a unique number that is created by the provider for each electronic claim and it's attachment in order for the AHCCCS system to link an attachment to the correct claim.

PROVIDER EDUCATION DATES

- Online Claim Submission: Professional Claims
10/5/2017
2:30 – 3:30 PM
- Online Claim Submission: Institutional Claims
10/12/17
2:00-3:00 PM
- IHS/638 Quarterly Forum
10/18/2017
1:30 – 3:00 PM
- Non-Emergency Medical Transportation
10/19/2017
2:30 - 3:00 PM
- All Inclusive Rate
10/26/2017
2:30 - 3:00 PM

UPCOMING HOLIDAY

- 10/9/2017 Columbus Day

ELECTRONIC PAYMENT SIGN UP

Contact:
ISDCustomerSupport@azahcccs.gov
-OR-
Call 602-417-4451

CONTACTS

- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670
- Provider Registration Process Questions - (602) 417-7670 Fax Applications (602) 256-1474
- Technical Assistance with Online Web Portal Please email ProviderTrainingFFS@azahcccs.gov

HOME HEALTH SERVICES

Face to face requirements for home health services, medical equipment, and supplies.

Effective 10/1/17, face-to-face encounter requirements pursuant to CFR §440.70 will apply to Home Health Services and Medical Equipment and Supplies ordered for FFS members.

A face-to-face encounter between the member and practitioner will be required within 90 days prior or 30 days following the start of home health services, and within the 60 days prior to an initial order for medical equipment or supplies.

The face-to-face encounter must be conducted by one of the following:

- The ordering physician,
- A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the physician in accordance with state law ,
- A physician assistant under the supervision of the ordering physician, or
- For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

Additional information will be forthcoming in Constant Contact.

More information, please see [Face to Face Training](#).



NAME THAT POLICY!



AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Emergency eye care which meets the definition of an emergency medical condition is covered for all members. For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, KidsCare Program and for adults when medically necessary following cataract removal. Refer to AMPM Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

AMPM Policy: 310-G EYE EXAMINATIONS/OPTOMETRY SERVICES

For more information on the policy, see the [Medical Policy Manual](#)