

September 2019

## Additional Trainings Added for 3rd Quarter

Two additions to the third quarter training schedule have been made. There will be a Behavioral Health Services update training on September 24th, 2019 and an additional training on Claims Disputes and Appeals on September 17th, 2019.

### **Behavioral Health Services Update**

Discussion of policy updates to AMPM 310-B, Behavioral Health Services; AMPM 320-T, Non-Title XIX/XXI Services; and the Behavioral Health Services chapters of the Fee-for-Service and IHS Provider Billing Manuals.

WebEx only training: September 24th, 2019 – Tuesday – 10:00 am to 10:30 am

### **Office of Administrative Legal Services – Claims Dispute Process**

What is the Claims Dispute Process? An overview of what are valid claims disputes, ways to resolve disputes, the time frames involved, and edit denial reasons.

WebEx only training: September 17th, 2019 – Tuesday – 9:00 am to 10:30 am

[Register](#)

## Assistant Surgeon Modifier AS and Modifier 80 Notification

AHCCCS has updated their billing policy documentation, to ensure consistency with coding practices related to the use of the AS/80 modifier combination for Physician Assistant (PA), Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) provider types.

Effective 9/1/2019, AHCCCS has updated the Fee-for-Service Provider Billing Manual to correctly reflect that only modifier AS will be needed, as appropriate, for these provider types when they serve as an assistant at surgery services.

The Fee-for-Service Provider Billing Manual has been updated with the below information:

### **MULTIPLE SURGEONS/ASSISTANTS**

If multiple surgeons participate in a surgery, the appropriate modifier is necessary to ensure proper payment of claims.

80 Assistant Surgeon

- 81 Minimum Assistant Surgeon
- 82 Assistant Surgeon (when qualified resident surgeon not available)
- 62 Two Surgeons
- 66 Surgical Team
- AS PA, NP, or CNS served as the assistant at surgery

If multiple providers bill for the same procedure without modifiers, all but the first claim received will be denied as duplicates.

**Modifier 80 - Assistant surgeon services shall be identified by adding modifier 80 to the procedure. This modifier pertains to physician's services only. A physician's surgical assistant services may be identified by adding the modifier 80 to the usual procedure code.**

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### **CONTACTS**

For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at [ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov).

- 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

### **ELECTRONIC PAYMENT SIGN UP**

Contact: [ISDCustomerSupport@azahcccs.gov](mailto:ISDCustomerSupport@azahcccs.gov) -OR- call 602-417-4451

## Assistant Surgeon Modifier AS and Modifier 80 Notification Continued

This modifier describes an assistant surgeon providing full assistance to the primary surgeon, and is not intended for use by non-physician providers.

Modifier 81 - Minimum assistant surgeon services shall be identified by adding modifier 81 to the procedure, and it is only submitted with surgical codes. It describes an assistant surgeon providing minimal assistance to the primary surgeon. This modifier pertains to physician's services only and is not intended for use by non-physician providers.

Modifier 82 - Assistant surgeon services, when a qualified resident surgeon is not available, shall be identified by adding modifier 82 to the procedure. This modifier applies to physician's services only. The unavailability of a qualified resident surgeon is a prerequisite for use of this modifier and the service must have been performed in a

teaching facility. Documentation must include information relating to the unavailability of a qualified resident in this situation. Only teaching hospitals may submit this modifier. This modifier is not intended for use by non-physician providers.

Modifier AS - Use the modifier "AS" for assistant at surgery services, when services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). The provider must accept assignment.

*NOTE: A Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) should not submit the "AS" modifier. This modifier is only valid for use by non-physician practitioners (NPP) when billing under their own provider number*

## Multi-Specialty Interdisciplinary Clinic Update MSIC

The Fee-for-Service Provider Billing Manual and the IHS Provider Billing Manual have been updated with information for MSIC's. The update is below.

### MULTI-SPECIALTY INTERDISCIPLINARY CLINIC

Multi-Specialty Interdisciplinary Clinics (MSIC) bring many specialty providers together in one location. For children with a CRS designation, or who formerly had a CRS designation, AHCCCS has an established rate schedule available on the [AHCCCS website](#).

MSICs are flagged in the AHCCCS system to ensure the appropriate rates are paid. For dates of service on or after October 1st, 2018, MSICs should follow the below billing guidelines (regardless of their currently registered Provider Type for the MSIC).

#### Claim Form

MSICs may submit claims using the:

- CMS 1500 Claim Form (or the 837 Professional Format)
- ADA 1200 Claim Form (or the 837 Dental Format)

Only these Form types will permit reimbursement using the MSIC fee schedule, including reimbursement of the T1015 procedure code.

For dental visits billed on either the ADA Form or the 837 Dental format, the MSIC may separately submit the

T1015 procedure code on a Form 1500.

The MSIC may include all services provided to a member on a single date of service on one or multiple claim forms. If multiple claim forms are used, the MSIC NPI must be used as the rendering provider on each claim.

#### Rendering Provider

MSICs should use the MSIC NPI as the rendering provider for the claim.

*NOTE: Reimbursement for T1015 (MSIC Service Coordination Payment) as well as use of the MSIC fee schedule will only apply when the MSIC is the rendering provider, which is triggered by the MSIC NPI.*

#### Billing T1015 for CRS Members

MSIC-eligible visits may be billed with a T1015 procedure code once per day, per MSIC, and only when the member is a current CRS or former CRS member.

Multiple visits in the same day by a single MSIC are eligible for only one T1015 code payment.

The T1015 procedure code may be added to any of the claims which account for the member's visit on a single date of service, or may stand alone on a separate claim form.

It is preferred that the MSIC bill utilizing the member's assigned AHCCCS ID. However, AHCCCS will accept a

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## Multi-Specialty Interdisciplinary Clinic Update MSIC Continued

claim if the historically-assigned CRS ID is utilized.

### Reimbursement

If the MSIC bills a rate for a CRS or former CRS member that is less than the AHCCCS MSIC fee schedule, the AHCCCS “lesser of” reimbursement policy will prevail and cause the claim to be paid at billed charges rather than the MSIC fee schedule rate.

If no covered procedure codes are reported for the T1015 date of service, no T1015 reimbursement will apply.

Services which are typically “incident to” a visit, such as lab, radiology, immunizations or other testing, and pharmacy, but are not provided on the same date of service as a visit, are not eligible for T1015 reimbursement.

### Professional Practitioner

In order to retain information related to the actual professional practitioner participating in or performing services associated with MSIC visits, the professional practitioner must also be reported on all claims as outlined below.

Reporting the professional (provider) participating in/ performing services:

CMS Form 1500 (Paper Claim): ITEM NUMBER 19 - TITLE: Additional Claim Information (Designated by NUCC)

837 Professional (Electronic Claim) and 837 Dental (Electronic Claim): 2300 NTE Loop

One Participating or Performing Provider –  
XXProviderNPI(if a registerable Provider) or  
9999999999(if not a registerable provider)  
ProviderName (last, first 20 characters)

Up to Two Participating or Performing Providers may be reported on a single claim –  
XXProviderNPI(if a registerable Provider) or  
9999999999(if not a registerable provider)  
Provider Name (last, first 20 characters) 3  
blanks XXProviderNPI(if a registerable Provider) or  
9999999999(if not a registerable provider)  
ProviderName (last, first 20 characters)

ADA Form (Paper Claim): Field 35. Remarks

One Participating or Performing Provider –  
XXProviderNPI(if a registerable Provider) or  
9999999999(if not a registerable provider)  
ProviderName (last, first 20 characters)

Up to Two Participating or Performing Providers may be reported on a single claim –  
XXProviderNPI(if a registerable Provider) or  
9999999999(if not a registerable provider)  
Provider Name (last, first 20 characters) 3  
blanks XXProviderNPI(if a registerable Provider) or  
9999999999(if not a registerable provider)  
ProviderName (last, first 20 characters)

| Loop | Element | Description<br>837-P 5010 A1 ENC | ID | Min.<br>Max. | Use | Note                    | AHCCCS Usage/Expected<br>Value (Codes/Notes/Comments)   |
|------|---------|----------------------------------|----|--------------|-----|-------------------------|---|
| 2300 | NTE     | CLAIM NOTE                       |    | 1            | S   |                         |   |
| 2300 | NTE01   | Note Reference Code              | ID | 3-3          | R   | Utilize assigned values | Expect 'ADD' – Additional Information   |
| 2300 | NTE02   | Claim Note Text                  | AN | 1-80         | R   | Expect Claim Note Text  | One Participating or Performing Provider -<br>XXProviderNPI(if a registerable Provider) or<br>9999999999(if not a registerable provider)Provid-<br>erName<br><br>Up to Two Participating or Performing Providers<br>may be reported on a single claim -XXProviderN-<br>PI(if a registerable Provider) or 9999999999(if<br>not a registerable provider)ProviderName XX-<br>ProviderNPI(if a registerable Provider) or<br>9999999999(if not a registerable provider)Provid-<br>erName |

## Multi-Specialty Interdisciplinary Clinic Update MSIC Continued

- Do not enter a space, hyphen, slash or other separator between the qualifier code and the number or the NPI number and the Provider Name.
- XX is the actual Qualifier Code designated by the standards body to indicate an NPI.
- When reporting a second practitioner, enter three blank spaces and then the next qualifier and number/code/Provider Name.
- At this time the reporting of Participating Providers beyond 2 occurrences is not supported, as defined in the standards for the transaction.

Generally all Billing Rules, unless noted as exceptions, apply to both Medicaid-only as well as Medicaid secondary claims. Billing instructions, with a Primary Payer other than AHCCCS to ensure appropriate processing, are outlined below.

### **When Medicare is the Primary Payer:**

Crossover claims may be received electronically from the Medicare plan with Medicare's specified coding that will not match to AHCCCS coding requirements for

the inclusion of a T1015 code. In this case the MSIC should:

- Submit a separate claim form with the T1015 code related to the visit(s), and
- Ensure that the Medicare deductible/coinsurance/copay total amounts are left blank (do not enter 0's) on the claim form.

If the Medicare claim did not electronically crossover from the Medicare plan, the MSIC may:

1. Submit the T1015 code on the related visit claim, or
2. Submit a separate claim with the T1015 code related to the visit(s). In this case, the Medicare deductible/coinsurance/copay total amounts should be left blank (do not enter 0's) on the claim form.

### **When Other Coverage Pays as Primary:**

The MSIC should either:

1. Submit the T1015 code on the related visit claim, or
2. Submit a separate claim form with the T1015 code related to the visit(s).

## Provider Enrollment Updates

### **\*\*\*UPDATE: Automated Online Provider Enrollment System to Launch in 2020**

In the spring of 2020, the AHCCCS provider enrollment process will move from a manual, paper-based system to a new, online system (the AHCCCS Provider Enrollment Portal) that will allow providers to:

- Enroll as an AHCCCS provider;
- Update information (such as phone and addresses);
- Upload and/or update licenses and certifications;
- And more, all online and in real time!

This change, from a 100% manual process to the new, automated system will streamline the provider enrollment process. Initial applications will be processed more quickly and changes to current enrolled providers will all be completed online.

The AHCCCS Provider Enrollment Portal (APEP) is anticipated to go live in the Spring of 2020. Additional information will be released closer to the

implementation date.

If you have questions please contact Provider Enrollment at:

- 1-800-794-6862 (In State - Outside of Maricopa County)
- 1-800-523-0231 (Out of State)

\*\*Please note that the "go live" date for the transition from paper based to the online AHCCCS Provider Enrollment Portal (APEP) has been moved from the Fall of 2019 to the Spring of 2020.

### **Name Change**

Did you know that the Provider Registration Unit of AHCCCS is changing its name? Moving forward Provider Registration will be called Provider Enrollment, and updates to the name will be seen across the AHCCCS website.

To access provider enrollment registration materials please visit us [online](#).

## Master PDF Documents of the Fee-For-Service and IHS/Tribal Provider Billing Manuals to Replace ZIP Files

In August of 2019, the **Zip Files** of the Fee-For-Service Provider Billing Manual and IHS/Tribal Provider Billing Manual shall be replaced by **Master PDF Documents** of both manuals.

Information contained within these Zip Files has already been transitioned into the **Master PDF Documents** available on the respective Billing Manual web pages.

[The Fee-For-Service Provider Billing Manual](#)

[FFS Master PDF Document](#)

[The IHS/Tribal Provider Billing Manual](#)

[IHS Master PDF Document](#)

This transition occurred early in 2019 and allows providers the flexibility of opening only one document, and being able to search for all topics within a single PDF.

For step-by-step instructions on how to use the master PDF documents to search for topics, please see the August edition of Claims Clues (2019).

It may be a good idea to include in the next CC, information on where to forward medical records/documents based on which dept at AHCCCS is requesting the records.

## Behavioral Health Facilities Providing Personal Care Services

Effective for dates of service 10/1/2019 and on, Behavioral Health Residential Facilities (BHRFs) who are also licensed through the Arizona Department of Health Services (ADHS) to provide personal care services may begin billing for H0018 (Behavioral health; short term residential, without room and board, per diem) with the TF modifier for personal care services.

This billing combination is only to be used by BHRFs licensed with ADHS to provide personal care services. Any member receiving such services must have had an assessment by a medical provider indicating that the member's condition requires assistance with personal care.

Please note that a BHRF that is licensed to provide personal care services should only bill H0018 with the TF modifier for members that require personal care services, as documented in their assessment and service/treatment plan.

For additional information please review AMPM Policy 320-V, Behavioral Health Residential Facilities.

## Telehealth Policy Updates

The AHCCCS Medical Policy Manual (AMPM) 320-I, Telehealth, has undergone revisions and shall remain available for Public Comment until September 28th. To review the policy and comment please visit:

<https://comments.azahcccs.gov/chapter-100-introduction/ampm-320-i-telehealth/>

This policy will become effective on October 1st, 2019.

Training sessions will be held regarding this policy throughout the 4th Quarter and are scheduled for the below dates. Providers may register for any of these sessions and may attend multiple sessions if they would like. These training sessions are for all providers regarding policy and general billing changes.

### First Training

**When:** October 2nd, 2019 - Wednesday - 9:30 am to 11:00 am (Phoenix Time)

**Location:** WebEx only.

Attendees must register in order to receive email instructions on how to join this meeting.

**Register**