

COVID-19

AHCCCS is responding to an outbreak of respiratory illness, called COVID-19, caused by a novel (new) coronavirus. Health officials urge good hand washing hygiene, covering coughs, and staying home if you are sick.

On March 11, Governor Doug Ducey issued a [Declaration of Emergency](#) and an [Executive Order](#) regarding the COVID-19 outbreak in Arizona, and subsequent [Executive Orders](#) with

further administrative actions.

To address Medicaid-related questions from providers and contractors about COVID-19, AHCCCS has developed a list of Frequently Asked Questions Regarding Coronavirus Disease 2019 (COVID-19), updated regularly as more information becomes available.

COVID-19 FAQs

Learn how to protect yourself and stop the spread of COVID-19. Visit azdhs.gov/COVID19 and cdc.gov/COVID19.

Telehealth

Important Notice: Information contained within the Telehealth Training Manual shall be transitioned into the following areas:

- AHCCCS Medical Policy Manual ([AMPM](#)) 320-I, [Telehealth Services](#).
- The Fee-For-Service (FFS) and IHS/Tribal Provider Billing Manuals
 - [Chapter 10, Individual Practitioner Services, of the Fee-for-Service Provider Billing Manual](#)

- [Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual](#)

AMPM 320-I, Telehealth Services, recently finished up a public comment period. AHCCCS is reviewing the public comments and upon finalizing our review will post updates in the AMPM.

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.
- Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the [DFSM Provider Training Web Page](#) on the AHCCCS website.
- DFSM is excited to announce the publication of a [Provider Video Library](#), available on the Provider Training Web Page on the AHCCCS website.

- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5
- Provider Registration – Fax Applications (602) 256-1474

ELECTRONIC PAYMENT SIGN UP

Electronic Payment Sign Up (Remittance Advice Sign Up/835)

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

EVV

In the summer of 2020 AHCCCS anticipates the implementation of Electronic Visit Verification (EVV) for Direct Care Worker Agencies.

Electronic Visit Verification (EVV) is mandated for all Medicaid personal care and home health services that require an in-home visit by a provider. EVV is a system in which a Direct Care Worker Agency (DCWA) will be equipped with an electronic device, similar to a smart phone, and utilize this device from the initial visit to a member's home until the visit's conclusion.

EVV is required for all AHCCCS registered Direct Care Agencies; therefore, these providers must participate in any and all upcoming meetings relating to the EVV implementation.

If you have any questions, or concerns regarding EVV please visit the [Arizona Medicaid EVV website](#).

Contact us directly at TribalALTCSinfo@azahcccs.gov if you have other questions/concerns.

APEP (AHCCCS Provider Enrollment Portal) Update

AHCCCS Provider Enrollment Portal (APEP) to Launch August 31st, 2020.

In late August of 2020, the AHCCCS provider enrollment process will move from a manual, paper-based system to a new, online system called the AHCCCS Provider Enrollment Portal (APEP). The new online system will allow providers to:

- Enroll as an AHCCCS provider.
- Update information (such phone and addresses).
- Upload and/or update licenses and certifications.

This change, from a manual process to a 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 portal is expected to be available August 31st, 2020.

For more information and Frequently Asked Questions please visit the [AHCCCS Provider Enrollment Portal web page](#).

Forward [this email subscription form](#) to anyone who would like to receive email updates regarding Provider Enrollment and the new portal.

If you have questions please contact Provider Enrollment at:

- 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)

AIMH (American Indian Medical Home)

What is the AIMH?

- The American Indian Medical Home is a care management model that puts American Indian Health Program (AIHP) members at the forefront of care.
- AIMHs help address health disparities between American Indians and Alaskan Natives in Arizona by enhancing case management and care coordination.
- AIHP enrolled members can select an AIMH when they access a participating AIMH provider or by contacting AHCCCS Division of Member Services.
- Members who join the AIMH can do so voluntarily and will have the choice to decline participation, dis-enroll or switch AIMHs at any time.

AIMH (American Indian Medical Home) Continued

Becoming an American Indian Medical Home is a simple process
that we are able to assist you with.

- Facilities who choose to become an American Indian Medical Home 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. Tier levels include annual rate increases.

First Tier Level AIMH

- Primary Care Case Management Services
- 24 hour telephonic access to the care team

PMPM Rate: \$15.18

Second Tier Level AIMH

- Primary Care Case Management Services
- 24 hour telephonic access to the care team
- Diabetes Education

PMPM Rate: \$17.46

Third Tier Level AIMH

- Primary Care Case Management Services
- 24 hour telephonic access to the care team
- Participates bi-directionally in the State HIE

PMPM Rate: \$23.76

Fourth Tier Level AIMH

- Primary Care Case Management Services
- 24 hour telephonic access to the care team
- Diabetes Education
- Participates bi-directionally in the State HIE

PMPM Rate: \$26.05

What are the Provider Requirements?

- Be a qualified IHS or Tribal 638 facility.
- Enter into an AIMH Intergovernmental agreement (IGA).
- Provide members 24 hour telephonic access to the care team.
- Obtain Primary Care Case Management (PCCM) accreditation.

- Dependent upon AIMH tier level participation:
 - Provide diabetes education
 - Participate bi-directionally in the State Health Information Exchange (HIE)

You can take the easy steps to become an American Indian Medical Home today, and we can assist you along the way.

Below are a few examples of organizations that provide accreditation for PCCM:

[The National Committee for Quality Assurance \(NCQA\)](#)

[The Joint Commission PCMH Accreditation Program](#)

[National IHS Improving Patient Care \(IPC\) program](#)

Or other appropriate accreditation body

Below are a few examples of organizations that provide accreditation for Diabetes Education Programs:

[American Association of Diabetes Educators](#)

[American Diabetes Association](#)

Or other appropriate accreditation body

Upcoming Provider Training Sessions

Additional provider training sessions will be posted in May of 2020. For the month of April in 2020, trainings are being offered on an ad hoc basis, or until the State's Declaration of Emergency regarding COVID-19 has expired.

Tuesday May 05, 2020 2:00pm – 3:30pm <u>Zoom Registration 05/05/2020 IHS/638 Tribal Forum</u>	IHS/638 Tribal Forum Discussion of policy updates, changes, or challenges AHCCCS and the IHS Facilities are experiencing. <i>This Quarterly forum will be held using Zoom or Google Hangouts Meet only.</i>
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Claim Dispute Process – Office of Administrative Legal Services

GENERAL INFORMATION

Providers should exhaust all authorized processing procedures before filing a claim dispute with the AHCCCS Office of Administrative Legal Services (OALS). It is recommended that providers follow these guidelines before filing a claim dispute.

If the provider has not received a Remittance Advice identifying the status of the claim, the provider should utilize AHCCCS Online at www.azahcccs.gov to view the claim's status to determine whether the claim has been received and processed.

Once at the website home page, click on the icon for Plans/ Providers (blue tab at top of the screen). A link on the Provider Website (AHCCCS Online) allows providers to create an account so that they can check the status of their claims.

Providers should allow 14 days following claim submission before inquiring about a claim. However, providers should inquire well before 6 months from the date of service because of the initial claim submission time frame and the time frame for filing a claim dispute.

If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim by the AHCCCS Administration may be cause for OALS to entertain a claim dispute on a pended claim provided all claim dispute deadlines are met.

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with OALS.

TIME LIMITS FOR FILING A DISPUTE

A provider must institute any claim dispute challenging the claim denial or adjudication within 12 months from the ending date of service; the date of a member's eligibility posting; or, for a hospital inpatient claim, within 12 months from the date of discharge; or within 60 days after the date of the denial of a timely claim submission, whichever is later. The date of receipt by OALS is considered the date the claim dispute is filed.

If action is taken on a timely submitted, clean claim fewer than 60 days before the expiration of the 12 month deadline or after the 12 month deadline has passed, the provider will be allowed 60 days from the date of the adverse action to file a claim dispute. The date of the "adverse action" is the status date for the claim as printed on the Remittance Advice.

Example:

03/06/2013 Date of service

05/15/2013 Initial claim denied by AHCCCS

12/16/2013 Date of resubmission of denied claim

03/04/2014 Claim is denied by AHCCCS (adverse action date)

03/06/2014 12-month claim dispute deadline (clean claim)

05/05/2014 Special 60-day claim dispute deadline

Because the denial of the claim was less than 60 days from the 12-month deadline, the provider is given 60 days from the date of the adverse action (03/04/2014) to file a claim dispute.

Federal Emergency Service Recipients

AHCCCS provides emergency health care services through the Federal Emergency Services Program (FESP) for qualified and nonqualified aliens, as specified in 8 USC 1611 et seq., who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship.

The covered services, limitations and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations and exclusions can be found in the [AHCCCS Medical Policy Manual \(AMPM\)](#) available on the AHCCCS website.

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.

“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 FESP.

Services that do not meet the federal definition of “emergency services” will be manually denied with the informational code MD034 “Emergency Criteria Not Met”. Additional information may be found in the [AHCCCS Fee-for-Service Provide manual, Chapter 18, Federal Emergency Services](#).

Medicare Savings Programs

FEE-FOR-SERVICE MEDICARE SAVINGS PROGRAMS

There are three Medicare Savings Programs:

Specified Low-Income Medicare Beneficiary (SLMB) Program

AHCCCS SLMB-PART B BUY-IN

This Medicare Savings Program pays the member’s Medicare Part B premium

Qualifications

- Receiving or eligible for Medicare Part A
- Must be an Arizona resident
- Must be a U.S. Citizen or Medicaid eligible non-citizen
- Must apply for pension, disability or retirement benefit, if available
- Income greater than 100% of the Federal Poverty Level but less than or equal to 120% of the Federal Poverty Level

AHCCCS SLMB-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. No claim payments are done by AHCCCS Administration.

Qualified Individual (QI) Program

AHCCCS QI1-PART B BUY-IN

This Medicare Savings Program pays the member’s Medicare Part B premium.

Qualifications

- Receiving or eligible for Medicare Part A
- Must be an Arizona resident
- Must be a U.S. Citizen or Medicaid eligible non-citizen
- Must apply for pension, disability or retirement benefit, if available
- Income greater than 120% of the Federal Poverty Level but less than or equal to 135% of the Federal Poverty Level
- QI is not available if one qualifies for other Medicaid Title XIX services

AHCCCS QI1-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. No claim payments are done by AHCCCS Administration.

Qualified Medicare Beneficiary (QMB) Only**AHCCCS QMB – ONLY**

This Medicare Savings Program pays the member's Medicare part A premium (when applicable), Medicare Part B premiums, Medicare (or Medicare HMO) Co-Insurance and Medicare Deductibles, and Medicare Copays.

Qualifications

- Receiving or eligible for Medicare Part A
- Must be an Arizona resident
- Must be a U.S. Citizen or Medicaid eligible non-citizen

- Must apply for pension, disability or retirement benefit, if available
- Income equal to or less than 100% of the Federal Poverty Level AHCCCS QMB – ONLY is Medicare Savings Program that pays Medicare Part A premium (when applicable) and Medicare Part B premium. Claim payments are limited to Medicare deductible, coinsurance, and copay when Medicare pays first. Claims are normally crossed over by Medicare to the AHCCCS Administration. Claims may be directly submitted to the AHCCCS Administration from registered AHCCCS providers with a matching EOMB.

* For questions regarding Medicare coverage, call 1-800-MEDICARE.

2020 All Inclusive Rate (AIR) Update

NEW 2020 ALL INCLUSIVE RATES RELEASED

The Federal Register published the new **2020** All Inclusive Rate on **April 20, 2020**. These new rates are retro-active back to **January 1, 2020**. AHCCCS will re-cycle the claims that were submitted with the **2019** AIR rate. The Claim Recycle will take place the first week of May and reflect on the following pay cycle.

The new rates were uploaded into the PMMIS system on **April 20, 2020**.

2020 inpatient rate is now \$3,675.00, increased from \$3,442.00

2020 outpatient rate is now \$479.00, increased from \$455.00

www.federalregister.gov/documents/2020/04/20/2020-08247/reimbursement-rates-for-calendar-year-2020

Only those claims submitted **January 1** through **April 30, 2020** (with the **2019** rates) will be recycled.

It will be the provider's responsibility to submit any adjusted claims with the correct rate if a claim is submitted with the **2019** AIR after **April 30, 2020**.