

July/August 2020

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.

COVID-19 Modifier Use

AHCCCS has designated the CR modifier to be used on all claims for services provided as a result of, or related to COVID-19.

It is imperative that providers begin utilizing this

modifier immediately in all appropriate instances in order for AHCCCS to identify the costs of services attributable to this emergency. All other guidance regarding use of modifiers continues to be applicable.

Long Acting Reversible Contraceptives (LARC)

Long Acting Reversible Contraceptive (LARC) devices are permitted to be separately reimbursed outside of the APR-DRG payment when billed by the Hospital on a CMS 1500 claim form with the appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code. In addition to procedure code 58300 (insertion of Intrauterine Device (IUD)), AHCCCS has identified LARC procedure codes as follows:

J7297 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg

3 Year Duration

• J7298 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg

5 Year Duration

• J7300 Intrauterine Copper Contraceptive

• J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg

Many unintended pregnancies could be prevented through the use of Immediate Postpartum LARC (IP-LARC). National organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) recommend improving access to IPLARC. Providing access to LARC in the hospital after delivery is expected to increase utilization of such devices.

Currently no ICD-10 PCS code for the LARC device exists for inpatient hospital use thus AHCCCS will pay hospitals for the device in addition to a DRG payment. For additional information, please refer to the Fee-For-Service (FFS) Provider Billing Manual, Chapter 11 Addendum – APR-DRG on the [AHCCCS Website](#).

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](#).
- The Third Quarter FFS Provider Training Schedule can be [found online](#).
- 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

Telehealth Materials on the AHCCCS Website

Telehealth information can be found on the AHCCCS website in the following locations:

- 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](#)

Trainings on telehealth are held throughout the year by the provider training team. Trainings are available on the [AHCCCS Division of Fee-for-Service Management \(DFSM\) Provider Training web page](#) 24 hours a day.

[Telehealth Training for IHS and 638 Providers:](#)

[Telehealth Training for FFS Providers.](#)

The “Four Walls” Provision and IHS & 638 Providers

For IHS and 638 providers, what services are eligible for reimbursement at the All Inclusive Rate (AIR), and which are not?

- Reimbursement depends on:
 - The provider type billing,
 - Whether or not the “4 Walls” apply to that provider type,
 - If the “4 Walls” does apply, the location of the member and provider rendering services, and
 - Whether or not the service being provided meets the definition of a clinic visit.

The “Four Walls” of an IHS/638 Clinic refer to the physical building the clinic operates within.

The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that “clinic services” do not include any services delivered outside of the “four walls” of the clinic, except if services are provided to a homeless individual.

Four Walls Applicability

1. The Four Walls provision **applies** to free-standing IHS/638 clinics:

- The AIR May Be Billed:
 - If either the member or the provider/clinician is located inside the four walls of the free-standing IHS or tribally-owned or operated 638 clinic, and the service provided meets the definition of a clinic visit/facility-defined service, the AIR may be billed the clinic.
 - NOTE: The clinic and the provider/clinician cannot both bill for the same service. Either the clinic bills for the AIR, or the provider/clinician bills at the capped FFS rate. It cannot be both.

- The AIR May Not Be Billed:
 - If neither the member nor the provider/clinician is located inside the four walls of the free-standing IHS or tribal-

ly-owned or operated 638 clinic, the service cannot be reimbursed at the AIR. It would have to be billed at the capped FFS rate (unless the service is being provided to a homeless individual).

2. The Four Walls provision **does not apply** to IHS/638 hospitals or to their hospital-affiliated (provider-based) outpatient clinics:

- Neither the member nor the provider/clinician need to be physically located within the four walls in order for the hospital or their affiliated clinic(s) to bill the All Inclusive Rate for services otherwise considered to be facility services.

Note: Either the hospital or their affiliated clinic(s) bills for the AIR under the hospital ID, or the provider/clinician bills at the capped FFS rate. It cannot be both.

3. The Four Walls provision **does not apply** to 638 FQHCs:

- Neither the member nor the provider/clinician need to be physically located within the four walls in order for the 638 FQHC to bill the APM for services otherwise considered to be clinic services.
- Note: Either the 638 FQHC bills for the APM, or the provider/clinician bills at the capped FFS rate. It cannot be both.

COVID-19 Notation: Consistent with CMS guidance, AHCCCS does not intend to review claims for services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021.

CMS released FAQs on January 18, 2017, regarding the review of services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021. This response can be found in Question #13, [in the FAQs](#).

AHCCCS will continue to follow the “Four Walls” issue since CMS is considering extending that timeline.

Billing for Telehealth and Telephonic Services as an IHS/683 Provider

Telehealth is billed [consistent with the guidance outlined in the IHS/638 billing manual](#).

IHS and 638 hospitals (including their satellite clinics) and free-standing IHS/638 clinics have the ability to bill for telehealth and telephonic services. This includes the newly released telephonic services released due to COVID-19.

The below excerpt on billing for telehealth services, as an IHS/638 provider, can be found in [Chapter 8, Individual Practitioner Services, of the IHS-Tribal Provider Billing Manual](#). **Please note** that the Division of Fee-for-Service Management has not changed the way to bill for telehealth services, but has expanded what services can be delivered via telehealth and telephonically.

Telehealth Billing Information for IHS and 638 Providers

Claim Form

Services being billed at the All Inclusive Rate shall be billed on a UB-04 claim form.

Services being billed at the Capped FFS Rate shall be billed on a CMS 1500 claim form.

638 FQHC services being billed at the Alternative Payment Methodology (APM) Rate shall be billed on a CMS 1500 claim form. For additional information on billing as a 638 FQHC please visit [Chapter 20, 638 FQHC of the IHS/Tribal Provider Billing Manual](#).

Providers

Telehealth, including Teledentistry services, may be provided by AHCCCS registered providers, within their scope of practice.

Place of Service (POS) **NOTE: To be used when billing on the CMS 1500 Claim form at the Capped FFS Rate or APM Rate. There is no POS field on the UB-04 Claim Form.

The Place of Service (POS) listed on the CMS 1500 claim form, when billing at the capped FFS Rate or APM Rate, shall be the originating site (where the AHCCCS member is located or where the asynchronous service originates).

- i.e. A member is located in their home (originating site) and the individual provider (who will submit the claim) is located in their office at a 638 clinic (distant site). The POS listed on the CMS 1500 claim (submitted by the individual

provider) will be POS 12 (Home).

NOTE: There is no POS field on the UB-04 Claim Form.

Codes

For Reimbursement at the AIR - Revenue Codes 0510, 0512 and 0516 may be submitted to AHCCCS on a UB-04 claim form. To indicate that the clinic visit (0510), a dental visit (0512) or urgent clinic visit (0516) was done via telehealth a modifier (GT or GQ) shall be included on the claim.

For Reimbursement at the Capped FFS Rate or APM Rate - For a complete code set of services, along with their eligible place of service and modifiers that can be billed as telehealth, please visit the [AHCCCS Medical Coding Resources web page](#).

Modifiers

When billing at the Capped FFS Rate, for a full list of available POS and appropriate modifiers, refer to the AHCCCS Medical Coding Resources [webpage](#).

Medicare Dual Claims

For Medicare Dual members, claims may be submitted with the POS listed as 02 (Telemedicine) to comply with Medicare guidelines. The POS 02 (Telemedicine) will designate the service being provided as a telehealth service.

- i.e. A member is located in their home (originating site) and the individual provider (who will submit the claim) is located in their office at a 638 clinic (distant site). The POS listed on the claim (submitted by the individual provider) will not be POS 12 (Home), but will instead be listed as POS 02 (Telemedicine).

NOTE: Medicare's telehealth coverage, conditions and limitations may vary from Medicaid's. However, for members with Medicare as the primary payer a claim must be submitted to Medicare first. The EOB would then be submitted to AHCCCS along with the claim. For additional information about the submission of claims for Medicare Dual members, including crossover claims, please refer to [Chapter 9, Medicare/Other](#)

AHCCCS Announces Provider Enrollment Portal (APEP) Launch Date Change

Due to a prioritized response to the COVID-19 emergency, AHCCCS has changed the launch date of the new AHCCCS Provider Enrollment Portal (APEP) to August 31, 2020.

On that date, the AHCCCS Provider Enrollment process will move from a manual, paper-based system to a new, online system. 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 an 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.

Until the automated APEP system is launched, providers are asked to use this [Provider Enrollment paper application](#).

If you have questions please contact AHCCCS Provider Enrollment at:

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

1-800-523-0231 (Out of State)

AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Fee-for-Service Health Programs

The below memo can be found on the [AHCCCS website](#).

Released: March 25th, 2020

Last Update: June 8th, 2020

This memo outlines the updated **AHCCCS Prior Authorization and Concurrent Review Standards for AHCCCS Division of Fee-for-Service Management (DFSM)** in response to Governor Ducey's declaration of a public health emergency for COVID-19 and is effective April 1, 2020, through the duration of the emergency. These changes impact members enrolled with a Fee-for-Service Program, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), and Tribal Arizona Long Term Care Services (Tribal ALTCS).

These standards are subject to change as the emergency conditions evolve.

All services reimbursed must be medically necessary, cost-effective, federally and state reimbursable, and will be subject to post-payment review.

I. Behavioral Health Services

Initial prior authorization is still required for non-emergency Behavioral Health Inpatient, Residential Treatment

Center (RTC) and Behavioral Health Residential Facility (BHRF) levels of care.

DFSM plans to extend concurrent reviews from 30 to 90 days for Residential Treatment Center (RTC) levels of care.

Clinical Staffings, Child and Family Teams (CFTs), Adult Recovery Teams (ARTs), and coordination of care between facilities and outpatient providers should continue to inform appropriate levels of care and continued stay. Telehealth and telephonic modalities are strongly encouraged for these staffings and coordination.

II. Dental Services

Dental prior authorization approvals, which are within 60 days of expiration, will be extended for 6 months.

III. Pharmacy Services

A. Refill-too-soon edits and 90 day fills

OptumRx Clinical Affairs is allowing members to refill their maintenance medications early to ensure they have an uninterrupted supply of medication during the COVID-19 emergent time as outlined below.

1. The refill-too-soon edit on all non-controlled medications has been removed.
 - a) Members may continue to fill prescriptions for up to a 30-day supply or they may fill a 90-day supply of maintenance medications, both of which may be done

continued

AHCCCS PA and CR Standards Continued

early. Members must have refills remaining on file at their pharmacy.

- b) Specialty medications, which are filled for a 30-day supply and delivered to the member's home, may be filled early for the same day's supply as previously filled.

To override for a specialty medication, IHS & 638 Pharmacies must submit the following in the NCPDP fields:

- A value of, the number, 1 in the Prior Auth Type Code Field (461-EU); and
- A value of, the numbers, 88885 in the Prior Auth Number field (462-EV).

The entry of values into both of these NCPDP fields will allow prescription claims from IHS/638 Pharmacies to override the 30 Day Supply Limit to a 60-day supply for AIR Specialty when the member has a history of the product in their claim history. The maximum days supply that may be adjudicated is for a 60-day supply.

- c) DFSM's pharmacy benefit manager (PBM), OptumRx, will continue to ensure that quantity limits and duplicate therapy edits will not cause a rejection when the prescription is refilled early.
- d) For IHS/638 Pharmacies, members may continue to obtain their chronic medications for up to a 90-day supply, for reimbursement at the AIR .

2. Controlled Substances may be refilled early when the pharmacy staff has checked with the prescribing clinician and the clinician has agreed to the early refill. The pharmacy staff or the prescribing clinician shall contact the OptumRx help desk for an immediate override.

- The opioid current maximum fill is 30-days and an additional fill would be for a maximum of 30 days.

3. Removal of prior authorization for specific therapeutic classes:

- a) Prior authorization requirements have been removed for the following Therapeutic Classes:
 - Beta2 Agonist Inhalers, Inhalant Solutions and Oral Agents
 - Inhaled Short and Long Acting Anticholinergic Inhalers
 - Long-acting Beta2 Agonist-Corticosteroid Com-

bination Inhalers

- Long-acting Beta2 Agonist-Anticholinergic Combination Inhalers
- Corticosteroid Inhalers and Inhalant Solutions
- Corticosteroid Oral Agents
- Nebulizers (must be available through pharmacies)
- Cough and Cold products
 - o Antihistamines
 - o Nasal Decongestants
 - o Combination products of antihistamines and nasal decongestants
 - o Cough suppression products including guaifenesin and combination products
 - o Guaifenesin oral tablets and combination products
 - o Analgesics/Anti-febrile products (aspirin, ibuprofen, acetaminophen, acetaminophen suppositories, etc.)
- Mast Cell Stabilizers
- Methylxanthines (aminophylline and theophylline)

For Dual Eligible Drug Plans – OTC products that are included in the drug classes above will also be added to the Dual Eligible Drug List.

B. Prior Authorization Extensions

For members enrolled in the American Indian Health Program (AIHP), Tribal ALTCS, or a TRBHA, approved prior authorizations for all medications, which are set to expire on or before May 1, 2020, will be extended for an additional 90 days. The pharmacy may have to contact the provider for an approval to request a fill of an expired prescription, but a prior authorization will not have to be submitted during the 90 day prior authorization extension.

Prior authorizations for medications with significant abuse potential (i.e. opioids) or those that are general dosed for finite durations or intermittently (i.e. hepatitis agents) will not be extended. Those PAs will follow the normal process for renewals.

C. Addressing Drug Shortages

1. The AHCCCS Drug List has preferred medications that the AHCCCS Medical Policy Manual (AMPM) 310-V specifies should be utilized prior to a non-preferred agent. In the event of a shortage, a non-preferred medication must be approved.

AHCCCS PA and CR Standards Continued

For example, ProAir is the preferred albuterol inhaler. Using ProAir as an example, if there is a shortage of ProAir, OptumRx, subject to AHCCCS' approval, will allow all other branded and generic albuterol products to be reimbursed through the pharmacy claims system without prior authorization.

- As of 3/26/20 ProAir and Tamiflu are both in short supply, and OptumRx will allow for reimbursement of all federally and state reimbursable generic and brand products.
2. Please check the FDA web links daily for shortage updates:
 - a) accessdata.fda.gov/scripts/drugshortages/default.cfm
 - b) www.fda.gov/news-events/press-announcements/coronavirus-covid-19-supply-chain-update
 3. To ensure access to care, DFSM and OptumRx shall not require a prior authorization for compounded drugs for children under the age of ten years old.

D. Signature Requirements

42 CFR 456.705 and the Arizona State Board of Pharmacy requires that members receive counseling when prescriptions are dispensed. While counseling is still required, the Arizona State Board of Pharmacy has waived the member's signature requirement, and will instead allow the pharmacist to enter confirmation that counseling occurred. This will allow members to not have to sign a document and to keep appropriate distance from the counter.

IV. Physical Health Services

A. COVID-19 Testing and Treatment Services

DFSM will not require prior authorization or concurrent review for services related to testing, diagnosis, and/or treatment of COVID-19.

B. Facility Services

1. DFSM will remove prior authorization requirements for the following levels of care:
 - Acute Inpatient hospitalization;
 - Assisted Living Facilities/Centers;
 - Skilled Nursing Facilities (SNFs); and
 - Inpatient Rehabilitation Facilities (e.g. Long Term Acute Care Hospitals).
2. FFS Providers shall coordinate care management activities to ensure FFS members have safe and effective

transitions between levels of care.

3. Prior Authorization approvals for elective inpatient services, which are within 60 days of expiration may be extended for 6 months, as needed.

C. Outpatient Services

1. DFSM may extend outpatient service prior authorization approvals, which are within 60 days of expiration, for 6 months, as needed.
2. For services related to the COVID-19 emergency, other than testing, diagnosis and treatment, the document submission period for Prior Authorization will be extended to 90 days. Covid-19 testing, diagnosis and/or treatment are exempt from Prior Authorization. Please see IV A.

V. Non-Emergency Medical Transportation (NEMT) Services

1. Prior authorization requirements have been temporarily waived for NEMT services over 100 miles.
2. AHCCCS has waived the requirement for NEMT drivers to collect a passenger's signature, whether on paper or electronically at this time.

VI. Home Health Services and Durable Medical Equipment: Face-to-Face Requirement Change

CFR § 440.70 requires that the initiation of home health services and medical equipment and supplies be subject to face-to-face encounter requirements for the FFS population. Pursuant to section 1135(b)(5) of the Social Security Act, CMS has temporarily approved an extension of the timeline required for completion of the face-to-face requirement. Effective 6/8/20, through the duration of the emergency, the face-to-face encounter does not need to be completed before the start of services, and may occur at the earliest time feasible for a provider, provided that the face to face encounter occurs within 12 months from the start of service. This is a temporary extension of the timeline for completion of the face to face requirement, and all services are subject to post-payment review.

VII. COVID-19 Frequently Asked Questions (FAQs)

We encourage everyone to please continue to check the AHCCCS COVID-19 FAQs. The [FAQs are updated daily](#).

Behavioral Health Matrix

As a reminder for our Behavioral Health Providers, the Medical Coding Resources web page on the AHCCCS website has the new and improved [Behavioral Health Services matrix](#) (Formerly B2 Matrix).

Please note this is a GUIDE only and all policy, correct coding and documentation guidelines must be met.

Instructions on how to use the Matrix:

1. The gold colored tabs have drop down options for you to search the specific pages.
2. The blue colored tabs contain all the complete information with no drop down capability.
3. Read tab 1 for the policy links and other pertinent information.
4. The revisions tab will reflect all the updates made with the

date. This “Matrix” will be updated monthly if needed. Always check the revision date on top of this page for the most current changes.

- The blue links below will take you to the correct page for the information listed. Just a reminder, Behavioral Health Services Matrix questions, changes and updates must be submitted via the Reference Table Review and Update (RTRU) Form listed on the page.

[Matrix with instructions](#)

[Update form with instructions](#)

Claim Dispute Process – Office of Administrative Legal Services (OALS)

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 <http://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.

Claim 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

NOTE: Because the denial of this example 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.

DON'T BE THE WEAK LINK IN THE CLAIM



Even if you don't submit Medicaid claims, providers who are not registered with AHCCCS, but who may be the Referring, Ordering, Prescribing, or Attending (ROPA) provider, **may keep members from getting needed health care.**

Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by **January 1, 2021.**



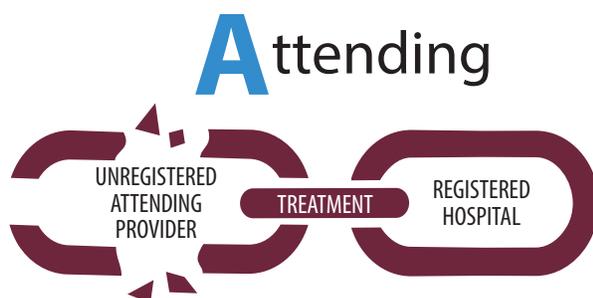
REFERRAL NOT ACCEPTED AND CLAIM FROM PHYSICAL THERAPIST NOT PAID OR MEMBER GOES WITHOUT NEEDED CARE



ORDER NOT ACCEPTED AND CLAIM FROM DME SUPPLIER NOT PAID OR MEMBER GOES WITHOUT DME



PRESCRIPTION NOT COVERED AND CLAIM FROM PHARMACIST NOT PAID OR MEMBER GOES WITHOUT PRESCRIPTION



ATTENDING NOT APPROPRIATE AND CLAIM FROM HOSPITAL NOT PAID OR MEMBER GOES WITHOUT NEEDED CARE