

March 2020

## Long Acting Reversible Contraceptive (LARC)

Effective dates of discharge on and after 10/01/2016, 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. 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

- J7307 Etonogestrel (Contraceptive) Implant System, Including Implant and Supplies

This does not apply to individuals on the Federal Emergency Services Program (FESP).

Refer to the Fee-For-Service (FFS) Provider Billing Manual, Chapter 11 Addendum – APR-DRG on the [AHCCCS Website](#).

Many unintended births could be prevented through postpartum use of Long-Acting Reversible Contraception (LARC). Offering members access to LARC devices in the hospital after delivery is expected to increase utilization of such devices since many members do not attend their 6-week post-partum office visits. Currently no ICD-10

PCS code for the LARC device exists for inpatient hospital use thus, effective October 1, 2016, AHCCCS will pay hospitals for the device in addition to a DRG payment.

## Arizona Court Care Website – Involuntary Treatment or “Civil Treatment” Process

Great news! There is a new website now available for public information regarding the involuntary treatment (civil commitment) process in Arizona. The website includes information on:

- What to do in a crisis situation – including calling non-police crisis hotlines, when appropriate.

- Forms and other resources needed.
- The process in general that can apply to any Arizona county.
- A glossary and collection of acronyms.

[azcourtcare.org/process-info/civil-commitment-process](http://azcourtcare.org/process-info/civil-commitment-process)

### 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).
- 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 First Quarter FFS Provider Training Schedule can be [found online](#).
- Prior Authorization Questions FFS PALine (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](mailto:ISDCustomerSupport@azahcccs.gov) -OR- call 602-417-4451

## Behavioral Health Residential Facility (BHRF) Notification for Codes H0031 and H2019

HCPCS codes H0031 (Mental Health Assessment, by non-physician) and H2019 (Therapeutic Behavioral Services, per 15 minutes) may not be submitted by Behavioral Health Residential Facilities (Provider Type B8) in addition to the BHRF per diem code H0018.

BHRFs receive a per diem rate for the provision of behavioral health services, and per policy, the per diem rate includes Mental Health Assessment and Therapeutic Behavioral Services as part of that rate. If there are circumstances in which other medically necessary specialized services are required, that cannot be performed by the BHRF, these services are to be billed by the provider/facility who performed the service and should not be

billed by the BHRF. The specialized service type, and the name of the provider rendering these services must be included in the member's treatment/service plan.

On 7/15/2019 of last year, AHCCCS closed H0031 and H2019 for the B8 Provider Type (BHRF) in our system.

This system update was not representative of a policy or billing change, and was only a system update. For additional information please review [AMPM Policy 320-V, Behavioral Health Residential Facilities](#).

## General Requirements for the Submission of Paper Claim Forms

When submitting paper claim forms to AHCCCS, the following are the general rules that apply to the ADA 2012, the CMS-1500, and the UB-04 claim forms:

- 1) No handwriting is permitted on any part of the claim form, including in the top margins, sides, and remarks sections. The only exception to this is the signature field, where a written signature will be accepted.
- 2) The preferred font for claim submission is Lucinda Console and the preferred font size is 10.
- 3) ICD-10 codes are required on all claim forms. Claims submitted with an ICD-9 diagnosis will be denied.
- 4) AHCCCS does not accept DSM-4 diagnosis codes. Any behavioral health service billed with a DSM-4 diagnosis code will be denied.
- 5) CPT and HCPCS procedure codes and modifiers must be used to identify other services rendered on the CMS-1500 and UB-04 claim forms.
- 6) Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system, so should not be used.
- 7) Liquid paper correction fluid ("White Out") may not be used.
- 8) Correction tape may not be used.
- 9) Labels and stamps on claim forms will not be accepted. The only exception to this is in the signature field, where a stamped signature will be accepted.
- 10) When submitting claims via fax it is recommended to fax in the following order: The claim form (UB-04, ADA-2012, or CMS-1500) first, the Explanation of Benefits (EOB) second (if applicable), and any applicable medical documentation third.
- 11) Instructions on filling out each individual claim form type can be found in the Fee-For-Service [Provider Billing Manual on the AHCCCS website](#).

## Tribal ALTCS Web Page

AHCCCS has updated its [Tribal ALTCS web page](#). Information contained on the web page includes:

- An overview of the Tribal ALTCS health plan benefits;
- A listing of Tribal ALTCS programs and contact information;
- Prior Authorization information;
- Tribal ALTCS Case Management Resources;
- Provider Enrollment Information; and
- [Tribal ALTCS Notifications](#) (sent out via Constant Contacts).

Additionally Tribal ALTCS programs and Case Managers are invited to sign up to receive email news alerts from the Division of Fee-for-Service Management (DFSM). These email news alerts are periodically sent out regarding changes to the program, benefits, policies, billing rules and rates updates. Sign up [here](#).

## Billing Reminders for the CMS 1500 and UB-04 Claim Forms

When either the CMS 1500 or UB-04 claim form is filled out, **the applicable ICD indicator must be entered**. If the ICD indicator is not entered, the claims' system is unable to identify which version of the ICD codes is being report.

In regards to field 21 of the CMS 1500 claim form, the below biling manual update will appear on 10/1/18 in the CMS 1500 chapter of the [FFS Provider Billing Manual](#):

### 21. Diagnosis Codes Required

Enter at least one ICD diagnosis code describing the member's condition. Behavioral health providers must not use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

**ICD Ind. Field:** Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM

9 = ICD-9-CM (no longer accepted)

If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

Enter the ICD indicator between the vertical, dotted lines in the upper-right hand area of the field.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												ICD Ind.	
A	B	C	D	E	F	G	H	I	J	K	L		

In regards to field 66 on the UB-04 claim form, the applicable ICD indicator must be entered in the indicated area below (it is indicated by an X highlighted in green).

66. DX	67	A	B	C	D	E	F	G	H
X	I	J	K	L	M	N	O	P	Q

### Paper Claim Reminders

When submitting paper claims please remember the following:

1. Claims that are not legible or that are not submitted on the correct form will be returned to providers without being processed.
2. Black and white paper copies of the CMS-1500 and UM-04 Claim Forms will be returned to the provider.
3. Claims that contain the following are not legible on the imaging system and cannot be read:
  - Highlighter marks,
  - Color marks,
  - Copy overexposure marks, and/or
  - Dark edges.

4. Blurred font is not legible. AHCCCS has been receiving a large number of claims where the font is blurred.
5. Stamps should not be placed in the claim fields. This can prevent the imaging system from reading the claim correctly.
6. Resubmissions do not need to have the word resubmission written on them. The claims system will mark it as a resubmission based on the included CRN.
7. Information must be aligned in the proper box/field on the claim form. Claims that are not aligned correctly cannot be read by the claims imaging system, and the submitted claim may not be read correctly. Aligning fields correctly allows for expedient and correct claims processing and reduces errors.
  - Personal printing of claim forms may result in claim fields not aligning correctly.
  - Misaligned printers can result in claim fields not aligning correctly.

Example of a misaligned claim:

24. A	DATE(S) OF SERVICE		B. PLACE OF SERVICE	C. PROCEDURE, SERVICE, OR SUPPLY (EXAM, TRANS, OBSERVATION)	D. PROCEDURE, SERVICE, OR SUPPLY (EXAM, TRANS, OBSERVATION)	E. DIAGNOSIS	F. CHARGES	G. CPT	H. ICD	I. ICD	J. RECORDING PROVIDER ID #
	FROM	TO									
1	01	01	18	01	01	18	CPT	100	1	NP	#####
2	01	01	18	01	01	18	CPT	100	1	NP	#####

8. Please do not staple claims forms and documentation together.
9. On the CMS 1500 Claim Form:
  - The diagnosis box, field 21, on the CMS 1500 claim form must be filled out correctly. One example that has been seen frequently and recently is diagnosis A will be filled out and diagnosis C will be filled out, but diagnosis B is skipped. Diagnosis B should be filled out before moving on to diagnosis C.
  - The applicable ICD indicator must be entered in field 21 in the ICD Ind. Field on the upper right portion of the box.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)												ICD Ind.	
A	B	C	D	E	F	G	H	I	J	K	L		

10. On the UB-04 Claim Form: The diagnosis box, field 66, on the UB-04 claim form must be filled out correctly. The applicable ICD indicator must be entered in the indicated area below (it is indicated by an X highlighted in green).

66. DX	67	A	B	C	D	E	F	G	H
X	I	J	K	L	M	N	O	P	Q

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

In August 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.

\*\*Date updated May 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)

## New Standards and Reporting Requirements for Opioid Treatment Programs

As a result of ARS 36-.2907.14, (SB1525) AHCCCS and its contracted health plans are implementing new standards and reporting requirements\* for all Opioid Treatment Programs (OTPs) receiving AHCCCS reimbursement. These new standards and reporting requirements are in addition to all State or Federal licensing and registrations requirements.

New OTP Sites:

- On August 27th of 2019, newly-established OTP sites were required to submit to and obtain AHCCCS approval for all the plans listed below along with a checklist (to be developed). AHCCCS approval of each plan is required prior to the provision of AHCCCS reimbursable services for these new OTP sites. If approved, the new OTP site will be required to submit an annual report containing all of the identified plans and checklist in November of each year.

Existing OTP Sites:

- Existing AHCCCS registered OTP sites are to submit/update annual reports each November.

Plans required from the OTPs include:

1. Detailed security plan
2. Neighborhood engagement plan
3. Comprehensive plan to demonstrate how the OTP ensures that appropriate medication-assisted standards of care are met
4. Community relations and education plan
5. Current diversion control plan

[Bullet pointed document listing the standards for designating 24/7 access points for treatment of Opioid Use Disorders Statewide.](#)

[Additional information on OTP topics](#)

*\*OTPs not required to hold Arizona Department of Health Services (ADHS) licensure are exempt from the requirements.*

## Electronic Visit Verification (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 [TribalALTCInfo@azahcccs.gov](mailto:TribalALTCInfo@azahcccs.gov) if you have other questions/concerns.



## Provider Training Web Page

AHCCCS Provider Training offers training to Fee-For-Service (FFS) providers on how to submit claims, prior authorization requests, additional documentation (i.e. the AHCCCS Daily Trip report or requested medical records), etc. using the [AHCCCS Online Provider Portal](#) and the [Transaction Insight Portal](#).

The AHCCCS Provider Training team also offers periodic trainings whenever there are significant changes in AHCCCS policy or to the AHCCCS billing manuals.

Additionally, AHCCCS offers a [provider training web](#) page on the AHCCCS website.

The AHCCCS Provider Training web page provides information on:

- The DFSM Claims Clues Newsletter;
- How to sign up for “Constant Contacts,” DFSM’s E-mail Notification System;
- The DFSM Provider Training Schedule;
- Access to Power Point Presentations for past trainings; and
- Contact information for the DFSM Provider Training Team.

By reading the DFSM Claims Clues Newsletter and signing up for Constant Contacts providers can remain apprised of changes to the AHCCCS program, claims and billing updates and requirements, and system changes.

## 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.

The Office of Administrative Legal Services has received an increase in claim disputes citing the Emergency Medical Treatment & Labor Act (EMTALA) as the reason for the dispute.

“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 deemed “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](#).

## Upcoming Provider Trainings

### [Provider Training Schedule First Quarter 2020](#)

Below are the upcoming training sessions held by DFSM. Please note that all attendees must register prior to the scheduled time and date. Providers will be notified via Constant Contacts of any changes.

Behavioral Health Residential Facility (BHRF) Overview and PA Submission Training	
<b>March 10, 2020 - Tuesday</b> 9:30 AM – 11:00 AM <a href="#">ZOOM Meeting Link</a>	BHRF Policy overview and How to submit a PA request for BHRF providers only. <i>Session will be held via Zoom or Google Hangouts Meet Only</i>
<b>March 31, 2020 - Tuesday</b> 9:00 AM – 10:30 AM <a href="#">Zoom Meeting Link</a>	BHRF Policy overview and How to submit a PA request for BHRF providers only. <i>Session will be held via Zoom or Google Hangouts Meet Only</i>

General Direct Care Agency (DCA) Worker Training : Audit Tool	
<b>March 9, 2020 - Monday</b> 9:00am – 9:30am <a href="#">ZOOM Meeting Link</a>	The purpose of this training is to ensure the safety of members and the Quality of Care they are receiving. <i>Session will be held via Zoom or Google Hangouts Meet Only</i>
<b>March 30, 2020 - Monday</b> 9:00am – 9:30am <a href="#">ZOOM Meeting Link</a>	The purpose of this training is to ensure the safety of members and the Quality of Care they are receiving. <i>Session will be held via Zoom or Google Hangouts Meet Only</i>

Reviewing the Remittance Advice	
<b>March 3, 2020 - Tuesday</b> 10:00am – 11:00 am <a href="#">ZOOM Meeting Link</a>	Understanding the Remittance Advice <i>Session will be held via Zoom or Google Hangouts Meet Only</i>

Office of Administrative Services (OALS) Claims Disputes Overview	
<b>March 3, 2020 - Tuesday</b> 11:00am – 12:00pm <a href="#">ZOOM Meeting Link</a>	An overview of what are valid claim disputes, ways to resolve disputes, the timeframes involved, and edit denial reasons. <i>Session will be held via Zoom or Google Hangouts Meet Only</i>

One on One Provider Training	
<b>March 4, 2020 - Wednesday</b> 9:00am- 10:00am 10:30am – 11:30am	By Appointment only. Availability for one-on-one provider sessions on AHCCCS Policies and Billing Procedures. Email <a href="mailto:ProviderTrainingFFs@azahcccs.gov">ProviderTrainingFFs@azahcccs.gov</a> to schedule a session. ProviderTraining may cover the following topics: <ul style="list-style-type: none"> <li>· Online Claim Submission (AHCCCS Online)</li> <li>· Online Prior Authorization Submission</li> <li>· Transaction Insight Portal</li> </ul> <i>Session will be held via Zoom or Google Hangouts Meet Only</i>
<b>March 16, 2020 - Monday</b> 9:30am- 10:30am 11:00am – 12:00pm	By Appointment only. Availability for one-on-one provider sessions on AHCCCS Policies and Billing Procedures. Email <a href="mailto:ProviderTrainingFFs@azahcccs.gov">ProviderTrainingFFs@azahcccs.gov</a> to schedule a session. ProviderTraining may cover the following topics: <ul style="list-style-type: none"> <li>· Online Claim Submission (AHCCCS Online)</li> <li>· Online Prior Authorization Submission</li> <li>· Transaction Insight Portal</li> </ul> <i>Session will be held via Zoom or Google Hangouts Meet Only</i>