AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

November 2022

Effective 10/14/2022 Covered Dental Services at an IHS/638 Facility Are Unlimited

As per Arizona Medicaid Section 1115 Demonstration Waiver extension, effective 10/14/2022 the $1000 dental services limits for AI/AN members over 21 years of age, and AI/AN ALTCS members, receiving services for medically necessary diagnostic, therapeutic, and preventative dental services at IHS/638 facilities are eliminated.

This expenditure authority applies only when dental services are provided to American Indian/Alaskan Native (AI/AN) beneficiaries who receive services from participating IHS facilities and/or participating Tribal 638 facilities operated under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Services performed outside of the IHS/638 Tribal facilities remain limited to the $1000 Emergency Dental Benefit for members 21 years of age and over, and additional $1000 for members on ALTCS.

Payment Error Rate Measurement (PERM) Audit

The Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) program recorded the Provider Education webinar conducted in April 2022. The recorded webinar is intended to educate the provider and supplier community about the PERM program and explain the responsibilities to those who are participating in the Medicaid program and/or Children's Health Insurance Program (CHIP). The PERM program is designed to measure and report improper payments in the Medicaid and CHIP programs. Improper payment rates are based on reviews of Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Reporting Year (RY) under review. The improper payment rate is not a "fraud rate" but a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. These improper payments may be overpayments or underpayments and do not necessarily represent expenses that should not have occurred.

The objectives of this recorded webinar is for those participating in the Medicaid and CHIP programs to better understand:

- The PERM program.
- The PERM medical review process.
- PERM medical record and documentation requests.
- Methods for record submission.
- Provider best practices.
- PERM resources for providers.

CMS uses a 17-state rotational approach to review the states' Medicaid program and CHIP so that the PERM program measures each state once every three years. Listening to this recorded webinar is an opportunity for the provider and supplier community to better understand their responsibilities during a PERM cycle. For additional information, please go to the CMS PERM website.

ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address of servicedesk@azahcccs.gov

TRAINING AND CONTACTS

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website at: https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

The DFSM Provider Training Team's First Quarter Training Schedule is posted on the DFSM Provider Training web page.

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

- 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

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 (Remittance Advice Sign Up/835)

ELECTRONIC PAYMENT SIGN UP

(Remittance Advice Sign Up/835) Contact: ISDCustomerSupport@azahcccs.gov –OR- call (602) 417-4451

COVID FAQ

FAQs COVID Fact Sheet.

Important Update

BILLING PER DIEM CODES

The Per Diem code is billed for each day the member receives a service. If the units submitted do not match the date of service range, the claim will deny.

Denial Code: AD357 Daily Service Limit Exceeded.

REMINDER: BEHAVIORAL HEALTH BILLING

Provider types that can submit their services using the CMS 1500 claim form only include:

- Behavioral Health Outpatient Clinic (77)
- Behavioral Health Residential Facility (B8)

CLAIM DENIALS INFORMATION

This guide is available for providers to review the most common claim denial codes and steps to take to help resolve the edit. The information presented on the website is to provide general guidance only.

Claim Denial Resolution Guide

USING THE TRANSACTION INSIGHT PORTAL TO ATTACH DOCUMENTATION TO AN EXISTING CLAIM

Did you know that you do not have to resubmit a claim to attach documentation to a submitted claim. Any provider that is submitting a claim to Fee-for-Service (FFS) may use the Transaction Insight Portal (TIBCO) to attach required documentation to the claim submission. This includes providers that use a Clearinghouse, billing organization, billing app or even paper claim submissions can use the AHCCCS 12-digit claim reference number to attach documents to the claim.

Using TIBCO is the fastest and most efficient way to attach documents to a (FFS) claim.

To use the TIBCO Foresight 275 Transaction Insight Portal providers must have an active account.

To set up a new account or request a password reset providers can email a request to servicedesk@azahcccs.gov

- Sharing account login credentials is prohibited and violates the AHCCCS User Acceptance Agreement.

THE TRANSACTION INSIGHT PORTAL

Providers must select the “live” production environment (PRD) when using the TIBCO portal Passwords expire periodically and if your password expires, a prompt appears for the old password, create a new password, and confirmation.

- Training Presentation

FFS PRIOR AUTHORIZATION

Providers can use the AHCCCS Online PA Status tool to check the status of a PA request, and submit case updates such as uploading required clinical documentation.

- Providers should periodically check the status of the PA request;
- Important Note: Provide relevant clinical information as requested at the time of your initial submission, which may allow for quicker decisions and improved efficiency for online submissions.

HOW TO DETERMINE IF A PRIOR AUTHORIZATION IS REQUIRED

AHCCCS requires prior authorization as a condition of payment for many services. The AHCCCS FFS Authorization Guidelines lookup tool can assist with determining if a CPT/HCPCS code has a prior authorization requirement.

Participating providers can check for CPT/HCPCS that require authorization via the FFS Authorization Guidelines tool.

We recommend that providers verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member’s eligibility at the time service is rendered. **Remember, prior authorization is not a guarantee of payment. Unauthorized services will not be reimbursed.**

COMMON PA SUBMISSION ERRORS

Incorrect Event Type: Selecting the incorrect Event Type based on the type of service and the provider type.

PA Activity Type: Fail to complete the PA request entry. Providers entering authorization requests online must enter CASE, EVENT, and ACTIVITY levels for each authorization request entered.

Missing / Not Submitting Documentation: When it is known that supporting documentation is required for a PA determination, documentation should be submitted at the time of the initial authorization request. This may include but not limited to documentation required from the medical doctor, face-to-face or the prescription order.

Durable Medical Equipment: Submitting PA requests for DME rental equipment that overlap a month span, for example incorrect entry 10/01/2022 - 01/30/2023 on a single PA event.

Adult Orthotics: Missing letter of medical necessity/least costly statement for adult orthotics.

FFS Rate Changes: Submitting PA request that overlap different

Important Update Continued

rate periods. AHCCCS Fee-For-Service (FFS) rates are effective for dates of service beginning October 1 – September 30.

By-Report Procedure: Not submitting the charge price for the equipment or procedure when it is not listed on the AHCCCS FFS rates.

How to Submit a Prior Authorization Training

EVV Update on Hard Claims Edit Date Extended to January 1, 2023

Providers, please read this entire communication for the most up-to-date information on Electronic Visit Verification (EVV) requirements and guidance.

Timeline for the Hard Claim Edits (starting January 1, 2023).

The hard claim edits will be in effect for dates of service starting January 1, 2023.

AHCCCS appreciates the efforts providers have undertaken to evaluate current compliance with EVV and develop resolutions when issues have been detected. Furthermore, AHCCCS and Sandata are working on a few change requests that will impact claims enforcement. Therefore, upon AHCCCS' request, CMS has granted a claims enforcement extension to January 1, 2023, to afford AHCCCS, Sandata and providers a little bit more time to prepare for the hard claims edit. It is strongly encouraged for providers not to consider this extension as a delay, but rather to maintain the momentum to assess and comply with the EVV requirement and use every minute of this extension to ensure their readiness for the claims enforcement.

AHCCCS EVV Website

Notice EVV Hard Claims Edit Extension 01/01/2023

Billing FAQ - October 2022

EVV Billing Check List 08/2022

What is Payment Error Rate Measurement (PERM) Audit

What is Payment Error Rate Measurement (PERM) AUDIT?
The PERM Audit is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Improvement Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 IPERIA). The improper payment rates are based on reviews of the Fee-for-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the year under review.

Provider Billing Reminders:
It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement. For each claim submitted, you must be sure to include the correct member's name and AHCCCS ID number, date(s) of service, revenue, procedure codes, units, and charge amounts (etc.). Claims should adhere to standard coding practices to also include modifiers if applicable. Providers should utilize the respective state and federal billing & coding resources to ensure claims meet the appropriate billing guidelines.

Responding to PERM Documentation Requests:
Providers must submit the requested information by the due date noted on the request. Please note that it will be the responsibility of the provider identified on the claim to ensure that all supporting medical records, from the provider who rendered an AHCCCS covered service for which the claim payment under review was requested, is submitted in a timely manner. Please see the webiste for more information.

Missing Remittance Requests

Paper Remit/Paper Explanation of Benefits
The Division of Business Finance DBF only supports providers that are receiving paper copies of the remittance advice and can be reached at 602-417-5500

Electronic Remittance Advice (ERA) 835
Providers that are receiving the 835/ERA, HIPPA compliant detailed explanation of how AHCCCS processed the claims. If you need a to request a copy of the 835/ERA, providers must open a ticket to servicedesk@azahcccs.gov. Providers should also include in their request to assign the service ticket to the **Data Security team.**

Serious Mental Illness (SMI) Changes Effective 10/1/2022

American Indian Health Program (AIHP) Integration for Members with a Serious Mental Illness (SMI) Designation Effective October 1st, 2022 – Information for Providers

The Arizona Health Care Cost Containment System (AHCCCS) Division of Fee-for-Service Management (DFSM) serves as the health plan for Fee-for-Service (FFS) Medicaid members. The DFSM is responsible for the clinical, administrative and claims functions for the FFS population. Effective 10/1/22, American Indian/Alaskan Native (AI/AN) members with a Serious Mental Illness (SMI) designation will have the choice to be part of the integrated American Indian Health Program (AIHP) for coverage of both behavioral and physical health services.

Individuals with an SMI designation currently enrolled with the American Indian Health Program (AIHP) for physical health services and receiving behavioral health services from a Regional Behavioral Health Authority (RBHA) will have:

- Behavioral Health services transition to AIHP effective 10/1/2022, and
- Physical health services continue with AIHP.

Individuals with an SMI designation currently enrolled with an AHCCCS Complete Care (ACC) plan for physical health services and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA) will have:

- Physical health services transition to AIHP effective 10/1/2022, and
- Behavioral health services continue with the TRBHA.

Effective 10/1/22, RBHAs will be called ACC-RBHAs (AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements). SMI members' choice of enrollment remains intact; they may choose between integrated ACC-RBHA or integrated FFS (AIHP). They may also continue to receive services via IHS/638 tribal facilities, same as they can today.

This integration of AI/AN SMI designated members will not affect the ability of both physical and behavioral health providers to offer services to these members. AHCCCS encourages all providers to continue to care for members with an SMI designation. Providers currently serving AI/AN SMI designated members who continue to serve these members after 10/1/22 may be eligible for Differential Adjusted Payments (DAP).

The DFSM seeks to partner with facilities/providers for ongoing care management support and health plan technical assistance. All providers of behavioral and physical health services who are registered with AHCCCS can provide care and submit claims to DFSM for services provided to members enrolled with AIHP. No separate contract beyond the Provider Participation Agreement is required. See the AHCCCS Provider Enrollment website for more information.

For additional care management resources please contact case-managers@azahcccs.gov.

For technical assistance with billing, claims and prior authorization please visit our website or email ProviderTrainingFFS@azahcccs.gov.

Please sign up for DFSM's "Constant Contact" E-mail notifications for providers and select the SMI Service list to receive SMI specific notifications.

Reminders: Behavioral Health Residential Facility (BHRF) Admission

Prior Authorizations for a BHRF admission must be submitted prior to the admission to the BHRF. All prior authorization requests must be submitted timely to AHCCCS and include the required documentation to include but not limited to BHP assessment/evaluation referral associated with the BHRF admissions. BHRFs are responsible to coordinate care with the member's RHBA/TRBHA/SMI Clinic/Case Managers and other treatment team members from admission, care planning through discharge.

A referring treatment plan with BHRF as a medically necessary and least restrictive environment with clear treatment goals shall be included in the prior authorization request.

The goal of the treatment plan is to assess and re-evaluate the member's care needs. The Assessment is critical to gathering information regarding supports, strengths, goals and expectations for treatment to maximize care and the importance of discharge planning. Care coordination to include care with others to support the member after discharge and may also be included in the discharge plan.

Important Billing Information for Providers - Common Billing Errors on Paper Claim Submissions (repeat)

When submitting paper claim forms to AHCCCS, the following are the general rules that apply to the CMS-1500 claim forms:

1) The preferred font for claim submission is Lucinda Console and the preferred font size is 10.

2) ICD-10 codes are required on all claim forms.

3) Any behavioral health service billed with a DSM-4 diagnosis code will be denied.

4) The following should not be included on the claim form:

White Out paper correction fluid,

Correction tape,

Labels and stamps except for stamped signatures.

5) 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.

6) Handwriting is not permitted on any part of the claim form. The only exception to this is the signature field, where a written signature will be accepted.

Important Update: Provider Participation Reporting Requirements Deadline Has Been Extended Until January 1, 2023

AHCCCS has extended the deadline for providers to begin reporting the individual practitioner who rendered services on professional and dental service claims until January 1, 2023.

In order to retain information related to the actual professional practitioner that is participating in or performing services associated with the clinic visit, this information must be reported on the claim and will impact all claims for AHCCCS providers registered as:

- Integrated clinics (Provider Type IC)
- Behavioral health outpatient clinic (Provider Type 77)
- Clinic (Provider Type 05)

AHCCCS and its Managed Care Organizations will deny claims for dates of service on and after January 1, 2023 if the individual practitioner who performed the services associated with the clinic visit is not reported.

Claim Form Types:

- CMS 1500 claim form, Field 19 Field Title: Additional Claim Information
- ADA claim form, Field 35 Field Title: Remarks

Denial Edit Code H482 "NPI Missing or Invalid" will append to the claim if the participating provider information is not entered or is in the incorrect format.

See Exhibit 10-1 of the AHCCCS Fee-For-Service Provider Billing Manual for billing instructions for proper claims submissions.