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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

January 2023

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.

Reminder: Provider Participation Reporting Requirements

Effective January 1, 2023, providers must begin reporting the individual practitioner who rendered services on professional and dental service claims. This requirement impacts all claims for AHCCCS providers registered as Integrated clinics (Provider Type IC), Behavioral health outpatient clinics (Provider Type 77) and Clinics (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.

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

Diabetes Self-Management Training

Effective October 1, 2022 AHCCCS will provide up to 10 program hours annually of diabetes outpatient self-management training services to a member with a new or existing diabetes diagnoses during the first year. Members are eligible for up to 2 hours of follow up education each year thereafter. The training must be prescribed by a primary care practitioner.

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

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: 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

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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.

EVV Update on Hard Claims Edits

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.

EVV Webpage

Notice EVV Hard Claims Edit Extension 01/01/2023

Billing FAQ - October 2022

EVV Billing Check List 08/2022

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:

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.***

Reminder: 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 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

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. Training Resources

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. PERM webpage

APEP Reminder –Service Addresses Can Be Updated Directly in APEP

If the user has APEP domain permissions to access the file, submit a modification request in APEP and add the service address(es) in Step 2: Locations.

If the user does not have domain permissions email APEPTrainingQuestions@azahcccs.gov to open a service ticket, include the APEP username of the person requesting domain permissions and the provider NPI and name.

Prior Authorization Reminders

Providers entering authorization requests online must enter CASE, EVENT, and ACTIVITY levels for each authorization request entered. Providers should use the online ATTACHMENT feature to upload supporting documents when needed. For training on how to enter authorizations using the Web Portal please submit your training request to: ProviderTrainingFFS@azahcccs.gov

REMINDER: NEMT Pick Up and Drop Off Address

Effective 11/01/2022 the pickup and drop off information must be reported for NEMT claim submissions. This change applies to paper submissions on the **CMS 1500** claim form, electronic EDI **(837P)** transaction and the **AHCCCS Provider Portal**. The pickup and drop off information can be entered in the **Additional Claim Information** field (Box 19) and please note spacing is limited.

Important Note: NEMT providers must continue to include a copy of the AHCCCS Daily Trip Report with each claim submission.

Example:

Tips:

- As spacing may be limited in the additional claim information field, use abbreviations when possible, i.e., St, Rd, Ave, Ln, Blvd., etc.
- If a house or street assignment is not available for the pick-up, providers can enter the GPS coordinates for the pickup information.
- Do not enter the city and state. The Zip code is ***mandatory*** and is used to identify the city and state.

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How to Submit a Prior Authorization Training

Provider Self-Service Tips AHCCCS Online Provider Portal

The AHCCCS Online Provider Portal is designed to help FFS providers to be able to perform many self-service functions. Providers can review claim details, narrow your search by date, CPT/HCPCS code, obtain check payment information to include EFT/Check numbers and much more.

- **Verify member eligibility.** Use the Eligibility & Benefits tab to view detailed information relating to the members' enrollment and eligibility.
- **Submit and Status FFS Claims**. Claims submitted on the Online portal are processed as electronic claims which can result in quicker payment of claims. Use the Claim status tab to search /view the progress of the claim.
- **Submit Correction Claims.** The Online Portal can be used to submit a correction claim, even when the initial submission was EDI, clearing house or by paper.
- **Claim Denials.** View claim denials and the Provider Denial Edit Resolution guide.
- **Submit Prior Authorizations.** Use the Authorization Submission transaction to initiate requests.
- Please note providers cannot adjust claims that are more than a year old using the AHCCCS Online Provider Portal.

Pended Prior Authorization Request Information

Did you know that you can view the status of a PA request using the AHCCCS Online Provider Portal? On the Portal, providers can view messages from the PA team to determine if any additional actions or steps may be required on the PA submission.

Pended PA cases will also show reason codes and understanding the reason codes can help providers determine next steps to take on a pended PA. Some common examples include, but is not limited to:

Reason Code	Description	Action
PH001	PEND/UTILIZATION NOTES REQUIRED	This will prompt the submitter to submit the utilization notes using the ***Attachment*** feature.
PD009	MEDICAL DOCUMENTATION NOT RECEIVED	This will prompt the submitter to submit the medical documentation using the ***Attachment*** feature.

Providers should periodically check the status of the PA request. For quicker decisions and improved efficiency for online submission, we recommend submitters provide relevant clinical information at the time of your initial submission.

For prior authorization questions that cannot be resolved using the AHCCCS Online Portal, providers can outreach the FFS Prior Authorization phone line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548