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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

May 2023

Alternate Care Site (ASC) Flexibility Ending for Indian Health Service (IHS) and Tribally Owned/Operated (638) Facilities

In alignment with the end of the COVID-19 PHE, the use of Alternative Care Sites (ACS) established by Indian Health Service (IHS) or tribally owned/operated 638 facilities will end on dates of service starting May 11, 2023. All services and reimbursements related to this flexibility will be discontinued in conjunction with the end of the PHE and the rollback of the CMS 1135 Blanket Waiver. This applies to all AHCCCS reimbursement of IHS and 638 facilities for services rendered at an ACS.

For more information about the ACS flexibility, please see the Centers for Medicare & Medicaid Services (CMS) Fact Sheet for State and Local Governments - CMS Programs & Payment for Care in Hospital Alternate Care Sites, as well as the Biden Administration's announcement of its intention to end the national public health emergency declarations on May 11, 2023.

Covid-19 Billing and Claims

ACS Memo

Reminder: Claim Date Span Billing Requirement

Effective with dates of service beginning February 17, 2023 and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service.

AHCCCS DFSM will deny any claim line submitted by a provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Example of a Correct Claim Submission:

1	02	13	23	02	13	23	11		H0004	HQ				95	00	4			1234567890
2	02	14	23	02	14	23	11		H0004	HQ				95	00	4			1234567890
3	02	15	23	02	15	23	11		H0004	HQ				95	00	4			1234567890

Example of an Incorrect Claim Submission:

1	02	13	23	02	28	23	11		H0004	HQ				1500	00	480			1234567890
2																			
3																			

TRAINING AND CONTACTS

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 this email address: servicedesk@azahcccs.gov

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/ updates, billing and FFS policies.

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

For Claims and Prior Authorization inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. Hours of Operation are Monday – Friday, 7:30am-5:00pm.

- Prior Authorization Questions FFS PA Line (602) 417-7670
- Claims Customer Service Billing Questions (602) 417-7670
- Provider Registration Process Questions (APEP) (602) 417-7670

For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

Electronic Payment Sign Up (Remittance Advice Sign Up/835) Contact: servicedesk@azahcccs.gov or call (602) 417-4451

COVID Frequently Asked Questions: FAQ COVID Fact Sheet

Attendant Care Provider Type 40 Non-Emergency Medical Transportation Services

Effective 06/01/2015, providers registering as a provider type 40 (Attendant Care Agency) will be required to be an AHCCCS registered provider for a period of twelve (12) months prior to being able to bill for non-emergency medical transportation (NEMT) services. Upon completion of the 12-month period this provider type will be able to bill for NEMT services.

However, the NEMT services should ***not exceed 30%*** of the overall services billed.

This guidance may be found in the FFS Provider Billing Manual, Chapter 3 Provider Records and Registration and Chapter 14 Transportation.

FFSChapter3ProviderRecordsandRegistration
FFSChapter14Transportation

Selecting the Correct Event Type for Medical and Behavioral Health Admissions

As a reminder, acute care hospitals that are requesting a prior authorization for an inpatient stay, the Event type must match the diagnosis code submitted on the prior authorization request.

For example, the primary admitting diagnosis code is “acute respiratory failure”. The correct Event type would be IP to indicate an inpatient medical stay.

In the same example, if the claim is submitted with a primary admitting diagnosis code that indicates a behavioral health condition, for example F10.239 for Alcoholism, and the Event type entered on the PA request is IP (inpatient) and not BI (behavioral health inpatient).

Result: The claim will deny due to mismatched Event and diagnosis billed.

Action: If the submitter determines the Event type is incorrect, please submit a Prior Authorization Correction form to correct the event type. If the claim was submitted with an incorrect primary admit diagnosis, please submit a replacement claim.

FFS Prior Authorizations Forms

Common Prior Authorization Submission Errors

AHCCCS has identified several common PA submission errors that include but are not limited to:

- PA request entered for CPT/HCPCS code that does not require a PA.
- Incorrect Date of Service(s).
- Incorrect Event type.
- Failure to complete the Event Tab.
- Failure to complete the Activity Tab.

PA request entered under the incorrect provider NPI number.

To learn more about procedures that may or may not require a prior authorization view the Fee for Service Prior Authorization Guide

Prior Authorization Tips

The AHCCCS processing system will automatically search for an prior authorization based on the following elements, Member ID, Provider NPI, Date of service(s) , Event type, CPT/HCPCS codes and service units.

The AHCCCS Online Provider portal ***will not allow*** a change or modification to an existing PA when the status has been changed from Pending to **Approved, Denied or Revoked.**

If the PA has been Revoked in error or Denied due to lack of information, the provider can submit any supporting documentation for reconsideration of the PA Case.

Providers may use the Prior Authorization Correction form to request a change or update to an existing prior authorization. The PA correction form can be linked to the PA by using the ***Attachment*** feature located on the Event tab.

If the PA status shows **Pending** the submitter can make any changes to the existing PA, for example, date of service, units, CPT/HCPCS, etc.

When is a Faxed Prior Authorization Request Acceptable

Providers MUST send their PA requests to AHCCCS via the AHCCCS Online Provider Portal. **Faxed prior authorization correction requests will be returned to the submitter.**

IMPORTANT NOTE: If submission for a Prior Authorization request or Documentation is not possible due to internet outage or other unforeseen events, the Prior Authorization Request Form must be utilized and faxed to the PA Department. Please include a separate document on your letterhead as to why the document could not be uploaded if the fax in option is being used.

Verifying if a Service Requires a Prior Authorization

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.**

Prior Authorization Submission Tips

Provider Type 02 Hospital – Outpatient day surgery

If the PA request is for a same day surgery but spans multiple dates due to the member was placed in Recovery or Observation after the procedure, the prior authorization request must cover the entire service dates.

- H220.3 Prior authorization mismatch – This edit will set if the dates of services billed do not match the date span on the PA.
- H228.6 Therapy Requires Prior Authorization; P/A mismatch.

PA Tip: Outpatient Surgery – Physician Prior Authorization Request

- The Event Type must be **MD** for the surgeon.
- The actual date of the scheduled procedure only must be entered on the PA request for the surgeon. **Date spans are not accepted and will result in a denial of the request.**
- CPT code(s) must be entered on the Activity tab with the correct number of units.
- Only modifier 50 (Bilateral) procedure should be submitted when applicable. The PA request for surgery should not include modifiers LT, RT, 59 etc.

PA Tip: BHRF (Provider Type B8) Prior Authorization Request

The PA must be submitted and approved prior to the member's admission to the BHRF. Documentation must be complete, legible and signed by the behavioral health professional. Additional information regarding PA requirements for BHRF.

BHRF Criteria for Continued Stay

BHRF request for a Continued Stay should be submitted to the prior authorization team at least two weeks prior to the last approved prior authorized date of the BHRF stay.

- The latest Assessment signed by the BHP (Behavioral Health Professional) or cosigned by the BHP.
- The latest Treatment Plan not older than 30 days from the submission date. Signed by both the member and the BHP.
- Group and Individual therapy notes and the seven-day schedule outlining the member day to day living.

Please note this is not an all-inclusive list, please note the PA team may request additional documentation as necessary for review.

Inpatient Psychiatric Facility (Provider Type 71) Prior Authorization Submission Tips

Event Type must be BI = Behavioral Health Inpatient.

Make sure to complete the Activity Tab with the appropriate Revenue code that identifies the level of care for the member (for example revenue code 0124 or 0126).

To add the missing Activity information, simply navigate to the PA case, click on the sequence number and complete the required fields on the **ACTIVITY** tab. The admit and discharge dates are required.

Providers should include the **Certificate of Need (CON)** For Level 1 Facilities with the initial prior authorization request and or the **Recertification of Need (RON)** for Level 1 Facilities for continued stay requests. All forms must be uploaded using the Attachment tool.

Uploading Documentation To A Prior Authorization Request

If you need to include additional supporting documentation to an existing authorization, select the **PA Submission** tab not the PA inquiry tab to complete this step.

Select the appropriate sequence number (i.e. 01, 02) for the date of service. Select the **Event List** tab to navigate to the ***Attachments*** tool which is located on the right hand side of the page. Select the file that you want to upload, hit the upload key, you will get the message "file uploaded". The file will appear under the heading **"Pending Attachments"**, click the **"Submit"** button to finalize the upload process which will move the file to the **"Submitted Attachments"** column on the page.

How to Add the Missing Event Information To An Existing PA

There are three steps to properly submit a prior authorization request, Case Creation, Event and Activity. If any of these steps are missed the PA team will add comments advising you to complete the necessary fields.

1. On the PA submission tab, navigate to the PA case.
2. Select the case number.
3. The Event page will open. If the message "No Records Found", click on the "Add New Event tab.
4. Complete the required fields and select "Next" to accept the new information and Submit to finalize the action.

How to Add the Missing Activity Information To An Existing PA

1. Select **Prior Authorization Submission** on the sign in page of the AHCCCS Online Provider Portal.
1. Search for the PA request by entering the required information on the **Case Search** screen.
1. Select the **Case Number** from the search results that you would like to add the activity information and select the **Update** feature on the right-hand side.
1. Next, click on the **Event List** tab on the upper right of the page.
1. Click on the **sequence number** next to the date span you wish to update. You can also **add attachments** on the Event List page using the attachment feature.
1. To add the Activity information, click on Add New Activity at the bottom on the **Event List** page.
1. On the Enter **Activity Information** page complete all required fields as indicated by the red asterisks.
1. Click on the Next button to go to the **Verify Activity Information** page.

Once you verify information is correct, click on **Submit** to finalize your PA request.

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.

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