ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

September 2024

September is National Self-Care Awareness Month

Self–Care Awareness Month in September is a time to remind us that taking care of ourselves, first and foremost, is essential. Our mind and bodies require rest and relaxation for optimal health and well being.

Prior Authorization Submission

Submitting a FFS prior authorization request must be sent using the secure AHCCCS Online Provider Portal. The Online PA submission process is fast and also is in "real time". This means the moment you press the "enter" key, the PA request is accessible by AHCCCS staff.

Providers must verify member eligibility/enrollment prior to submitting a prior authorization request. A prior authorization is not required for members enrolled in the Federal Emergency Services program, with the exception of outpatient ESRD services. All claims for FES members are reviewed on a per case basis.

- Providers are required to submit documentation to substantiate medical necessity. Examples of required supporting documentations include history and physical, discharge summary, physician orders, etc.
- It is the provider's responsibility to upload only the requested documentation..
- Each prior authorization request is reviewed for medical necessity and cost effectiveness.
- If the PA request is approved, a copy of the authorization letter will be sent to the provider.
- If the PA request is denied, a copy of the Notice of Action (NOA) or denial letter with the reason for denial of service will be sent to the provider, member, parent or legal guardian by mail.

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

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

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.

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

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

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: servicedesk@azahcccs.gov

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

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

COVID FAQ: FAQ COVID Fact Sheet

Behavioral Health Residential Facility (B8)
Rate Change Effective 10/1/2024 and PA Submission Process

Effective for dates of service on and after October 1, 2024, AHCCCS FFS rates may change for some provider types. This change may impact prior authorization requests that overlap different fee-for-service rate periods.

- **Contract Year** - For AHCCCS Contractors and Fee-For-Service (FFS) Programs, the contract year runs from October 1 through September 30 of the following year.

In this example, a behavioral health residential facility, provider type (B8), the client was admitted on 09/01/2024 and based on the treatment plan is expected to require medically necessary services for up to 90 days.

The BHRF would submit two prior authorization cases, the first case would be for the effective date span 09/01/2024 thru 09/30/2024, (through the end of the current FFS rate period).

- The **Effective Date field** is used to report the current FFS contract year rate period.
- The **Authorized Dates field** shows the actual dates of services that you are requesting for the prior authorization.

Example PA case #1 is for the current contract year.

```
     AHCCCS ID: A00000000           NAME:                                            SEX
 EFFECTIVE DATES: 09/01/2024  -  09/30/2024              ELG: IH BIRTHDATE            AGE
       PA NUMBER: 000000009          SEQ: 01             CASE TYPE: P  CASE STATUS: A
     PROVIDER ID:               NPI:                       NAME:                      TYPE: B8
AUTHORIZED DATES: 09/01/2024  -  09/30/2024                ADMIT DATE:                CCR: Y
      EVENT TYPE: BP   STA: A   REAS:                      MEDICARE TYPE:
ICD 10 DIAGNOSIS:   F10.20      DESC: ALCOHOL DEPENDENCE, UNCOMPLICA
         REQUEST: BHRF

      DATE SPAN: 30
SEL  LN TYP    CODE       MOD    ALLOWED        USED     STA REAS   UNIT PRICE SRC
 _   01  H    H0018              30.000                   A          261.6700  S
```

The second PA case, the provider will create a new PA case that will be assigned a new PA case number. This case will cover the new FFS contract rate period. The **effective dates** on the new PA case will be 10/01/2024 thru 09/30/2025 (the end of the contract year).

Example PA case #2 is for the new contract year.

```
     AHCCCS ID: A00000000           NAME:                                            SEX
 EFFECTIVE DATES: 10/01/2024  -  09/30/2025              ELG: IH BIRTHDATE            AGE
       PA NUMBER: 000000002          SEQ: 01             CASE TYPE: P  CASE STATUS: A
     PROVIDER ID:               NPI:                       NAME:                      TYPE: B8
AUTHORIZED DATES: 10/01/2024  -  09/30/2025                ADMIT DATE:                CCR: Y
      EVENT TYPE: BP   STA: A   REAS:                      MEDICARE TYPE:
ICD 10 DIAGNOSIS:   F10.20      DESC: ALCOHOL DEPENDENCE, UNCOMPLICA
         REQUEST: BHRF

      DATE SPAN:
SEL  LN TYP    CODE       MOD    ALLOWED        USED     STA REAS   UNIT PRICE SRC
 _   01  H    H0018              61.000                   A          NEW RATE   S
```

- If the PA request is incomplete and lacks supporting documentation to substantiate medical necessity. AHCCCS will request the provider to submit additional information and not be able to take any further action until the information requested is received.

Federal Emergency Services Inpatient Hospitals Services Prior
Authorization Not Required for FES Members

In accordance with R9-22-217 (D) A provider (hospital) is not required to obtain prior authorization for emergency services for Federal Emergency Services (FES) members, except outpatient dialysis services. Based on this guidance, providers should not submit to AHCCCS FFS a prior authorization request for a FES enrolled member.

Per R9-22-217 All services must meet the federal definition of emergency services to be considered for reimbursement. Based upon these criteria, all claims are subject to retrospective review.

Fee-for-Service Prior Authorization Process

Starting your request: There are three steps that must be completed to successfully submit a prior authorization request.

Step 01. Initiating the Case Creation. If there is no case on file that meets the search criteria, the system will automatically create a new case number for you to complete steps two and three.

Step 02. Completing the Event Tab. The event type provides details in regards to the type of authorization that you are requesting, for example MD for surgery, IP for inpatient facility medical stay, BP for BHRF.

Quick Training Guide Selecting the Correct Event Type

Step 03. Completing the Activity Tab is the last step in the PA submission process and is most commonly missed or not completed. On the activity tab, you must enter the CPT/HCPCS/Revenue code and or modifier for the PA request and make sure to include the appropriate date span and units.

Accurate PA Details Matter

The standard required information is the member's AHCCCS ID, Date(s) of service, Service, provider NPI, CPT/HCPCS code, Revenue code, units of service, Modifier (if applicable).

The AHCCCS Fee-for-Service Prior Authorization Guide is a master list of CPT and HCPCS codes that may or may not require an authorization.

Timely Follow-Up:

Prioritize authorizations and work through them in a systematic and organized manner. Track the status of the PA request. Many requests remain incomplete for several months without follow-up by the submitter.

Making Corrections to Your PA Request - Status is Pend, Approved, Denied

Pend Status: If the PA case is in a Pend status, providers can make a correction via the PA Submission tab, for example changing the date of service, CPT/HCPCS, revenue code, units. If the service provider NPI needs to be changed, the Prior Authorization Correction form must be completed and submitted via the PA attachment tool.

Approved and Denied authorizations are handled differently, please review the guidance below.

Approved Authorizations PA cases that are in an Approved status cannot be changed via the Online portal. To request an update or modification to an existing approved case, providers must complete the Prior Authorization Correction Form (PAC). Any additional medical documentation for this request should be submitted with the request. The PAC form must be completed in its entirety and can be uploaded using the PA attachment tool located on the Event tab.

Prior Authorization Correction Form

DD-THP Tribal Health Program Authorization Correction Form

Paper Claim Forms - ADA Dental 2024 and CMS 1500

The ADA Dental Claim Form is the standard form used by dental healthcare providers for submitting insurance claims for dental services. Dental claim submissions must be on the original ADA claim form.

Copies and or reproductions of the dental claim form will be returned to the sender as unprocessable.

What Actions Can Be Done Using The AHCCCS Online Self Service Provider Portal

Through this secure and easy to use portal, AHCCCS enrolled providers can inquire on the status of their claims and payments, inquire on a patient's eligibility, prior authorization requests. Our online resources provide quick and easy access to the information you need to work effectively with the AHCCCS Fee-for-Service program.

- Member enrollment and eligibility can be verified for members enrolled in the Fee-for-Service and MCO plans. Providers can also verify if a member has a primary payer for example TPL or Medicare.
- Claim Status information can only be obtained through our online self-service portal.
- Prior authorizations and status updates.
- Providers can use the Online portal to check their provider information, for example, service and pay-to-locations, group billing affiliations.
- if you need to report changes or modifications to your existing enrollment please login to the AHCCCS Provider Enrollment Portal (APEP) APEP FAQs.

Payer Identification Numbers

Payer ID numbers are created by vendors/clearinghouses; it is how they enumerate payers within their system so that claims are routed to the appropriate payer. It is part of the claim submission process between the provider and the clearinghouse. AHCCCS would not have this type of information.
The payer ID for AHCCCS could be enumerated differently by the many different clearinghouses we exchange electronic transactions with. You would need to reference the Payer ID list made available on the clearinghouse website to find the appropriate payer ID.

Checking Claim Status using the AHCCCS Online Provider Portal Claim Status:

- Any claim action initiated by AHCCCS will reflect on the AHCCCS Online Provider portal the same day the claim is processed.
- If the claim status shows “Unadjudicated” this means the claim is currently under review and no action at this time is required by the provider.