Revision Dates: 3/11/24; 8/29/2023; 10/1/21; 9/12/2019; 10/1/2018; 4/13/2018; 1/26/2018; 12/22/2017; 01/01/2015; 05/31/2012; 12/16/2011

General Information

A person or company may participate as an AHCCCS provider if the person or company is qualified to render a covered service and complies with Arizona laws, rules, policies, procedures, and other requirements for provider participation. All providers, including out-of-state providers, must register to be reimbursed for covered services provided to AHCCCS members.

To become an AHCCCS provider, a provider must sign the Provider Participation Agreement (PPA). Per the PPA providers must follow all AHCCCS guidelines, policies and manuals, including but not limited to the following: the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Fee-For-Service Provider Billing Manual, AHCCCS Claims Clues, and Reporting Guides. These guidelines, policies and manuals are available on the AHCCCS website.

Providers are encouraged to subscribe to receive notifications about upcoming trainings, forums, and important business updates via AHCCCS' email notification system.
The email notifications, sent straight to a FFS provider's email inbox, are sent out regarding changes to the program, claims and billing updates and requirements, and system changes.

In accordance with the Affordable Care Act, Section 6401 and 42 CFR Subpart E, institutional and other designated providers are required to submit an enrollment fee.

For purposes of the enrollment fee, institutional and other designated providers includes but is not limited to:

- A range of ambulance service suppliers;
- Ambulatory Surgical Centers (ASCs);
- Community Mental Health Centers (CMHCs);
- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Durable Medical Equipment, Prosthetics/Orthotics Suppliers (DMEPOS);
- End State Renal Disease (ESRD) facilities;
- Federally Qualified Health Centers (FQHCs);
- Histocompatibility Laboratories;
- Home Health Agencies (HHAs);
- Hospices;
- Hospitals, including but not limited to acute inpatient facilities, Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and physician-owned specialty hospitals;
- Critical Access Hospitals (CAHs);

- Independent Clinical Laboratories;
- Independent Diagnostic Testing Facilities (IDTFs);
- Mammography Centers;
- Mass Immunizers (Roster Billers);
- Non-Emergency Medical Transportation Providers;
- Organ Procurement Organizations (OPOs);
- Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Groups;
- Personal Care Agencies;
- Portable X-Ray Suppliers;
- Skilled Nursing Facilities (SNFs);
- Radiation Therapy Centers;
- Religious Non-Medical Health Care Institutes (RNHCIs);
- Residential Treatment Centers; and
- Rural Health Clinics (RHCs).

In addition to the providers and suppliers listed previously, other agencies may be included.

The enrollment fee **does not** apply to physicians and non-physician practitioners.

Provider types requiring an enrollment fee can be found on the AHCCCS website at www.azahcccs.gov. Providers will be instructed during the registration process regarding payment submission requirements.

Note: If a provider appropriately validates that the fee has previously been paid to Medicare or another State's Medicaid Agency, the fee for Arizona may be waived. The enrollment fee is effective January 1, 2012.

Fee-For-Service providers do *not* need to contract with AHCCCS AIHP, Tribal ALTCS or a TRBHA to continue providing Medicaid Title XIX and XXI services to FFS members. A provider simply must be an AHCCCS registered provider.

Definitions

Servicing/Rendering Provider:

A servicing (rendering) provider is the provider who actually performed the services for/to an AHCCCS eligible member.

- For purposes of AHCCCS claim submissions, the servicing (rendering) provider cannot be an AHCCCS registered provider type of "01," a Group Billing Entity. Health care service providers were associated with the group and one check was produced and paid to the Group Billing Entity.

The Billing Provider:

The billing provider is the “Pay-To” provider associated in the AHCCCS system (PMMIS) with the rendering provider. This is the entity/person who will receive the check/wire/remit.

A Billing Entity:

AHCCCCS identifies a billing entity as the “member of the payment.” This provider can be a servicing (rendering) provider, a group billing entity/group biller (provider type 01), or a billing entity.

Group Billing Entity:

The group billing entity is the “member of the payment.” This provider can be a servicing (rendering) provider, a group billing entity/group biller (provider type 01), or a billing entity.

AHCCCS Provider Registration Materials

Providers are required to:

- Complete an application;
- Sign a provider agreement;
- Complete and sign all applicable forms (i.e., criminal offenses form, attestations etc.);
- Submit documentation of their applicable licenses, certificates, and/or CMS certification;
- Submit documentation of their National Provider Identification (NPI) Number (if applicable); and
- Submit a Disclosure of Ownership if registering as a company or facility

Information and registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area:	(602) 417-7670 (Option 5)
In-state:	1-800-794-6862 (Option 5)
Out of state:	1-800-523-0231 Ext. 77670

AHCCCS Provider Registration materials are also available on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/NewProviders/packet.html.

This can also be reached by going to the AHCCCS website at www.azahcccs.gov. Once there click on the "Plans/Providers" tab and choose the "Provider Registration" option. Once on the "AHCCCS Provider Registration" page, in the left hand column under "New Providers" click on "Provider Registration Packets." The forms can be filled out on the AHCCCS website, but must be submitted by fax or mail to the Provider Registration Unit.

AHCCCS Provider Registration Unit
MD 8100
P.O. Box 25520
Phoenix, AZ 85002

AHCCCS Provider Registration Application Approval

When a provider's application is approved, an AHCCCS registration number is assigned, and the provider is notified by letter.

Out-Of-State Waiver (One Time Only):

Out-of-state providers, under limited circumstances, may qualify for a one-time waiver of full registration requirements. A provider who qualifies for this waiver must complete the following:

- Provider Agreement
- Form W-9: Request for Taxpayer Identification Number and Certification
- Copies of license and/or certifications
- Copy of the provider's claim

Medicare-certified facilities are registered as active providers for the dates of service.

Other providers who qualify for this waiver are registered for 30 days. The provider must complete the full registration process, except in extenuating circumstances when approved by the AHCCCS Office of the Inspector General.

For additional information about registering as an out-of-state provider please contact the AHCCCS Provider Registration Unit at:

Phoenix area:	(602) 417-7670 (Option 5)
In-state:	1-800-794-6862 (Option 5)
Out of state:	1-800-523-0231, Ext. 77670

AHCCCS Provider Types

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. The provider type indicates what services a provider can bill for. The AHCCCS Provider Registration Unit will assist providers in identifying the most appropriate provider type, based on the provider's license/certification and other documentation.

A listing of provider types can also be found in AMPM 610, Attachment A – AHCCCS Provider Types.

AHCCCS Provider Categories of Service (COS)

Within each provider type, mandatory and optional categories of service (COS) are identified.

Mandatory COS are defined by mandatory license or certification requirements. The provider must submit documentation of license and/or certification for each mandatory COS.

Optional COS are those that the provider may be qualified to provide and chooses to provide.

- Optional COS, which do not require additional license and/or certification, are automatically posted to the provider's file.
- Optional COS, which do require additional licensure and/or certification, are posted once proof of current, valid licensure and/or certification is received.

Mandatory and optional COS, licensure/certification requirements, and the applicable procedure codes for each provider type are listed in the Provider Profile. Providers may be limited to certain procedures within a COS. If limitations are applicable, the allowable procedures are identified in the Provider Profile.

Documents Required for Registration (Except for One Time Waiver)

The following documents must be completed, signed by the appropriate parties, and on file with the Provider Registration Unit before an AHCCCS Provider Registration number will be issued and the provider registration records activated:

- Provider Registration Application Form

  This form must be completed in its entirety and must be signed by the provider, administrator, CEO, or owner.

- Provider Agreement

  The Provider Agreement is a contractual arrangement between AHCCCS and the provider and is required by federal and state law and regulation.

  The form and content of the Provider Agreement are consistent with Federal and State laws and regulations, and no changes may be made to the language or terms of the agreement.

  By signing the agreement, the provider indicates the following:

  - The provider has read the document in its entirety,
  - The provider understands all the terms of the agreement, and
  - The provider agrees to all of the terms of the agreement.

  Any provider who violates the terms of the agreement is subject to penalties and sanctions, including termination of the Provider Agreement.

  The Provider Agreement remains in effect until terminated by either AHCCCS or the provider.

  The agreement for long term care facilities must be renewed annually, concurrent with the expiration date (survey date) for Medicare/Medicaid recertification.

  This agreement is required of all providers, including one-time only providers.

- Proof of Licensure and Certification

  Each provider must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

  Documentation of all licenses and certifications must be provided.

  An out-of-state provider must hold current, valid certification/license in the provider's own state.

- Proof of National Provider Identification Number (if applicable)

- Form W-9: Request for Taxpayer Identification Number and Certification

- Disclosure of Ownership and Criminal Offenses Statements (when applicable)

- All providers are required to revalidate their enrollment with AHCCCS every five years beginning January 1, 2012. Providers will be contacted when their renewal is due.

Providers registered prior to January 1st, 2012 will be required to re-enroll and then revalidate every five years thereafter. Providers will be contacted regarding their reenrollment date.

Billing Providers and Group Billing Providers

Billing providers and group billing providers, who have elected to act as a financial representative for a provider or a group of providers, who have authorized the arrangement, may register as a Group Biller with AHCCCS. Group billers may not provide services or bill as the service provider. They will receive a separate Group Billing AHCCCS Registration Number.

The billing provider process has been modified to allow a service provider to act as a financial representative for another single service provider or a group of service providers. Providers who act in or participate in this capacity are still required to register with AHCCCS and to sign a Group Biller Authorization Form.

The service provider must sign a Group Billing Authorization Form. The form allows the group biller to submit the provider's claims and to receive the provider's AHCCCS payments. The authorization form may be obtained from the AHCCCS Provider Registration Unit or online at: https://www.azahcccs.gov/PlansProviders/Downloads/ProviderRegistration/GroupBillingAuthorization.pdf.

The service (rendering) provider's NPI number must appear on each claim, even though a billing provider NPI (as noted above) may be used for payment.

The service (rendering) provider will remain affiliated with the authorized group billing provider until the provider furnishes written notification, signed by the authorized signer or the provider, to the Provider Registration Unit indicating a termination from the group billing arrangement.

All payments for the service provider will be sent to the pay-to address of the group billing provider, with whom the service provider is affiliated, if the group billing provider ID number is entered on the claim.

If a provider has multiple locations, the provider may have multiple billing provider affiliations.

Registering for the Provider Portal (AHCCCS Online)

Providers may register for the provider portal (AHCCCS Online) and typically register after they have received approval as an AHCCCS registered provider. The provider portal allows providers to check for member eligibility, to submit and track the status of prior authorization requests, and to submit and track the status of claims.

To create an account and begin using AHCCCS Online providers must go to the following web address and follow the instructions provided on the website:

https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

There is no charge for creating an account and there is no transaction charge.

When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the **master account holder**.

- Note: The master account holder is typically the first employee or agent to register an account from that provider. However, another user can be designated as the master account holder at the provider's request.

Upon registering the master account holder's *account*, AHCCCS will send the master account holder a temporary password. The master account holder will then log into AHCCCS Online with the temporary password and shall change it to a new password.

After the master account holder is set up, other employees and agents of the newly registered provider (such as a biller) may then register for an account on AHCCCS Online.

- At that point, **it will be the master account holder's responsibility** to change that user's account settings to ensure they have been granted the appropriate access to the subsystems that are directly related to that user's specific employment related duties.

The master account holder is responsible for informing itself and its employees and agents of the requirements of all applicable privacy laws.

In the event that a master account holder leaves employment with the provider, the facility must call AHCCCS to request that another user's account be changed to the master account holder designation.

Correspondence, Pay-To, and Service Addresses

AHCCCS maintains a correspondence address, a pay-to address or addresses, and a service address or addresses for each provider except group billers. For group billers, AHCCCS maintains a correspondence address and a pay-to address only.

The *correspondence address* is the address where billing instructions, letters, and all other correspondence, except checks, are mailed.

Each provider has only one correspondence address.

- Even if a provider has multiple service addresses, the provider has only one correspondence address.
- A provider must indicate the address where the provider wishes correspondence to be sent regardless of the service address(es).

  If the provider changes practices, partnerships, or place of practice, the provider must timely update the correspondence address; otherwise new correspondence will not be directed to the correct address. The provider may update this by using the AHCCCS Online provider portal at: https://azweb.statemedicaid.us

The *pay-to address* is the address on the reimbursement check from AHCCCS.

The Remittance Advice, along with the reimbursement check, are mailed to the provider's pay-to address, as determined by the provider's tax identification number (see next section).

NOTE: ACH payments (electronic reimbursement) are sent directly to your bank. Paper copies of the Remittance Advice are mailed to your pay-to address. If your pay-to address is a lockbox at the bank you should contact the Provider Registration Unit to change the pay-to address to the location where your payment posting occurs. This will prevent delays in receiving the remits from the lockbox. Should duplicate remits be required, the AHCCCS Finance Unit charges $2.00 per page to reproduce.

The *service address* is the business location where the provider sees patients or otherwise provides services.

A locator code (01, 02, 03, etc.) is assigned to each service address.

As new service addresses are reported to AHCCCS, additional locator codes are assigned.

When a service address is no longer valid, then the provider must notify AHCCCS of the new service address to ensure the new service address locator codes are updated. A provider must report in APEP a change in servicing address at least 30 days prior to the effective date of the change.

Tax Identification Number

A provider's tax identification number (TIN) determines the address to which payment is sent.

AHCCCS requires providers to enter their TIN on all Fee-For-Service claims submitted to the AHCCCS Administration. If no TIN is on file, the AHCCCS system will deny the claim because

it will be unable to direct payment to a specific address.

If a provider's record shows more than one address linked to a TIN, the system will direct payment and the Remittance Advice to the first address with that TIN. Providers who request reimbursement checks directed to more than one address must establish a separate TIN for each pay-to address.

> Note: Previously, a provider's two-digit service address locator code (01, 02, 03, etc.) was linked to one or more pay-to addresses. The locator code determined the address to which payment was sent.
>
> Providers should continue to append the service address locator code to their AHCCCS provider ID number to indicate the location where a service was performed. However, using the locator code will no longer direct payment to a specific address.
>
> Providers must enter the appropriate TIN on the claim form to direct payment to the correct address

Providers who have questions about TIN information on file with AHCCCS should contact the AHCCCS Provider Registration Unit.

Changes to Information on File

It is the provider's responsibility to timely notify the Provider Registration Unit in writing of any changes to the information on file at AHCCCS. Failure to report changes may result in misdirected payments and correspondence and could result in the termination of the provider's active status or recoupment of payment.

All changes to information on file must be signed by the provider or the provider's authorized agent. The authorized agent must be authorized by the provider and on file with the Provider Registration Unit.

Changes that must be reported include, but are not limited to, changes affecting:

- Licensure/Certification

  A copy of the licensure or certification document must accompany notification.

- Addresses (correspondence, pay-to, and/or service)

  Change of address forms are available from the Provider Registration Unit.

  When a provider changes an address, a letter is sent to the provider for verification.

  If the address information on the verification letter is incorrect, the provider must indicate the necessary changes, sign the letter, and return it to the Provider Registration Unit.

If the address information on the verification letter is correct, no further action by the provider is required.

A provider must report in APEP a change in servicing address at least 30 days prior to the effective date of the change.

- Name

  A letter advising AHCCCS of the name change and supporting documentation (marriage license, divorce decree, or a copy of the provider's current license) is required.

  A new Provider Agreement must be signed under the new name.

- Group Billing Arrangements
- Ownership

  The Provider Registration Unit will mail the provider a new registration packet.

  The provider must complete a new Provider Registration Packet.

  When all information is received from the appropriate agencies, the Provider Registration Unit will assign a new AHCCCS Registration number.

- Hours of Operation

  A provider must report in APEP a change in hours of operation at least 5 days prior to the effective date of the change.

  In case of an emergency that results in a facility closure, a provider must provide AHCCCS written notice within 24 hours of the emergency. The closure and the reason for closure must be posted at the entrance of the facility.

Licensure/Certification Updates

Each provider must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

AHCCCS systematically sends a letter requesting a renewed license/certificate to a provider's license/certification board or agency (except the Arizona Medical Board), prior to expiration of the provider's license.

If a response is not received from the board or agency within 45 calendar days, a request for a copy of a renewed license/certificate is sent directly to the provider. If the provider does not provide a copy of current license/certification within 21 calendar days of the notification, the provider's active status will be terminated.

All providers are required to revalidate their enrollment with AHCCCS every five years beginning January 1, 2012. Providers will be contacted when their renewal is due.

Providers registered prior to January 1st, 2012 will be required to re-enroll and then revalidate every five years thereafter. Providers will be contacted regarding their reenrollment date.

Medical Records

As a condition of participation, providers must maintain and make available all records and information including, but not limited to, medical and financial records, relating to the AHCCCS program. Upon request such records shall be provided at no cost to the AHCCCS Administration or its Contractors.

The member's medical records must be maintained in a current, detailed, organized, and comprehensive manner that permits effective review. Records must be legible and reflect all aspects of care, including ancillary services.

Electronic Health Records

Providers must ensure that its Electronic Health Records (EHR) System accurately records, maintains, and reflects all original entries including, but not limited to, original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). Providers shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.

Signature Requirements

Medical records documented on hard copy shall be written legibly in blue or black ink, signed, and dated by the rendering provider for each entry. Electronic format medical records shall also include the provider's name who made the entry and the date for each entry. Providers in multi-provider offices shall have the treating provider sign his or her treatment notes after each appointment and/or procedure. Provider signature shall occur as close to the actual entry of treatment notes as possible and based on either professional standards of care and/or requirements specified within A.A.C. Title 9, Chapter 10.

Acceptable Signatures:

Valid signatures may be electronic or physically handwritten; however, both shall have the legible name of the signer printed, signer's credentials (specific license type of professional credentials), and the date of signing. The signature must be unique to that individual and linked to the medical record. Providers shall adhere to all electronic signature requirements as described in detail in AHCCCS policy AMPM 940, ARS 44-7031 and applicable CMS rules.

Not allowed:

Rubber stamps, copy/paste signatures, manually typed or word-processed name or "electronic signature" or typed timestamp if not part of the certificate of secure electronic system. Per ARS 18-106, "An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated."

On-Sight Audit

For providers serving AHCCCS members, AHCCCS reserves the right to conduct on-sight audits for quality-of-care purposes, either directly or via a Managed Care Organization. On-sight audits will be conducted on any related documentation for these members.

1. AHCCCS and/or MCO audit teams will internally identify documentation to be audited, and a list of specified items will be given to the provider at the commencement of the on-site visit.

2. Audits will occur on site and will be based on members utilization of services.

3. Providers shall supply the complete documentation as requested by the AHCCCS and/or MCO Audit Team within two hours of the request. Documentation shall be delivered as a paper copy of the documents.

Agencies/Companies

Agencies and companies without licensing requirements must provide **documentation** of all employees (i.e. attendant care companies, non-emergency transportation providers etc.) and their required licenses or certification upon request.

Agencies and companies are responsible for verification of their employees' qualifications to participate in the Medicaid program. Failure to do so will result in termination of participation in the Medicaid program.

Incentives

Contractors may not offer members incentive items (e.g. gift cards, discounts for merchandise or services, manufacturer or store coupons for savings on products) to influence their enrollment or continued enrollment with a particular Contractor, as specified in A.A.C R9-22-504.

Among other activities not permitted, 42 USC 1320a-7b (b)(2) prohibits individuals from (knowingly and willfully) offering or paying any remuneration, whether it is cash or in kind, to anyone for the purpose of inducing that individual to order or arrange for any service or item for which payment may be made by a federal health care program, including Medicaid. The offer or payment may be direct or indirect. Such conduct is considered a felony with the possibility of imprisonment up to 5 years as well as a fine not to exceed $25,000.

Contractors *may* offer incentive items to members to participate in health-related promotions, but the total value of the items at each event or program may not exceed $50.00 per member annually.

Physician/Mid-Level Practitioner Registration

Hospitals and clinics may not bill the AHCCCS Administration or its Contractors for physician and mid-level practitioner services using the hospital or clinic NPI number.

Physicians and mid-level practitioners must register with AHCCCS and bill for services under their individual NPI numbers.

Mid-level practitioners include:

- Physician Assistants
- Registered Nurse Practitioners
- Clinical Nurse Specialist
- Certified Nurse-Midwives
- Certified Registered Nurse Anesthetists (CRNAs)
- Surgical First Assistants
- Affiliated Practice Dental Hygienist

Note**:** Physician Assistants, Certified Nurse-Midwives, Clinical Nurse Specialist, and Nurse Practitioners are reimbursed at 90 per cent of the AHCCCS capped fee or billed charges, whichever is less. Surgical First Assistants are reimbursed at 70 per cent of the AHCCCS capped fee or billed charges, whichever is less. CRNAs are reimbursed at 100 per cent of the AHCCCS capped fee or billed charges, whichever is less. Affiliated Practice Dental Hygienists are reimbursed at 80 per cent of the AHCCCS capped fee or billed charges, whichever is less.

Hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners. In these cases, the claims submitted to AHCCCS must include *both* the physician's/mid-level practitioner's NPI as the rendering/service provider and the hospital's/clinic's or group biller NPI number.

AHCCCS Registration in Accordance with 42 CFR 455.410

Per 42 CFR 455.410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) must require all ordering or referring physicians, or other professionals providing services under the State plan or under a waiver of the plan, to be enrolled as participating providers. All providers, including but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

After January 1st, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny.

A provider who chooses to order, refer, or prescribe items and/or services for AHCCCS members, but who chooses not to submit claims to AHCCCS directly, must still be registered with AHCCCS to ensure payment of those items and/or services. If a rendering provider submits a claim to AHCCCS based on the order, referral, or prescription of a provider *not* registered with AHCCCS then that claim will be denied. To ensure payment of claims when submitting for items and/or services ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is both registered with AHCCCS and that their NPI number is on the submitted claim.

Locum Tenens

BILLING UNDER LOCUM TENENS ARRANGEMENTS

It is the policy of the AHCCCS Administration to recognize locum tenens arrangements but to restrict them to the length of the locum tenens registration with the Arizona Medical Board. The Arizona Medical Board issues locum tenens registration for a period of 180 consecutive days once every three years to allow a physician, who does not hold an Arizona license, to substitute for or assist a physician who holds an active Arizona license. Locum tenens registration with the Arizona Medical Board is required before AHCCCS recognizes a locum tenens arrangement.

The locum tenens provider must submit claims using the AHCCCS provider ID number of the physician, for whom the locum tenens provider is substituting for or temporarily assisting.

All services provided by the locum tenens provider must be billed with the “Q6” modifier. Practices using locum tenens arrangements must maintain a log identifying which locum tenens providers are substituting for or assisting which AHCCCS-registered providers.

Provider Types 40 (Attendant Care)

Effective 6/1/2015 a provider registering as a Provider Type 40 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 these provider types will be able to bill NEMT services. However, the NEMT services should not exceed 30% of the overall services billed.

Terminations

There are several reasons a provider's participation in the AHCCCS program may be terminated.

- Voluntary Termination

  Upon thirty (30) days written notice, either party may voluntarily terminate this Agreement. Providers may voluntarily terminate participation in the program by providing 30 days written notice to:

  AHCCCS Provider Registration Unit
  MD 8100
  P.O. Box 25520
  Phoenix, AZ 85002

- Loss of Contact

  AHCCCS may terminate a provider's participation due to loss of contact with the provider.

  Contact is considered to be lost if mail is returned as undeliverable by the Postal Service.

  Providers must inform the Provider Registration Unit of any address changes to avoid misdirected or lost mail and possible termination of the provider's active status.

- Termination for Cause

  AHCCCS will terminate participation in the program by providing 24 hours written notice when:
  - It is determined that the health or welfare of a member is endangered,
  - That the provider fails to comply with federal and state laws and regulations, or
  - There is a cancellation, termination, or material modification in the provider's qualifications to provide services.

  Any provider determined to have committed fraud or abuse related to AHCCCS, ALTCS or the Medicaid program in other states will be terminated or denied participation. This provision is also extended to providers terminated from Medicare participation.

  Providers, who AHCCCS determines to be rendering substandard care to AHCCCS or ALTCS members, may be terminated, suspended, or placed on restrictions or

review. Restrictions may be placed on the scope of services, service areas, health plan participation, or other limitations imposed related to quality of care.

If the provider's mandatory license or certification is revoked, suspended or lapses, the provider's participation shall be terminated or suspended.

Providers may be suspended or terminated when arrested by law enforcement.

Providers whose scope of service has been restricted by the licensing board may be terminated from the AHCCCS program.

Sanctions

Providers may be sanctioned by AHCCCS for violations of the terms of the Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the provider. The decision to sanction will be based on the seriousness of the offense, extent of the violation, and prior violation history.

AHCCCS may impose any one or any combination of the following sanctions against a provider, who has been determined to have abused the AHCCCS or ALTCS programs:

- Recoupment of overpayment
- Review of claims (prepayment or post-payment)
- Filing complaint with licensing/certifying boards or agencies, local, state or federal agencies, and/or reporting to National Data Banks.
- Peer Review
- Restrictions (e.g., restricted to certain procedure codes)
- Suspension or termination of provider participation

AHCCCS may impose any one or a combination of the following sanctions against a registered provider, who AHCCCS has determined to be guilty of fraud or convicted of a crime related to the provider's participation in Medicare, Medicaid, AHCCCS, or ALTCS programs:

- Recoupment of overpayment
- Suspension of provider participation
- Termination of provider participation
- Civil monetary penalty
- Criminal prosecution

Notice of Adverse Action

The Provider Registration Unit will provide written notice of termination or suspension to

providers, which will include the effective date, the reason, and the provider's grievance rights.

- Actions based on fraud or abuse convictions are effective on the date of the conviction.
- Actions due to revocation, suspension, or lapse of licensure or certification are effective the date that the license or certification becomes invalid.
- Actions due to the quality or appropriateness of care provided are effective on the date specified by the AHCCCS Office of Special Programs.
- All other adverse actions are effective 15 calendar days from the date of notification.

For adverse actions requiring 15 calendar days notice, the provider may submit evidence to Provider Registration disputing the action within 15 calendar days of the date of the notice. Provider Registration will review all documentation received by the first workday following the expiration of the 15-day notice period.

If Provider Registration confirms that the provider is eligible to participate, a notice will be sent to the provider verifying that no action will be taken to terminate participation.

Providers may grieve any adverse action including termination, suspension, and restriction

Claim Types

CMS-1500 (08/05), Item Number 24J, if not the same as 33

The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care.

UB-04, FL01

The name and service location of the provider submitting the bill.

ADA Dental Claim Form, Data Element 53

The treating, or rendering, dentist's signature and date the claim form was signed. (The ADA Dental Claim form does not contain a place for the treating dentist name, separate from the signature line.)

837 004010A1, Professional

AHCCCS recognizes the rendering/servicing provider from the electronic 837 professional claim, depending on how the transaction was created.

Starting at the "bottom" of the transaction the rendering provider may be

2420A – Rendering Provider Name.
Note 2.
Required if the Rendering Provider NM1 information is different than that

carried in the 2310B (claim) loop, or if the rendering provider information is carried in the 2310B (claim) loop, or if the rendering provider information is carried at the billing/pay-to provider loop level (2010AA/AB) and this

particular service line has a different rendering provider than what is given in the 2010/AA/AB loop. The identifying payer specific numbers are those that belong to the destination payer identified in loop 2010BB.

AHCCCS Billing Requirements

AHCCCS does not recognize multiple rendering providers on one claim. If the line level rendering provider (Form locater 24J) is different from the claim level rendering provider (Form locator 31), separate claims must be submitted for payment. Claims submitted with multiple rendering providers will be accepted by AHCCCS, but denied within the adjudication system.

2310B – Rendering Provider Name:

Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.

Used for all types of rendering providers, including laboratories. The rendering provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.

OR

2000A – Billing/Pay-To Provider Hierarchical Level:

Use the billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID - 2010BC. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.

2010AA – Billing Provider Name

Although the name of this loop/segment is “Billing Provider” the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.

If the rendering provider and the billing provider are one and the same, the rendering/billing provider MUST be a registered AHCCCS provider with an AHCCCS Registered Provider Type that allows the services performed to be provided by that provider type.

837 004010A1, Dental

AHCCCS recognizes the rendering/servicing provider from the electronic 837 Dental claim, depending on how the transaction was created. Starting at the “bottom” of the transaction the rendering provider may be:

2420A – Rendering Provider Name

Required if the rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider than what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.

AHCCCS does not recognize multiple rendering providers on one claim. If the line level rendering provider is different from the claim level rending provider, separate claims must be submitted for payment. Claims submitted with multiple rendering providers will be accepted by AHCCCS, but denied within the adjudication system.

AHCCCS does not recognize the Assistant Surgeon Name Loop (2420C) within the 837 Dental transaction.

OR

2310B – Rendering Provider Name

This is required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.

OR

2000A – Billing/Pay To Provider Hierarchical Level:

Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in the Loop ID2010BC. The Billing provider entity may be a health care provider, a billing service, or some other representative of the provider.

2010AA – Billing Provider Name:

Although the name of this loop/segment is “Billing Provider” the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payer do not accept claims from non-provider billing entities.

If the rendering provider and the billing provider are the same, the rendering/billing provider MUST be a registered AHCCCS provider with an AHCCCS Registered Provider Type that allows the services performed to be provided by that provider type.

The following examples illustrate how claims would be processed and reimbursed in specific situations:

Example:

Dr. Jones is registered as a Physician under NPI# 9999999999. Dr. Jones has a

Physician Assistant that is also registered with AHCCCS and rendering services under NPI# 1111111111.

For services rendered by the Physician:

Dr. Jones will complete Field 33 with NPI #9999999999. Reimbursement is sent to the provider's pay-to address.

For services rendered by the Physician Assistant and are being billed by the Physician:

The Physician Assistant will insert the NPI #1111111111 in Field 33 under PIN#. Dr. Jones's NPI #9999999999 will also show in the Field 33 under GRP#. Reimbursement will be payable and delivered to Dr. Jones's pay-to-address.

The Physician Assistant would need to authorize Dr. Jones as a billing provider when setting up their provider registration file.

Revision/Update History

Date	Description of changes	Page(s)
3/11/24	Medical Records section updated with new subsection for Electronic Health Records, Signature Requirements, and Acceptable signatures.	12
8/29/23	Additional details added to the Servicing Address requirements. New language added for Hours of Operation change requirements. New section added for On-site Audit process.	9 & 11 11 12
10/1/21	Added Clinical Nurse Specialist to the list of Mid-level practitioners	13
9/12/2019	The 'Inactivity' section was removed as this is no longer AHCCCS' standard practice.	15

10/1/2018	The following clarification was added: "To become an AHCCCS provider, a provider must sign the Provider Participation Agreement (PPA). Per the PPA providers must follow all AHCCCS guidelines, policies and manuals, including but not limited to the following: the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Fee-For-Service Provider Billing Manual, AHCCCS Claims Clues, and Reporting Guides. These guidelines, policies and manuals are available on the AHCCCS website. Providers are encouraged to subscribe to receive notifications about upcoming trainings, forums, and important business updates	1
	via AHCCCS' email notification system. The email notifications, sent straight to a FFS provider's email inbox, are sent out regarding changes to the program, claims and billing updates and requirements, and system changes." The following was added regarding integration questions: "Fee-For-Service providers do *not* need to contract with AHCCCS AIHP, Tribal ALTCS or a TRBHA to continue providing Medicaid Title XIX and XXI services to FFS members. A provider simply must be an AHCCCS registered provider."	2
4/13/2018	A new section called "AHCCCS Registration in Accordance with 42 CFR 455.410" was added, detailing the Affordable Care Act's requirement for all providers to be registered with AHCCCS in order to be reimbursed.	13
1/26/2018	Registering for the Provider Portal (AHCCCS Online) section added, detailing information about the Master Account Holders account	7-8
12/22/2017	Acronym clarifications were added. The definitions section was moved. The Provider Registration Materials section was updated. The revalidation of enrollment information was updated. The Billing Providers & Group Billing Providers section was updated ACH Payment information was added. The Tax Identification Number section was updated. The Terminations section was updated. An Incentives section was added. General Formatting & Updates	1 1 & 2 3 3 7 11 12 13 14-15 All
05/29/2015	Correction – remove Provider Type 37; update percentage from 20% to 30%	14

01/01/2015	New document format; content, definitions updated by Provider Registration	All