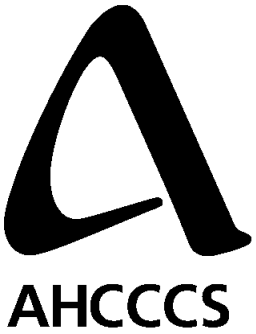
Chapter 1

Introduction to AHCCCS



This Page

Intentionally

Left Blank

USE OF THIS MANUAL

The *Fee-For-Service Provider Manual* is a publication of the Arizona Health Care Cost Containment System (AHCCCS), Claims Department, Division of Fee-for-Service Management. The Claims Department also publishes *Claims Clues* as a supplement to the manual. Questions or comments related to this manual should be directed to the AHCCCS Claims Policy Unit, 701 E. Jefferson, Mail Drop 8000, Phoenix, AZ 85034.

This manual also is available on line at www.azahcccs/gov. Any changes to the manual will be made on-line and available to providers for viewing.

This manual contains basic information concerning AHCCCS, Arizona's Medicaid Program (Title XIX), KidsCare and Arizona's SCHIP Program (Title XXI). The intent of this manual is to furnish providers' billing staff and contracted billers with information about AHCCCS, coverage of specific services, and requirements for completion and submission of fee-for-service claims to the AHCCCS Administration. Additional requirements are found in AHCCCS regulations, the provider agreement and Claims Clues.

Physicians, hospital administrators, and other medical professionals may only be interested in reviewing Chapter 1 of the manual. However, providers' office staff/billers should become familiar with requirements for recipient eligibility and enrollment, prior authorization requirements, and billing policies and procedures. Use of the manual will help reduce questions and expedite the claims process by ensuring that claims are filed correctly the first time.

This manual provides guidance for **fee-for-service claims** and it is **not** intended as a substitute or replacement for a health plan's or program contractor's billing manual. If you contract with or provide services to recipients enrolled with one or more AHCCCS health plans or program contractors, please continue to follow their instructions when providing and billing for services rendered to a recipient enrolled with that health plan or program contractor.

Note: The covered services, limitations, and exclusions described in this manual are global in nature and are included to offer general guidance to providers. The *AHCCCS Medical Policy Manual (AMPM)* also is available on the AHCCCS website at *www.azahcccs.gov.*

AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System was implemented on October 1, 1982, as the nation's first statewide indigent health care program designed to provide services to eligible persons primarily through a prepaid capitated managed care system. Operating as a demonstration project under the federal Medicaid program, AHCCCS receives federal, state and county funds to operate, plus some monies from Arizona's tobacco tax.

The Arizona Long Term Care System (ALTCS) was implemented December 19, 1988, for the developmentally disabled and on January 1, 1989, for the elderly and physically disabled. ALTCS provides institutional care and home and community based services to individuals who meet financial eligibility requirements and are at risk of institutionalization.

AHCCCS enrolls most eligible persons with acute care health plans and long term care program contractors. The health plans assume responsibility for the provision of all acute care covered services to enrolled recipients. The program contractors are responsible for providing and managing acute, behavioral health, and long term care services for ALTCS recipients.

NOTE: In this manual, the term "recipient" is used to describe an AHCCCS or ALTCS eligible individual who may be either fee-for-service or enrolled with a health plan or program contractor. The term "contractor" refers to both health plans and program contractors.

The contractors also are responsible for reimbursing providers for services rendered to eligible recipients during the prior period coverage (PPC) time frame that precedes the actual posting of enrollment with a contractor. The PPC period extends from the beginning date of an AHCCCS recipient's eligibility to the date prior to the recipient's date of enrollment with a contractor.

AHCCCS reimburses providers for services in only two ways:

1. Contractors receive a prepaid capitation payment each month to cover services provided to their enrolled members and members covered under PPC coverage. The contractors directly reimburse providers who subcontract with them or provide services to their enrolled recipients.
2. AHCCCS reimburses providers on a fee-for-service basis for services rendered to recipients eligible for AHCCCS or ALTCS but not enrolled with a contractor or covered under PPC coverage.

In limited situations, AHCCCS is authorized to reimburse recipients.

AHCCCS FEE-FOR-SERVICE POPULATIONS

The fee-for-service populations include the following groups:

- ☑ Recipients in the Federal Emergency Services (FES) program
- ☑ Recipients enrolled in Indian Health Services (IHS)
- ☑ On-reservation Native Americans enrolled with a tribal contractor

AHCCCS FEE-FOR-SERVICE PROVIDERS

The provider's primary role is to render medically necessary services to AHCCCS recipients. Prior to billing for services, the provider must be an active registered provider with AHCCCS. Providers may elect to only provide services to AHCCCS fee-for-service recipients or may subcontract with one or more contractors to provide services to enrolled recipients. However, the provider must be registered with AHCCCS in order to receive payment for services provided from either AHCCCS or any contractor.

AHCCCS-COVERED SERVICES

AHCCCS provides coverage for medically necessary services furnished to Fee-for-Service recipients by registered AHCCCS providers. AHCCCS-covered services are outlined for each Fee-for-Service population as follows:

Coverage of services falls into two broad categories:

☑ AHCCCS Acute Care

- ✓ Preventive and acute medical care services
- ✓ Behavioral health services
- ✓ Limited rehabilitative services, home health care, and nursing home care

AHCCCS Acute Care offers preventive, acute, and behavioral health care services with limited coverage of rehabilitative services, home health care and long term care, as specified in A.A.C. Title 9, Chapter 22, Articles 2 and 12. Acute care services covered under the Title XXI State Children's Health Insurance Program, known as KidsCare, are specified in A.A.C. Title 9, Chapter 31, Articles 2, 12, and 16.

☑ AHCCCS Long Term Care

- ✓ Preventive and acute medical care services
- ✓ Behavioral health services
- ✓ Long term care institutional services
- ✓ Alternative residential living services
- ✓ Home and community based services
- ✓ Speech, physical, respiratory, and occupational therapies
- ✓ Nursing services for ventilator dependent individuals residing at home

AHCCCS Long Term Care services are covered more extensively in ALTCS regulations, as specified in A.A.C. Title 9, Chapter 28, Articles 2 and 11.

Note: Out-of-state services are covered as provided for under 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical

emergency. Services furnished to AHCCCS members outside the United States are not covered.

Medical Necessity

Medical necessity may be determined through professional review for appropriateness of services provided in conjunction with established criteria related to severity of illness and intensity of services. Documentation submitted by providers is key to the determination of medical necessity. Failure to submit documentation that substantiates medical necessity may result in denial of reimbursement.

Utilization Management

Payment for services is subject to AHCCCS rules, the Provider Agreement, policies and requirements, including, but not limited to the following Utilization Management functions:

- ☑ Prior authorization
- ☑ Concurrent review
- ☑ Medical claims review
- ☑ Postpayment review
- ☑ Special consent requirements

Contact Telephone Numbers

Please see Exhibit 1-4 for a quick reference to important telephone numbers.