

REVISION DATES: 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 recipients.

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: The range of ambulance service suppliers; ASCs; CMHCS, CORFs; DMEPOS suppliers; ESRD facilities; FQHCs; histocompatibility laboratories; HHAs; hospices; hospitals, including but not limited to acute inpatient facilities; inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities, (IRFs), and physician-owned specialty hospitals; CAHS; independent clinical laboratories; IDTFs; mammography centers; mass immunizers (roster billers); OPOs; outpatient physical therapy/occupational therapy/speech pathology groups, portable x-ray suppliers; SNFs; radiation therapy centers; RNHCIs; and RHCs. In addition to the providers and suppliers listed previously, other agencies such as: Personal care agencies, non-emergency transportation providers, and residential treatment centers are included. (Note: the enrollment fee does not apply to physicians or non-physician practitioners).

Provider types requiring an enrollment fee can be found on the AHCCCS website www.azahccc.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.

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 and/or certificates
- 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 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

AHCCCS Provider Registration materials are available on the AHCCCS web site at www.azahcccs.gov. Click on the “Plans”, “Providers” and “Contractors” tabs. On the AHCCCS “Provider Registration” tab, click the “About Provider Registration” tab. The forms can be completed on the AHCCCS web site; however must be submitted by fax or mail.

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:

- 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.

Additional information about registering as an out-of-state provider can be found at <http://www.azahcccs.gov/commercial/ProviderRegistration/onetimewaiver>.

Definitions:

Servicing/Rendering Provider:

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

For purposes of AHCCCS claim submissions, the servicing (rendering) provider cannot be an AHCCCS registered provider type “01” – 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; the entity/person who will receive the check/wire/remit.

A Billing Entity:

AHCCCS identifies a billing entity as the recipient of the payment. This Provider can be a rendering/servicing provider; group biller (Provider type 01) or billing entity.

Group Billing Entity:

The group billing entity is the recipient of the payment. This provider can be a rendering/servicing provider, a group biller or a billing entity.

AHCCCS Provider Types

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. 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.

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 license/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.

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)

Billing Providers

(Refer to Definitions section above)

In addition to allowing any organization electing to act as a financial representative for any provider or group of providers who has authorized this arrangement to register as a Group Biller with AHCCCS (and 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 sign a group biller authorization form.

Each service provider using either billing provider arrangement (as noted above) must register as an AHCCCS provider and must sign a Billing Provider Authorization Form. The authorization form is available from the Provider Registration Unit. 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.

Each service (rendering) provider is the provider which remains affiliated with the authorized billing provider arrangement until the service (rendering) provider furnishes written notification to Provider Registration indicating termination of the billing arrangement.

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

Claim Types:

(Refer to Definitions section above)

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 locator 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 payor 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 rendering 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

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 the 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 Physician:

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

For service rendered by the Physician Assistant 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.

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. This may be accomplished by the Provider using the AHCCCS on-line web site.

<https://azweb.statemedicaid.us/Home.asp>

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).

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.

Tax Identification Number

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

AHCCCS requires providers to enter their tax identification number on all fee-for-service claims submitted to AHCCCS. If no tax ID 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 tax ID number, the system will direct payment and the Remittance Advice to the first address with that tax ID number. Providers who request reimbursement checks directed to more than one address must establish a separate tax ID for each pay-to address.

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

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 1/1/12 will be required to reenroll and then revalidate every five years thereafter. Providers will be contacted regarding their reenrollment date.)

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.

Companies/Agencies 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.

Changes to Information on File

It is the provider's responsibility to timely notify the Provider Registration Department 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 Department.

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 Department.

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 Department.

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

- 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 Department 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 Department will assign a new AHCCCS Registration number.

Physician/Mid-Level Practitioner Registration

Hospitals and clinics may not bill 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
- Certified nurse-midwives
- Certified registered nurse anesthetists (CRNAs)
- Surgical first assistants
- Affiliated Practice Dental Hygienist

Note: Physician assistants, certified nurse-midwives, 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.

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 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.

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 recipient'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.

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 Department
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 Department of any address changes to avoid misdirected or lost mail and possible termination of the provider's active status.

- Inactivity

Provider participation will be terminated if the provider does not submit a claim to AHCCCS or one of the AHCCCS-contracted health plans or program contractors within a 24-month period.

- 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 recipient is endangered.
- That the provider fails to comply with federal and state laws and regulations.
- 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 or 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 are determined to be rendering substandard care to AHCCCS or ALTCS recipients 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 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/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 including fraudulent or abusive conduct on the part of the provider. In determining consideration, a 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 sanctions, including those described below:

- 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.
- Restrictions (e.g., restricted to certain procedure codes)
- Suspension or termination of provider participation

Revision/Update History

Date	Description of changes	Page(s)
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