FEE-FOR-SERVICE PROVIDER BILLING MANUAL

(ALL CHAPTERS)

CHAPTER 1 ~ INTRODUCTION TO AHCCCS

CHAPTER 1 – INTRODUCTION TO AHCCCS

Revisions: 10/22/2018; 10/1/2018; 4/26/2018; 3/9/2018

USE OF THIS MANUAL

The **Fee-For-Service Provider Billing Manual is intended** to outline billing requirements for providers who are billing the AHCCCS FFS unit for reimbursement.

The AHCCCS *Fee-For-Service Provider Billing Manual* is a publication of the Arizona Health Care Cost Containment System's (AHCCCS) Claims Department of the Division of Fee-for-Service Management (DFSM). The Claims Department also publishes *Claims Clues* as a supplement to this 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 is also available online at:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html.

Any updates to the manual will be posted on the AHCCCS website and available to providers for viewing. Any updates will *also* be listed at the bottom of each, individual chapter, under the Revision History section, so that providers may see, at a glance, the most recent updates to each chapter.

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 the completion of Fee-For-Service claims that are submitted to DFSM. Additional requirements are found in AHCCCS regulations, the Provider Agreement, and the Claims Clues publications.

Physicians, hospital administrators, and other medical professionals may only be interested in reviewing chapters pertaining directly to their specialty, in addition to chapter 1 of this manual. However, the office staff and billers of providers should also become familiar with the requirements for member eligibility and enrollment, prior authorization requirements, claims submissions, billing policies and procedures, and the use of modifiers. Use of this

manual will help reduce questions and expedite the claims process by ensuring that claims are submitted correctly the first time.

This manual provides guidance for **Fee-For-Service claims *only*** and it is **not** intended as a substitute or a replacement for a health plan's or a program contractor's billing manual.

- If you contract with and/or provide services to members enrolled with an AHCCCS health plan or program contractor, please continue to follow their instructions when providing and billing for services rendered to a member 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)* contains additional information about covered services, limitations and exclusions, and is available on the AHCCCS website at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/.

AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System (AHCCCS) 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 members. The program contractors are responsible for providing and managing acute health, behavioral health, and long term support services for ALTCS members.

On October 1, 2018 AHCCCS integrated physical and behavioral health care for most members. This is referred to as AHCCCS Complete Care (ACC). For additional information on integration please visit the AHCCCS website.

NOTE: In this manual, the term "member" 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 members 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 member's eligibility to the date prior to the member'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. The contractors then directly reimburse providers who subcontract with them or provide services to their enrolled members.
2. AHCCCS reimburses providers on a Fee-For-Service basis for services rendered to members eligible for AHCCCS or ALTCS, who are not enrolled with a contractor or covered under PPC.

In limited situations, AHCCCS is authorized to reimburse members.

AHCCCS FEE-FOR-SERVICE POPULATIONS

The Fee-For-Service populations include members that are enrolled in the following programs:

- The American Indian Health Program (AIHP),
- Tribal Regional Behavioral Health Authority (TRBHA),
- Tribal ALTCS,
- Federal Emergency Services Program (FESP),
- FFS Regular,
- FFS Temporary,
- FFS Prior Quarter,
- Hospital Presumptive Eligibility (HPE), and
- Third Party Accounts.

AHCCCS FEE-FOR-SERVICE PROVIDERS

The provider's primary role is to render medically necessary services to AHCCCS members. 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 members or may subcontract with one or more contractors to provide services to enrolled members.

NOTE: The provider **must** be registered with AHCCCS in order to receive payment for any services provided from **either** AHCCCS or any contractor.

AHCCCS-COVERED SERVICES

Emergency Services

Per A.A.C. R9-22-210, AHCCCS provides coverage for emergency medical and behavioral health services for members who are not in the Federal Emergency Services Program (FESP), for the treatment of an emergency condition.

An emergency condition is a medical or behavioral health condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the member's health, including mental health, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Serious physical harm to self or another person.

Emergency medical services are covered for members when there is a demonstrated need and/or after triage/emergency medical assessment services indicate an emergency condition. A provider is not required to obtain prior authorization for emergency services.

For additional information on emergency services for members, who are not in FESP, please refer to AMPM 310-F, Emergency Services.

For information on FESP coverage please refer to AMPM Chapter 1100, Federal Emergency Services (FES) Program or to Chapter 18, Federal Emergency Services Program of the Fee-For-Service Provider Billing Manual.

Acute and Long Term Care Services

AHCCCS provides coverage for medically necessary services furnished to Fee-For-Service members by registered AHCCCS providers.

Coverage of services falls into two broad categories: AHCCCS Acute Care and the Arizona Long Term Care System (ALTCS).

AHCCCS Acute Care

AHCCCS Acute Care offers preventive, acute, and behavioral health care services (except for members determined to be SMI, or Seriously Mentally Ill), and it also covers General Mental Health and Substance Use Disorders (GMH/SA). There is 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.

- For an overview of AHCCCS covered services for Acute Care refer to:
  - AMPM Exhibit 300-1, AHCCCS Covered Services Acute Care; and
  - The AHCCCS Medical Policy Manual (AMPM), which has policies that detail additional covered and uncovered services.
- For an overview of AHCCCS covered services for Behavioral Health refer to AMPM Exhibit 300-2A, AHCCCS Covered Services Behavioral Health.

Acute care services covered under Title XXI, the State Children's Health Insurance Program (also known as KidsCare), are specified in A.A.C. Title 9, Chapter 31, Articles 2, 12, and 16.

- For an overview of AHCCCS covered services for Title XXI (KidsCare) members refer to:
  - AMPM Exhibit 300-1, AHCCCS Covered Services Acute Care; and
  - The AHCCCS Medical Policy Manual (AMPM), which has policies that detail additional covered and uncovered services.
- For an overview of AHCCCS Behavioral Health services for Title XXI (KidsCare) members refer to AMPM Exhibit 300-2A, AHCCCS Covered Services Behavioral Health.

Arizona Long Term Care System (ALTCS)

The Arizona Long Term Care System covers, but is not limited to, the below list of services.

- Preventive and acute medical care services such as:
  - Doctor visits,
  - Hospitalizations,
  - Prescriptions (prescription coverage is limited for people who have Medicare),
  - Labs,
  - X-rays, and/or
  - Tests and other specialist treatments.
- Home and Community Based Services (HCBS) such as:
  - Home Health Nursing;
  - Personal Care;
  - Homemaker;
  - Home Health Aide;
  - Habilitation;
  - Medical Transportation;
  - Attendant Care;
  - Home Delivered Meals;
  - Adult Day Care;
  - Behavioral Health;
  - Respite Care;
  - Hospice;

  - Nursing services for ventilator dependent individuals residing at home;
  - Services may also be provided in a supervised alternative setting, such as an Adult Foster Care Home, Assisted Living Home, Group Home, or a Level I, II, or III Behavioral Health Center.
- Long term care institutional services such as:
  - Alternative residential living services,
  - Nursing Home Care, or
  - Intermediate Care Facility.
- Residential treatment facility for persons under 21 years of age;
- Psychiatric hospital for persons age 65 or older;
- Speech, physical, respiratory, and occupational therapies; and/or
- Dental, including:
  - Medically necessary dental services up to $1,000.00 per benefit year for:
    - Diagnostic,
    - Therapeutic,
    - Preventative care; and/or
    - Dentures.
- Emergency dental services up to $1,000 per benefit year.

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

Note: Out-of-state services are covered when the conditions outlined in 42 CFR, Part 431, Subpart B are met.

- Services are needed because of a medical emergency;
- Services are needed and the member's health would be endangered if he were required to travel to his/her State of residence;
- The State determines, on the basis of medical advice, that the needed services, or necessary supplemental resources, are more readily available in the other State; or
- It is the general practice for the members in a particular locality to use medical resources in another State.

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

Medical Necessity

Medical necessity may be determined through a professional review for appropriateness of services 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
- Post-Payment Review
- Special Consent Requirements

Prior Authorization

Certain services may require prior authorization. Prior Authorization (PA) is a process by which the AHCCCS Division of Fee-For-Service (FFS) Management (DFSM) determines in advance whether a service that requires prior approval will be covered, based on the initial information received.

For information on Prior Authorization please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual and to AMPM 820, Prior Authorizations. Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process and services requiring PA, which can be found at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

Contact Telephone Numbers

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

REVISION HISTORY

Date	Description of changes	Page(s)
10/22/18	The following verbiage was added: The **Fee-For-Service Provider Billing Manual is intended** to outline billing requirements for providers who are billing the AHCCCS FFS unit for reimbursement.	1
10/1/2018	Information on Integration/AHCCCS Complete Care (ACC), when it begins, and which populations are excluded added. Clarification added to the AHCCCS Acute Care section. "AHCCCS contracted health plans" changed to "AHCCCS Complete Care (ACC) health plans" "MCOs" removed throughout.	2 5 All All

4/26/2018	Prior Authorization section added, including a link to the PA webpage.	6-7
3/9/2018	AHCCCS Fee-For-Service Populations section updated Emergency Services section added AHCCCS Covered Services section updated to include updates for Emergency Services, Acute Care Services, and ALTCS Services	3 3-4 3-6
12/22/2017	Formatting	All

EXHIBIT 1-3 – INDIAN HEALTH SERVICES (IHS) OFFICES

Phoenix IHS
Two Renaissance Square
40 N. Central Ave., Suite 600
Phoenix, AZ 85004
(602) 364-5039

Tucson Area IHS
7900 S. J Stock Road
Tucson, AZ 85746
(520) 295-2405

Navajo Area IHS
P.O. Box 9020
Window Rock, AZ 86515
(928) 871-5811

For a more complete listing of Indian Health Service (IHS), Tribally-Operated 638 Programs and Urban Indian Health Programs in Arizona please visit the AHCCCS website at:

https://www.azahcccs.gov/AmericanIndians/AmericanIndianHealthFacilities/ITUsList.html

Exhibit 1-4~ Help Line Directory

For information related to **member eligibility and enrollment**:

AHCCCS Eligibility Interactive Voice Response System (IVR)
Phoenix area: (602) 417-7200
In state: 1-800-331-5090

AHCCCS Eligibility Verification Unit
Phoenix area: (602) 417-7000
All others: 1-800-962-6690 (In state)
1-800-523-0231 Ext. 6024177000 (Out of state)

For **prior authorization** for certain services and information about these services:

AHCCCS Prior Authorization Unit (Monday - Friday 8:30 a.m. - 4:30 p.m.)
Phoenix area: (602) 417-4400
In State (Outside Maricopa County): 1-800-433-0425
Out of State: 1-800-523-0231 Ext. 6024174400 (*or* ask for the PA area)
Fax # (general) - (602) 256-6591
Fax # (transportation providers only) – (602) 254-2431

To **register as an AHCCCS provider or to update your provider records**:

AHCCCS Provider Registration Unit
Phoenix area: (602) 417-7670 (Option 5)
In State (Outside of Maricopa County): 1-800-794-6862
Out of State: 1-800-523-0231 Ext. 6024177670 (Option 5)

If you have **questions related to claims in process and/or billings:**
**** See Claims Status information below (automated process)**

AHCCCS Claims Customer Service Unit
Phoenix area: (602) 417-7670 (Option 4)
In State:
Out of State: 1-800-523-0231, Ext. 6024177670 (Option 4)

For **information about covered services please email:**

AHCCCS Office of Medical Policy and Programs
DHCMContractsandPolicy@azahcccs.gov.

For **information about electronic claims *Submission or Electronic remittance advice SETUP Assistance* please email*:***

Electronic Claims Submission Unit
edicustomersupport@azahcccs.gov

For **information about electronic claim *TRANSMISSION* please email:**

AHCCCS Customer Support
edicustomersupport@azahcccs.gov

For **information about "Credit Memos" on Remittance Advice:**

AHCCCS Division of Business and Finance
(602) 417-5500

****Claim Status** – AHCCCS has developed a web application (the AHCCCS Online Provider Portal) that allows providers to check the status of claims using the Internet, https://azweb.statemedicaid.us. Customer support for this web application is at 602-417-4451.

If a provider does not have access to the Internet, they may call Claims Customer Service at 602-417-7670 (option 4), 1-800-654-8713 (In State), or 1-800-523-0231, Ext. 6024177670 (Out of State).

Information regarding submitting claims via the Web – AHCCCS allows providers to submit Professional, Institutional and Dental claims via the AHCCCS website. Go to https://azweb.statemedicaid.us. AHCCCS registered providers will need to establish a username and password for login purposes if you have not already established one.

CHAPTER 2 ~ ELIGIBILITY

CHAPTER 2 – ELIGIBILITY

Revision Dates: 10/1/2018; 12/29/2017; 12/22/2017

GENERAL INFORMATION

All Arizona residents can apply for AHCCCS services or the Arizona Long Term Care System (ALTCS) program. There are many programs that individuals may qualify for in order to receive AHCCCS medical or behavioral health services or ALTCS coverage.

The programs have a number of different financial and non-financial requirements that applicants must meet, including, but not limited to:

1. Proof of Arizona residency at the time of application.
2. Proof of U.S. citizenship and identity or proof of qualified alien status.
   - If a non-citizen does not meet the qualified alien status requirements for full services, but meets all other requirements for the Caretaker Relative, SOBRA Child, SOBRA Pregnant Woman, Young Adult Transitional Insurance (YATI), Adult, or SSI-MAO category, the individual is eligible to receive Federal Emergency Services (FES) only.
3. An income test that requires applicants to identify all individual and/or family earned and unearned income and to provide documentation if needed.
4. A resource test that requires applicants to identify resources (e.g., homes, other property, liquid assets, vehicles, and any other item of value) and provide documentation of their value.

   NOTE: A resource test is only required for the ALTCS program.
5. Other requirements
   - Each program has certain non-financial and/or financial requirements that are unique to the program and are aimed at servicing specific groups of people.

For additional information please refer to https://azahcccs.gov/Members/GetCovered.

Eligibility

Eligibility determination is not performed under one roof, but by various agencies, depending on the eligibility category.

For example:

- Pregnant women, caretaker relatives, children, and single individuals enter AHCCCS by way of the Department of Economic Security.

- The blind, aged or disabled, who receive Supplemental Security Income, enter through the Social Security Administration.
- Eligibility for categories such as ALTCS, SSI – Medical Assistance Only (Aged, Blind and Disabled, who do not qualify for Supplemental Security Income cash payment), KidsCare, Freedom to Work, Breast and Cervical Cancer Treatment Program and Medicare Cost Sharing programs are handled directly by the AHCCCS Administration.

Each eligibility category has its own eligibility criteria. This information is also available on the AHCCCS website at:

https://azahcccs.gov/AHCCCS/AboutUs/programdescription.html

1. Coverage for parents and caretaker relatives is provided under Caretaker Relatives.
2. Coverage for children is provided under the following eligibility categories:
    a. ALTCS
    b. KidsCare
        i. KidsCare is Arizona's version of the Title XXI State Children's Health Insurance Program.
        ii. It covers low-income children under age 19, if the family income is less than 200 percent of the Federal Poverty Level (FPL).
    c. Child Group
    d. SSI Cash (Title XVI) or SSI MAO
    e. Young Adult Transitional Insurance (YATI) for former Foster Care Children aged 18 to 26
    f. Foster Care Children
    g. Adoption Subsidy Children
    h. Newborns
    All babies born to AHCCCS-eligible mothers are also deemed to be AHCCCS eligible and may remain eligible for up to one year, as long as the newborn continues to reside in Arizona.
        i. Newborns born to mothers receiving Federal Emergency Services (FES) also are eligible up to one year of age. While the mother will be covered on a Fee-For-Service basis under FESP, the newborn will be enrolled with a health plan.
        ii. Newborns born to mothers enrolled in KidsCare will be approved for KidsCare beginning with the newborn's date of birth, unless the child is Medicaid eligible.
        iii. Newborns receive separate AHCCCS ID numbers and services for them must be billed separately using the newborn's ID. Services for a newborn that are included on the mother's claim will be denied.
3. Coverage for single individuals and couples is provided under the following eligibility categories:
    a. ALTCS
    b. Breast and Cervical Cancer Treatment Program

c. Family Planning Services (FPS) provides family planning services for up to 24 months to SOBRA pregnant women after a 60-day post partum period.
d. SOBRA Pregnant Women
e. SSI Cash (Title XVI) or SSI MAO
f. Adults
g. Freedom to Work
h. Transplants
i. Medicare Cost Sharing
j. Hospital Presumptive Eligibility (HPE)

Various Medicare Savings Programs help members pay Medicare Part A & B premiums, deductibles, and coinsurance.

1. Qualified Medicare Beneficiary (QMB)
2. Qualified Individual 1 (QI-1)
3. Specified Low Income Medicare Beneficiary (SLMB)

COVERAGE OUT OF STATE

A member, who is temporarily out of the state but still a resident of Arizona, is entitled to receive AHCCCS benefits under any of the following conditions:

1. Medical services are required because of a medical emergency. Documentation of the emergency must be submitted with the claim to AHCCCS.
2. The member requires a particular treatment that can only be obtained in another state.
3. The member has a chronic illness necessitating treatment during a temporary absence from the state or the member's condition must be stabilized before returning to the state.

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

ELIGIBILITY EFFECTIVE DATES

The following general guidelines apply to eligibility effective dates:

1. For most members, eligibility is effective from the first day of the month of application, the first day of the month in which the member meets the qualifications for the program, or their date of birth, whichever is later.

2. For KidsCare members, if the eligibility determination is completed by the 25th day of the month, eligibility begins on the first day of the following month. For eligibility determinations completed after the 25th day of the month, eligibility begins on the first day of the second month following the determination of eligibility.

3. For Medicare Savings Program (MSP) – QMB members, eligibility begins with the month following the month that QMB eligibility is determined.

4. For Breast and Cervical Cancer Treatment Program (BCCTP) members, eligibility begins on the later of the first date of the month (the application month for BCCTP is the month of the BCCTP diagnosis), or the first day of the month in which the customer meets all the BCCCTP eligibility requirements.

5. For a move into state or release from prison, the begin date is no sooner than that date.

ENROLLMENT

AHCCCS *pre-enrolls* most acute care members with contractors of their choice when they apply for eligibility through DES and the Social Security Administration. Each member who applies at a DES or SSA office receives information about the contractors available to him or her.

ALTCS applicants in Maricopa County and all SSI-MAO applicants also have the opportunity to select a contractor during the application process.

KidsCare applicants may choose a contractor prior to approval of their application.

Because the member can select a contractor while the eligibility decision is pending, he or she is enrolled on the same day that he or she is determined eligible. A member who does not choose a contractor is auto-assigned to a contractor on the same day that his or her eligibility is posted in the AHCCCS system. The person then has 30 days to enroll with a different contractor, if they wish.

A person who is in the Address Confidentiality Program (ACP) has a pre-assigned address in Maricopa County, regardless of where the individual lives. If the person is not currently enrolled with an AHCCCS contractor, AHCCCS enrolls the person in Fee-For-Service until a choice is obtained. If the person is currently enrolled with an AHCCCS contractor they will remain with that contractor, unless the person is in another county and qualifies for a plan change.

Contractors are responsible for reimbursing providers for covered services rendered to members during the Prior Period Coverage (PPC) time frame. The PPC time frame is the period between the member's starting date of AHCCCS eligibility and their date of enrollment with a contractor.

Example

05/12	Member applies at DES and indicates their choice of health plan, which is sent to AHCCCS.

06/18	DES approves the application and sends the transaction to AHCCCS.
06/19	Eligibility is approved by AHCCCS with an effective date of 05/01 and enrollment is posted and back-dated to 5/01.

The member is enrolled in his or her pre-selected plan. If the member did not make a pre-enrollment choice, then AHCCCS follows re-enrollment rules and family continuity rules before auto-assigning the member to a plan.

The health plan is responsible for the Prior Period Coverage (PPC) time frame from 05/01 (the start of eligibility) through 06/18 (the day before the enrollment was processed). The plan is capitated at the appropriate PPC rate for this time frame. Starting on 06/19, the plan is then capitated under the appropriate on-going rate.

The eligibility begin date may be different than the Program Contractor enrollment date, if the member is acute care eligible. The member will remain enrolled in the acute care health plan until the day of ALTCS approval.

AHCCCS Complete Care (ACC) members, who maintain eligibility, may change plans once a year during their enrollment anniversary month. The enrollment anniversary is the month in which a member was first enrolled with an AHCCCS contractor. American Indian/Alaskan Native (AI/AN) members may choose to switch their enrollment between an AHCCCS Complete Care (ACC) health plan or the American Indian Health Program (AIHP) at any time. However, they may only change between different ACC plans once per year during annual enrollment.

If more than one person in a household/case is on AHCCCS, that household's anniversary is the month in which enrollment occurred for the member who has been an AHCCCS member continuously for the longest period of time. Any member of the household who wants to change plans may do so at the same time.

Two months prior to their anniversary date, members are reminded of their opportunity to change plans. Those who wish to change contractors have two months to notify AHCCCS of their decision.

The month following the choice is the transitional month, during which time AHCCCS notifies both the former plan and new plan of the enrollment changes. This allows the plans adequate time to transfer records and welcome new members.

Members who do not want to change plans will remain enrolled with their current plan as long as the eligibility remains open.

This same process applies to ALTCS members in Maricopa and Pima Counties, where a choice of contractors is available. Only one ALTCS contractor is available in other counties.

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.

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.

Prior Quarter Coverage Eligibility

Beginning on January 1, 2014, AHCCCS will be required to expand the time period that AHCCCS pays for covered services for an eligible individual. The expanded time period will include the three months prior to the month that the individual applied for AHCCCS, if the individual met AHCCCS eligibility requirements during the month in which the Medicaid covered service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

1. Received one or more AHCCCS covered services during the month, and
2. Would have qualified for AHCCCS at the time services were received if the person had applied for AHCCCS.

If the applicant is determined to qualify for AHCCCS during one or more of the three months prior to the month of their Medicaid application, then the individual will be determined to have “Prior Quarter Coverage” eligibility during those months.

As stated above, Prior Quarter Coverage eligibility began on January 1, 2014, which means that individuals applying for AHCCCS in February 2014 may be determined to qualify for prior quarter coverage during the month of January 2014. Persons applying in March 2014 may qualify for prior quarter coverage in January and February. Persons who apply on or after April 1, 2014 may qualify for prior quarter coverage for up to the full 3 months prior to the month of the Medicaid application.

AHCCCS will not institute prior quarter coverage eligibility before January 1, 2014.

The AHCCCS Administration will determine whether or not an applicant meets prior quarter coverage criteria. If so, the providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the member of prior quarter coverage eligibility.

For further information regarding the submission of prior quarter coverage claims, please refer to Chapter 4, General Billing Rules, of the IHS/638 Tribal Provider Billing Manual.

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)

In accordance with the Affordable Care Act, qualified hospitals may elect to participate in the Hospital Presumptive Eligibility (HPE) Program. Qualified hospitals may determine persons, who have not submitted a full application to AHCCCS, to be presumptively eligible for AHCCCS Medicaid covered services. Persons determined presumptively eligible will qualify for Medicaid services from the date the hospital determines the individual to be presumptively eligible through the last day of the month following the month in which the determination of presumptive eligibility was made.

- If a person is determined to be presumptively eligible on March 3rd then that person would qualify for Medicaid services, under HPE, from March 3rd through April 30th.
- Claims for persons determined to be presumptively eligible for AHCCCS should be submitted to the AHCCCS Administration until a full application is completed by the member and they have been enrolled with a Contractor.

For persons who apply for presumptive eligibility and who also submit a full application to AHCCCS, coverage of Medicaid services will begin on the date that the hospital determines the individual to be presumptively eligible and will continue through the date that AHCCCS issues a determination on that application. All persons determined presumptively eligible for AHCCCS will be enrolled with AHCCCS Fee-For-Service for the duration of the HPE period.

- Claims for persons determined to be presumptively eligible for AHCCCS should be submitted to the AHCCCS Administration until a determination is made on the application's status.

If a member, made eligible via HPE, is subsequently determined eligible for AHCCCS via the full application process, then Prior Period Coverage for the member will also be covered by AHCCCS Fee-For-Service. The member will be enrolled with the Contractor only on a prospective basis.

VERIFYING AHCCCS ELIGIBILITY AND ENROLLMENT

Even if a member presents an AHCCCS ID card or a decision letter from an eligibility agency, the provider must always verify the member's eligibility and enrollment status.

Effective dates of eligibility can only be verified through the AHCCCS system and may change as information is updated in the system. Eligibility categories also may change or be overridden by other eligibility categories. Members also may change their choice of contractors.

Although there are no Prior Authorization (PA) requirements during the PPC time frame, once prospective enrollment begins the contractors may impose PA requirements. These requirements may differ from those established by AHCCCS for Fee-For-Service members.

Providers may use any one of several verification processes to obtain eligibility, enrollment, and Medicare/TPL information (if available).

1. AHCCCS encourages verifications through a batch process (270/271), in which the provider sends a file of individuals to AHCCCS, which AHCCCS returns with information the following day. Information on that process can be obtained by calling the AHCCCS Help Desk at (602) 417-4451.

2. AHCCCS has developed a Web application that allows providers to verify eligibility and enrollment using the Internet. Providers also can obtain Medicare/TPL information for a member.
   a. To create an account and begin using the application, providers must go to https://azweb.statemedicaid.us.
   b. For technical support when creating an account, providers should call (602) 417-4451.

3. The Medical Electronic Verification System (MEVS) uses a variety of applications to provide member information to providers. For information on MEVS, please contact EMDEON at https://www.changehealthcare.com/contact-us.

4. The Interactive Voice Response system (IVR) allows an unlimited number of verifications by entering information on a touch-tone telephone.

   Providers may call IVR at:

   Phoenix: (602) 417-7200
   All others: 1-800-331-5090

5. In Maricopa County only, providers can request faxed documentation.
   Medifax EDI: 1-800-444-4336

6. If a provider cannot use the AHCCCS batch or web processes, IVR or EMDEON, for verification of eligibility or enrollment, the provider may call the *AHCCCS Verification Unit.*

The unit is staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Providers should be prepared to give the operator the following information:

a. *Provider* NPI (if applicable) or the AHCCCS Provider Registration number; and
b. *Member's* name, date of birth, and AHCCCS ID number or Social Security number; and
c. Date(s) of *s*ervice.

NOTE: Rate Codes can be referenced on the AHCCCS website.

Revision History

Date	Description of changes	Page(s)
10/1/2018	The Enrollment section was updated to include information about AHCCCS Complete Care and the fact that American Indian/Alaskan Native (AI/AN) members may choose to switch their enrollment between an AHCCCS Complete Care (ACC) health plan or the American Indian Health Program (AIHP) at any time. However, they may only change between different ACC plans once per year during annual enrollment.	5
12/29/2017	Hospital Presumptive Eligibility (HPE) section added	7
12/22/2017	Incentives information added Formatting	5 All

CHAPTER 3 ~ PROVIDER RECORDS AND REGISTRATION

Chapter 3 ~ Provider Records and Registration

Revision Dates: 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 (Outside of Maricopa County): 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231 Ext. 6024177670 (Option 5)

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 (Outside of Maricopa County): 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231 Ext. 6024177670 (Option 5)

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.
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.

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.

- 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.

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.

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
- 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.

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.

- 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 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)
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 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."	1 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

CHAPTER 4 ~ GENERAL BILLING RULES

Chapter 4 ~ General Billing Rules

Revision Dates: 7/10/2018; 4/13/2018; 3/28/2018; 2/9/2018; 1/12/2018; 09/14/2016; 05/24/2016; 03/31/2016; 09/15/2015; 12/18/2013

GENERAL INFORMATION

This chapter contains general information related to the AHCCCS billing rules and requirements. Policies regarding submission and processing of Fee-For-Service claims are communicated to providers via channels such as this AHCCCS Fee-For-Service Provider Billing Manual and the Claims Clues articles.

Claims must meet AHCCCS requirements for the submission of claims.

AHCCCS follows the HIPAA Compliant 837 transaction guidelines and the coding standards described in the UB-04 Manual; the 1500 Manual; the ADA Manual; International Classification of Diseases (ICD) Manual; Physicians' Current Procedural Terminology (CPT) Manual; Health Care Procedure Coding System (HCPCS) Manual; the CDT Manual for Dental (Current Dental Terminology); as well as the First Data Bank Blue Book for pharmacy information.

Claims Clues articles can be found on the AHCCCS website at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html

CLAIM SUBMISSION REQUIREMENTS FOR PAPER CLAIMS

When a claim is submitted please ensure that the printed information is aligned correctly with the appropriate section/box on the form. If a claim is not aligned correctly, it may cause the OCR system to read the data incorrectly and the claim will reject.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

Claims for services must be legible and submitted on the correct form for the type of service(s) billed. Claims that are not legible or that are not submitted on the correct form will be returned to providers without being processed.

- If a claim is returned, you must resubmit the claim on the correct type of claim form, submit it within the required time frame, and ensure that it is legible.
- This resubmitted claim **cannot** be a black and white copy of the previously submitted claim. The resubmitted claim **must** be submitted on a new, red claim form.

AHCCCS retains a permanent electronic image of all paper claims submitted, in accordance with State retention record requirements, requiring providers to file clear and legible claim forms.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Any documentation submitted with a claim is imaged and linked to the claim image. Documentation is required when resubmitting claims, even if the documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim. Documentation **must** be resubmitted. Each claim must stand on its own, as the system is unable to pull documentation from the previously submitted claim.

All paper claims should be mailed, with adequate postage, to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

Claim Submission Requirements for 837 Submitted Claims

AHCCCS also accepts HIPAA-compliant 837 electronic Fee-For-Service claims from all certified submitters. Providers and clearinghouses must successfully complete testing to be certified to submit 837 transactions.

For EDI inquiries, roster issues or to become an AHCCCS Trading Partner, please email EDICustomerSupport@azahcccs.gov.

Claim Submission Requirements for AHCCCS Online (Provider Portal)

Claims may also be submitted through the AHCCCS Online claim submission process. Document attachments may be submitted through the web upload attachment process in the Transaction Insight (TI) Portal or through batch 275.

For further information on how to submit claims through the Provider Portal please review the provider training available at:

https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2017/OnLineClaimsSubmission.pdf

CLAIM SUBMISSION TIME FRAMES

In accordance with ARS §36-2904 (G), an initial claim for services provided to an AHCCCS member must be received by AHCCCS no later than 6 months after the date of service, unless the claim involves retro-eligibility. In the case of retro-eligibility, a claim must be submitted no later than 6 months from the date that eligibility is posted. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

Claims initially received beyond the 6-month time frame, except claims involving retro-eligibility, will be denied.

If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

As defined by ARS §36-2904 (G)(1) a "clean claim" is:

> A claim that may be processed without obtaining additional information from the subcontracted provider of care, from a non-contracting provider, or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

PRIOR QUARTER COVERAGE ELIGIBILITY

Effective 1/1/2014, AHCCCS is required to expand the time period that AHCCCS pays for covered services for an eligible individual. The expanded time frame will include up to the three months prior to the month the individual applied for AHCCCS, if the individual met the eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

1. Received one or more AHCCCS covered service(s) during the month, and

2. Would have qualified for AHCCCS at the time services were received if the person had applied for Medicaid.

Note: If a member qualifies for AHCCCS during any one or more of the three months prior to their application, Prior Quarter Coverage will only apply to those months where there was a qualifying Medicaid claim.

If a member qualifies for Prior Quarter Coverage for January, February and March of 2014, but they only had one doctor's appointment during this time frame that took place in February, then their Prior Quarter Coverage would only apply to the month of February. They would not have Prior Quarter Coverage for January or March, since they had no qualifying claims for those months.

The AHCCCS Administration will determine whether or not an applicant meets Prior Quarter Coverage criteria.

If the applicant meets the Prior Quarter Coverage criteria, providers will be required to bill the AHCCCS Administration for services provided during the prior quarter eligibility period.

Providers will be required to bill the AHCCCS Administration for these services upon verification of eligibility *or* upon notification from the member of Prior Quarter Coverage eligibility.

Upon notification of Prior Quarter Coverage eligibility, A.A.C.R9-22-703 *requires* the provider to promptly refund to the member any payments that have been received for services in an approved prior quarter period and must accept payment by AHCCCS as payment in full. Providers failing to reimburse a member for any payments made by the member will be referred to the AHCCCS Office of Inspector General for investigation and action.

For covered services received during the prior quarter, which have not yet been reimbursed or billed, the provider must submit a claim to the AHCCCS Administration.

AHCCCS Managed Care Contractors are ***not*** responsible for determining Prior Quarter Coverage or for payment for covered services received during the prior quarter. Claims submitted to AHCCCS Managed Care Contractors for Prior Quarter Coverage will be denied.

Providers may submit Prior Quarter Coverage claims for payment to AHCCCS in one of the following ways:

1. The HIPAA compliant 837 transaction,
2. Through the AHCCCS Online claim submission process, or
3. By submitting a paper claim form.

All providers, including RHBA and TRHBA providers, must submit a claim directly to the AHCCCS Administration. Pharmacy point of sale claims must be submitted to the Pharmacy Benefits Manager (PBM). The current PBM is OptumRx, and further information regarding the PBM can be found in Chapter 12, Pharmacy, of the Fee-For-Service Provider Billing Manual.

Hospital Presumptive Eligibility (HPE)

Claims for persons determined to be presumptively eligible for AHCCCS by a qualified hospital should be submitted to the AHCCCS Administration until a full application is completed by the member and they have been enrolled with a Contractor.

Members eligible under HPE, where providers are billing for prenatal services, should bill the AHCCCS Administration for prenatal visits utilizing the appropriate E&M code performed during the HPE period.

Global obstetric billing for total OB care is only applicable for the plan in effect on the date of delivery and is only applied if global delivery guidelines are met (i.e. 5 or more visits performed while member is eligible under the plan). If guidelines are not met services should be billed as Fee-For-Service.

RETRO-ELIGIBILITY

Retro-eligibility affects a claim when no eligibility was entered in the AHCCCS system for the date(s) of service(s), but at a later date eligibility was posted retroactively to cover the date(s) of service(s).

Fee-For-Service claims are considered timely if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of eligibility posting. Claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the AHCCCS date of eligibility posting. This time limit does not apply to adjustments which would decrease the original AHCCCS payment due to collections from third party payers.

BILLING AHCCCS MEMBERS

Arizona Revised Statute §36-2903.01(K) prohibits providers from billing AHCCCS members, including QMB Only members, for AHCCCS-covered services.

Upon oral or written notice from the patient, that the patient believes the claims to be covered by the system [AHCCCS], a provider or non-provider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or non-provider has verified through the Administration that the person has been determined ineligible, has not yet been determined eligible, or was not, at the time services were rendered, eligible or enrolled:

1. Charge, submit a claim to, and/or demand or otherwise collect payment from a member or person who has been determined eligible, unless specifically authorized by this article or rules adopted pursuant to this article.

2. Refer or report a member or person, who has been determined eligible, to a collection agency or credit reporting agency for the failure of the member or person, who has been determined eligible, to pay charges for system covered care or services, unless specifically authorized by this article or rules adopted pursuant to this article.

Note: “QMB Only” is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible and coinsurance amount when Medicare pays first.

For further information on QMB Only please refer to Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual.

REPLACEMENTS AND VOIDS

The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to you on the AHCCCS Remittance Advice. You should correct claim errors and resubmit claims to AHCCCS for processing within the 12 month clean claim time frame.

A replacement can be used to adjust a paid or denied claim, and it can also be used to recoup previously paid lines. A replacement will allow individual lines to be recouped, rather than the entire claim to be recouped.

A void is a straight recoupment of a claim, with the entire claim being recouped.

For further information on how to correct claim errors please refer to Chapter 26, Claim Errors, of the Fee-For-Service Provider Billing Manual for a list of the most common denial and disallowance edits and how to fix them.

Replacements

For the purposes of this section, when a claim is resubmitted it will be referred to as a **replacement**. A replacement ***is*** the resubmission of a claim.

There are times when a previously submitted claim (paid or denied) will need to be replaced with a new submission.

You will **replace** a corrected claim when:

- The original claim was denied or partially denied; or
- When a claim was paid by AHCCCS and errors were discovered afterwards in regards to the amounts or services that were billed on the original claim. For example, you may discover that additional services should have been billed for on a service span, or that incorrect charges were entered on a claim paid by AHCCCS.

When **replacing a denied claim or adjusting a previously paid claim** you must submit a new claim form containing all previously submitted lines. The original AHCCCS Claim Reference Number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied due to it appearing to have been received beyond the initial submission time frame ***or*** it may be denied as a duplicate submission.

If any previously paid lines are blanked out the AHCCCS system will assume that those lines should not be considered for reimbursement and payment will be recouped.

When **replacing** a claim, you must resubmit any documentation that was sent with the denied or previously paid claim.

Every field can be changed on the **replacement** except the service provider ID number, the billing provider ID number and the tax ID number. If these must be changed, you must void the claim and submit a new claim.

To **replace** a denied CMS 1500 claim:

Enter "A" or "7" in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim or the CRN of the claim to be adjusted in the field labeled "Original Ref. No." *Failure to replace a 1500 claim without Field 22 completed will cause the claim to be considered a "new" claim and then it will not link to the original denial/paid claim. The "new" claim may be denied as timely filing exceeded.*

Replace the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example 1:

You submit a three-line claim to AHCCCS. Lines 1 and 3 are paid, but Line 2 is denied.

When replacing the claim, you should replace all three lines. If only Line 2 is replaced, the AHCCCS system will recoup payment for Lines 1 and 3.

Example 2:

You replace a three-line claim to AHCCCS. All three lines are paid.

You discover an error in the number of units billed on Line 3 and submit an adjustment.

When submitting the adjustment, you should replace all three lines. **If only Line 3 is replaced, the AHCCCS system will recoup payment for Lines 1 and 2.**

An adjustment for additional charges to a paid claim must include all charges -- the original billed charges *plus* additional charges.

Example 3:

You bill for two units of a service with a unit charge of $50.00 and are reimbursed $100.00. After receiving payment, you discover that three units of the service should have been billed.

When adjusting the claim, you should bill for three units and total billed charges of $150.00 (3 units X $50.00/unit). The AHCCCS system will pay the claim as follows:

Allowed Amount (3 units)	$150.00
Previously Paid to Provider	<$100.00>
Reimbursement	$50.00

If you billed for the one additional unit at $50.00, the AHCCCS system would recoup $50.00 as shown below:

Allowed Amount (1 unit)	$50.00
Previously Paid to Provider	<$100.00>
Reimbursement (Amount recouped)	<$50.00>

To **replace** a denied UB-04 claim:

Replace the UB-04 with the appropriate Bill Type:
xx7 for a replacement and corrected claim

Failure to replace a UB-04 without the appropriate Bill Type will cause the claim to be considered a "new" claim and it will not link to the original denial. The "new" claim may be denied as timely filing exceeded.

Type the CRN of the denied claim in the "Document Control Number" (Field 64).

To **replace** a denied **ADA claim** or a previously paid ADA claim, the CRN of the denied claim must be entered in Field 2 (Predetermination/Preauthorization Number).

- *Failure to replace an ADA claim without Field 2 completed will cause the claim to be considered a "new" claim and it will not link to the original denial or the previously paid claim. The "new" claim may be denied as timely filing exceeded.*
- **Do not put the CRN in the Remarks section or in the white space at the top of the form. Replacements that have the CRN in the wrong section will be denied. The CRN *must* go in Field 2.**

Voids

When **voiding a claim**, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.

Unlike resubmissions and adjustments, you should submit only the line(s) to be voided. Lines that should not be voided should be blanked out to avoid recoupment of payment for those lines.

To **void** a paid CMS 1500 claim enter “V” or “8” in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

To **void** a paid UB-04 claim:

Use bill type xx8

Enter the CRN of the claim to be voided in the “Remarks” field (Field 80).

If Field 80 is used for other purposes, type the CRN at the top of the claim form.

To **void** a paid ADA claim type the word “VOID” and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

OVERPAYMENTS

A provider must notify AHCCCS of any overpayments to a claim. The provider can notify AHCCCS by submitting a replacement claim, which will allow recoupment of the overpayment to occur.

In the event that an adjustment is needed then providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.

In the event that an entire claim needs voided so that the entire payment would be recouped then no documentation is required.

The claim will appear on the Remittance Advice showing the original allowed amount and the new (adjusted) allowed amount.

Do NOT send a check for the overpayment amount. The claim must be adjusted and the overpaid amount will be recouped.

GENERAL AHCCCS BILLING RULES

Most of the rules for billing AHCCCS follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by AHCCCS:

- Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

- Billing Multiple Units:

  If the same procedure is provided multiple times on the same date of service, the procedure code must be entered **only once** on the claim form.

  The units field is used to specify the number of times the procedure was performed on the date of service.

  The total billed charge is the unit charge multiplied by the number of units.

- Medicare and Third Party Payments

  By law, AHCCCS has liability for payment of benefits after all other third party payers, including Medicare.

  The provider must determine the extent of third party coverage and bill all third party payers **prior** to billing AHCCCS.

  NOTE: For further information please refer to Chapter 9, Medicare/Other Insurance Liability, in the Fee-For-Service Provider Billing Manual.

- Age, Gender and Frequency-Based Service Limitations:

  AHCCCS imposes some limitations on services based on member age and/or gender.

  Some procedures have a limit on the number of units that can be provided to a member during a given time span.

  AHCCCS may revise these limits as appropriate.

All claims are considered non-emergent and subject to applicable prior authorization requirements, unless the provider clearly identifies the service(s) billed on the claim form as an emergency.

UB-04 Claim Form

On the UB-04 claim form, the Admit Type (Field 14) must be “1” (emergency), “5” (trauma), or “4” (newborn) on all emergency inpatient and outpatient claims.

All other Admit Types, including a “2” for urgent, designate the claim as non-emergent.

CMS 1500 Claim Form

On the CMS 1500 claim form, Field 24 C must be marked to indicate that the service billed on a particular claim line was an emergency.

ADA Claim Form

AHCCCS staff will review ADA 2012 dental claims for adults to determine if the service provided was emergent.

Note: Adults are eligible for limited emergency dental services only. For further information please refer to the Dental Services section of Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual for coverage limitations.

Recoupment

A.R.S. §36-2903.01 L. requires AHCCCS to conduct post-payment review of all claims and recoup any monies erroneously paid.

Under certain circumstances, AHCCCS may find it necessary to recoup or take back money previously paid to a provider.

Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

Upon completion of the recoupment, the Remittance Advice will detail the action taken.

If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), you will be afforded additional time to provide justification for re-payment as outlined below.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter.

In the case of recoupments, the time span allowed for resubmission of a clean claim will be the *greatest* of:

- Twelve months from the date of service, or
- Twelve months from the date of eligibility posting for a retro-eligibility claim, or
- Sixty days from the date of the adverse action.

If recoupment is initiated by the AHCCCS Office of Inspector General (OIG) as a result of identified misrepresentation, you will not be afforded additional time to resubmit a clean claim. For additional information please refer to Chapter 28, Claim Disputes, of the Fee-For-Service Provider Billing Manual.

Additional Billing Rules

Multiple Page Claims

Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.).

- To ensure that all pages of a multiple-page, UB-04 claim are processed as a single claim the pages **must** be numbered.

Keep all pages together, back-to-back. All pages should be paper-clipped or rubber-banded together. **Do not staple.**

Totals should not be carried forward onto each page, and each page can be treated as a single page. **The total should be entered on the last page only.**

Zero Charges

AHCCCS will key revenue and procedure codes billed with **zero charges**. AHCCCS **will not** key revenue and procedure codes billed with **blank charges.** When submitting zero charges, $0.00 must be listed and it cannot be left blank.

Revenue codes with zero charges will not be considered for reimbursement.

Mothers and Newborns

Newborns whose mothers are AHCCCS members are eligible for AHCCCS services from the time of delivery.

Newborns receive separate AHCCCS identification numbers, and services for a newborn must be billed separately using the newborn's AHCCCS ID.

- Services for the newborn that are included on the mother's claim will be denied.

Contact the AHCCCS Eligibility Verification Unit for newborn eligibility and enrollment information. For further information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual.

Changes in Member Eligibility

If the member is ineligible for any portion of a service span, those periods should not be billed to AHCCCS.

If a member's eligibility changes, then each eligible period should be billed separately to avoid processing delays.

Changes in Reimbursement Rate

It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.

If a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rates, then the claim must be split.

DOCUMENTATION REQUIREMENTS

Medical review is a function of the AHCCCS Claims Department and is performed to determine if services are provided according to AHCCCS policy as it relates to medical necessity and emergency services. Medical review and adjudication also are performed to audit appropriateness, utilization, and quality of the service provided.

In order for this medical review to take place, providers may be asked to submit additional documentation for Fee-For-Service CMS 1500 claims, which are identified in the AHCCCS claims processing system as near duplicate claims. The documentation is necessary to allow the AHCCCS Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

Near duplicate claims are claims for the same procedure, on the same day, for the same member, for different providers.

Near duplicate claims for certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, adjudication staff will release the claim for payment, assuming that the claim has not failed any other edits.

If no medical documentation is submitted, the adjudication staff will deny the claim with a denial reason specifying what documentation is required.

- For example, a claim may be denied with the Medical Review denial code "MD008 - Resubmit with progress notes." Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

It is expected that certain E&M codes such as 90491 (Critical care, evaluation and management) and 90431-90433 (Subsequent hospital care) will frequently fail the near duplicate edit, because it is feasible that a member could be seen by more than one

provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill AHCCCS for CPT Code 90491 for April 22 for Mr. Jones.

Either claim may fail the near duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the Medical Review nurse will deny the claim with denial code "MD008 - Resubmit with progress notes."

Note: AHCCCS requires **all** claims related to hysterectomy and sterilization procedures to be submitted with the respective consent forms. For further information please refer to the sections on Hysterectomy Services and Family Planning Services in Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual.

While it is impossible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation. Also, not all Fee-For-Service claims submitted to AHCCCS are subject to Medical Review.

CMS 1500 Claims		
Billing For	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report, and emergency room report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, & pathology report	Information must substantiate fetal demise.
Emergency room visits	**Complete** emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, & consult reports	Documentation should be specific to code(s) billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, & history and physical	Examples: Cardiac catheterizations, Doppler

		studies, etc.
UB-04 Claims		
Billing for	**Documents Required**	**Comments**
Observation	Refer to FFS Chapter 11 Hospital Services for required documentation.	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, & pathology report.	Information must substantiate fetal demise
Outlier	Refer to FFS Chapter 11, Hospital Services, and to Exhibit 11-4, the Outlier Record Request, for information on the required documentation.	

Providers should *not* submit the following unless specifically requested to do so:

- Emergency admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- Ultrasound/X-ray films
- Medifax information
- Nursing care plans
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays (Exception: claims that qualify for outlier payment.)
  Entire medical records

Social Determinants

Beginning with dates of service on and after **April 1st, 2018**, AHCCCS will begin to monitor all claims for the presence of social determinant ICD-10 codes.

As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about the social determinant should be included in the member's chart.

Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for AHCCCS members, in order to comply with state and federal coding requirements.

Note: Social determinants are **not** the primary ICD-10 code. They are secondary ICD-10 codes.

Dental providers will be **exempt** from the use of social determinants.

For a list of ICD-10 codes relevant to social determinants of health, please see Exhibit 4-1, Social Determinants of Health ICD-10 Code List in the Fee-For-Service Provider Billing Manual. The list of social determinants of health codes may be added to or updated on a quarterly basis. Providers should remain current in their use of these codes

Claim Submission & Provider Registration

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.

For additional information on 42 CFR 455.410 and the necessity for providers to be registered to receive payment from AHCCCS, please refer to Chapter 3, Provider Records and Registration, of the Fee-For-Service Provider Billing Manual.

Revision History

Date	Description of changes	Page(s)
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	1-2
4/13/2018	Note on QMB Only Medicare reimbursable amounts updated to read as: *"QMB Only" is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible and coinsurance amount when Medicare pays first.* Information on providers needing to be registered with AHCCCS in order to receive payment added.	6 16

2/9/2018	Social Determinants of Health section added Exhibit 4-1, Social Determinants of Health ICD-10 Code List added	15-16 Exhibit 4-1
1/12/2018	Claim Submission Requirements for Paper Claims section added Claim Submission Requirements for 837 (Electronic) Claims section added Claim Submission Requirements for AHCCCS Online (Provider Portal) section added Prior Quarter Coverage section updated with examples Hospital Presumptive Eligibility (HPE) section added Replacements and Resubmissions sections combined into one section titled “Replacements” Void section updated Documentation Requirements section updated Updates to Billing Rules Formatting	1-2 2 2 3-5 4 7-9 9 14-16 All All
09/14/2016	Correction to ARS §36-2901 from (H) to correct section (G) PBM section, removed name of PBM	2 3
05/24/2016	Clarified: when resubmitting a claim, documentation must also be resubmitted	1
3/31/2016	UB-04 Field 80 corrected to UB-04 Field 64	5
09/15/2015	New format HPE section added Grammar, language corrections Added language to advise consequences of failing to resubmit/replace with prior CRN indicated “ICD-9” replaced with “ICD”	All 3 All All All All
12/18/13	Prior Quarter Coverage section added	4

Exhibit 4-1 ~ Social Determinants of Health ICD-10 List

Revision Dates: 2/9/2018

Social Determinants of Health ICD-10 Code List

Beginning on March 1st, 2018, the following ICD-10 diagnosis codes will be defined as **Social Determinants of Health** codes.

Please note that Social Determinants of Health codes may be added to or updated on a quarterly basis. Providers should remain current in their thorough utilization of these codes.

ICD-Code	Description
Z550	Illiteracy and low-level literacy
Z551	Schooling unavailable and unattainable
Z552	Failed school examinations
Z553	Underachievement in school
Z554	Educational maladjustment and discord with teachers and classmates
Z558	Other problems related to education and literacy
Z559	Problems related to education and literacy, unspecified
Z560	Unemployment, unspecified
Z561	Change of job
Z562	Threat of job loss
Z563	Stressful work schedule
Z564	Discord with boss and workmates
Z565	Uncongenial work environment
Z566	Other physical and mental strain related to work
Z5681	Sexual harassment on the job
Z5682	Military deployment status
Z5689	Other problems related to employment
Z569	Unspecified problems related to employment
Z570	Occupational exposure to noise
Z571	Occupational exposure to radiation
Z572	Occupational exposure to dust
Z5731	Occupational exposure to environmental tobacco smoke
Z5739	Occupational exposure to other air contaminants
Z574	Occupational exposure to toxic agents in agriculture
Z575	Occupational exposure to toxic agents in other industries
Z576	Occupational exposure to extreme temperature
Z577	Occupational exposure to vibration
ICD-Code	**Description**
Z578	Occupational exposure to other risk factors
Z579	Occupational exposure to unspecified risk factor
Z590	Homelessness

Z591	Inadequate housing
Z592	Discord with neighbors, lodgers and landlord
Z593	Problems related to living in residential institution
Z594	Lack of adequate food and safe drinking water
Z595	Extreme poverty
Z596	Low income
Z597	Insufficient social insurance and welfare support
Z598	Other problems related to housing and economic circumstances
Z599	Problem related to housing and economic circumstances, unspecified
Z600	Problems of adjustment to life-cycle transitions
Z602	Problems related to living alone
Z603	Acculturation difficulty
Z604	Social exclusion and rejection
Z605	Target of (perceived) adverse discrimination and persecution
Z608	Other problems related to social environment
Z609	Problem related to social environment, unspecified
Z620	Inadequate parental supervision and control
Z621	Parental overprotection
Z6221	Child in welfare custody
Z6222	Institutional upbringing
Z6229	Other upbringing away from parents
Z623	Hostility towards and scapegoating of child
Z626	Inappropriate (excessive) parental pressure
Z62810	Personal history of physical and sexual abuse in childhood
Z62811	Personal history of psychological abuse in childhood
Z62812	Personal history of neglect in childhood
Z62819	Personal history of unspecified abuse in childhood
Z62820	Parent-biological child conflict
Z62821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62890	Parent-child estrangement NEC
Z62891	Sibling rivalry
Z62898	Other specified problems related to upbringing
Z629	Problem related to upbringing, unspecified
Z630	Problems in relationship with spouse or partner
Z631	Problems in relationship with in-laws
Z6331	Absence of family member due to military deployment
Z6332	Other absence of family member
Z634	Disappearance and death of family member
Z635	Disruption of family by separation and divorce
Z636	Dependent relative needing care at home
Z6371	Stress on family due to return of family member from military deployment
Z6372	Alcoholism and drug addiction in family
Z6379	Other stressful life events affecting family and household
Z638	Other specified problems related to primary support group
Z639	Problem related to primary support group, unspecified
Z640	Problems related to unwanted pregnancy

Z641	Problems related to multiparity
Z644	Discord with counselors
Z650	Conviction in civil and criminal proceedings without imprisonment
Z651	Imprisonment and other incarceration
ICD-Code	**Description**
Z652	Problems related to release from prison
Z653	Problems related to other legal circumstances
Z654	Victim of crime and terrorism
Z655	Exposure to disaster, war and other hostilities
Z658	Other specified problems related to psychosocial circumstances
Z659	Problem related to unspecified psychosocial circumstances
Z7141	Alcohol abuse counseling and surveillance of alcoholic
Z7142	Counseling for family member of alcoholic
Z7151	Drug abuse counseling and surveillance of drug abuser
Z7152	Counseling for family member of drug abuser
Z72810	Child and adolescent antisocial behavior
Z72811	Adult antisocial behavior
Z7289	Other problems related to lifestyle
Z729	Problem related to lifestyle, unspecified
Z730	Burn-out
Z731	Type A behavior pattern
Z732	Lack of relaxation and leisure
Z733	Stress, not elsewhere classified
Z734	Inadequate social skills, not elsewhere classified
Z7389	Other problems related to life management difficulty
Z739	Problem related to life management difficulty, unspecified

CHAPTER 5 ~ BILLING ON THE CMS 1500 CLAIM FORM

Chapter 5 ~ Billing on the CMS 1500 Claim Form

Revision Dates: 11/23/2018; 10/1/2018; 7/10/2018; 7/3/2018; 4/20/2018; 3/23/2018; 10/15/2015; 9/14/2015; 5/31/2012

GENERAL INFORMATION ON THE CMS 1500 CLAIM FORM & CLAIM SUBMISSIONS

Please read the below section in full, prior to proceeding to the section called *Completing the CMS 1500 Claim Form*.

The following instructions explain how to complete the CMS 1500 Claim Form and whether a field is "Required," "Required if applicable," or "Not required."

These instructions are only applicable to filling out a **paper CMS 1500 claim form.**

- Note: The preferred method of claim submission remains the HIPAA-compliant 837 transaction process.

  If a provider is not set up to perform the 837 transaction process, then the preferred method of claim submission is via the AHCCCS Online Provider Portal. Only one claim at a time can be submitted via the AHCCCS Online Provider Portal, as it is not set up to accept batches.

  The preferred method of submission for **replacement/voided** claims is via the AHCCCS Online Provider Portal.

  For information on how to submit claims using the HIPAA-compliant 837 transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate implementation guides. Companion documents for 837 transactions are available on the AHCCCS website at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgical centers and independent laboratories also must bill for services using the CMS 1500 claim form. FQHC services may also be billed on a CMS 1500 claim form.

CPT and HCPCS procedure codes must be used to identify all services.

ICD-10 codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

All claims must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 31.

The preferred font for claim submission is Lucinda Console and the preferred font size is 10.

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

For the purposes of this chapter the term "member" refers to an AHCCCS eligible member.

Completing the CMS-1500 Claim Form

The revised CMS-1500 health insurance claim form version 02/12 replaced version 08/05. On the new version 02/12 the 1500 symbol at the top left corner is replaced with a scanable Quick Response (QR) code symbol and the date approved by the NUCC.

Effective 4/1/2014, the revised CMS-1500 version 02/12 will be required**.** Data receipt for 4/1/2014 and forward received with the old CMS 1500 08/05 form will be returned to the provider, regardless of the date of service being billed for on the claim.

1. Program Block **Required**

Mark the second box labeled "Medicaid."

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH	FECA BLK	OTHER

					PLAN	LUNG		
☐ *(Medicare#)*	☒ *(Medicaid#)*	☐ *(ID# / DoD#)*	☐ *(member ID #)*	☐ *(ID#)*	☐ *(ID#)*	☐ *(ID#)*		

1a. Insured's ID Number **Required**

Enter the member's *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. For additional information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual. Behavioral Health providers must be sure to enter the client's AHCCCS ID number, *not* the client's BHS number.

1a. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)
A99999999

2. Patient's Name **Required**

Enter member's last name, first name, and middle initial as shown on the AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Doe, John

3. Patient's Date of Birth and Sex **Date of Birth is Required**

Sex is Required if Applicable

Enter the member's date of birth. Mark the appropriate box to indicate the patient's gender, if applicable.

3. PATIENT'S BIRTH DATE	SEX
MM DD YY	

01	1	19XX	M ☒ F ☐

4. Insured's Name **Not Required**

Enter the insured person's last name, first name, and middle initial.

5. Patient Address **Not Required**

Enter the member's street number, street name, city, state, zip code, and telephone (including area code) in the indicated fields.

6. Patient Relationship to Insured **Not Required**

Mark the appropriate box to indicate the patient's relationship to the insured person (self, spouse, child, or other).

7. Insured's Address (Street & Street Number) **Not Required**

8. Reserved for NUCC Use **Not Required**

9. Other Insured's Name **Required if applicable**

If the member has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the member, enter "Same."

9a. Other Insured's Policy or Group Number **Required if applicable**

9b. Reserved for NUCC Use **Not Required**

9c. Reserved for NUCC Use **Not Required**

9d. Insurance Plan Name or Program Name **Required if applicable**

Enter name of insurance company or program name that provides the insurance coverage.

10. Is Patient's Condition Related to: **Required if applicable**

Mark "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)

☐ YES ☒ NO

b. AUTO ACCIDENT? PLACE (State)

☒ YES ☐ NO | AZ |

c. OTHER ACCIDENT?

☐ YES ☒ NO

10d. Claim Codes (Designated by NUCC) **Not Required**

11. Insured's Policy Group or FECA Number **Required if applicable**

11a. Insured's Date of Birth and Sex **Required if applicable**

11b. Other Claim ID (Designated by NUCC) **Not Required**

11c. Insurance Plan Name or Program Name **Required if applicable**

11d. Is There Another Health Benefit Plan **Required if applicable**

Mark the appropriate box to indicate coverage other than AHCCCS. If "Yes" is marked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature **Required**

If the signature is on file, then stating that the signature is on file is acceptable.

The signature may be handwritten, but it must be done in black pen.

13. Insured's or Authorized Person's Signature **Required if applicable**

If the member is under 18 years of age, then a signature is required from the insured member/authorized person. If the signature is on file, then stating that the signature is on file is acceptable.

The signature may be handwritten, but it must be done in black pen.

14. Date of Illness, Injury, or Pregnancy (LMP) — Required if applicable

15. Other Date — Not Required

16. Dates Patient Unable to Work in Current Occupation — Not Required

17. Name of Referring Provider or Other Source — Required if applicable

If applicable, enter the Qualifier:

DN Referring Provider

DK Ordering Provider*****

DQ Supervising Provider

Next, enter the name of the provider or other source.

***** The ordering provider is *required* for:

Laboratory	Drugs (J-codes)
Radiology	Temporary K and Q codes
Medical and surgical supplies	Orthotics
Respiratory DME	Prosthetics
Enteral and Parenteral Therapy	Vision codes (V-codes)
Durable Medical Equipment	97001 – 97546

Ordering provider can be any of the following: M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Psychologist or Certified Nurse Midwife.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ID Number of Provider **Required if applicable**

17b. NPI # of Provider **Required**

18. Hospitalization Dates Related to Current Services **Not required**

19. Additional Claim Information (Designated by NUCC) **Required if applicable**

Any additional information required for the processing of a claim (that is not found in another field) shall be entered under the Additional Claim Information field.

The standard format is as follows:

FQHC Indicator\Any other additional information

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

The CRN and the original reference number are the same.

In the remarks section, for FQHC professional claims, the claims processing system is only able to accept *one* provider name at a time. If two providers are providing services to a member at the FQHC, please see Chapter 10, Addendum FQHC/RHC, for additional information. The standard FQHC format is as follows:

- If the provider has a NPI: XXNPIProviderName; *or*
- If the provider does not have a NPI: 999999999ProviderName
  Example: XX1234567890Smith, Hillary

For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Examples:

- An FQHC provider is submitting an original claim: XX1234567890Smith, Andrew

  If this provider had additional information to add after the FQHC indicator, then a backslash would be needed after the provider name.

XX1234567890Smith, Andrew\Additional information here

- An FQHC provider is billing for a replacement claim of a previous submission: XX1234567890Smith, Hillary

  If this provider had additional information to add after the FQHC indicator, then a backslash would be needed after the provider name.
  XX1234567890Smith, Stacy\Additional information here

For questions on this field please outreach the provider training e-mail inbox at ProviderTrainingFFS@azahcccs.gov.

20. Outside Lab and $ Charges **Not required**

21. Diagnosis Codes **Required**

Enter at least one ICD diagnosis code describing the member's condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

ICD Ind. Field: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM

9 = ICD-9-CM (no longer accepted)

- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

Enter the ICD indicator between the vertical, dotted lines in the upper-right hand area of the field.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind.
A.	B.	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

Relate diagnosis lines A – L to the lines of service in 24E by the letter.

22. Medicaid Resubmission Code & Original Ref. No. Required if applicable

Enter the appropriate code ("7" or "8") to indicate whether this claim is a replacement (resubmission) of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being replaced or the paid claim being adjusted or voided in the field labeled "Original Reference No."

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

22. MEDICAID RESUBMISSION	
CODE	ORIGINAL REF. NO.
7 or 8	130010004321

23. Prior Authorization Number Not required

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process. See Chapter 8, Authorizations, of the Fee-For-Service Provider Billing Manual for information on prior authorization.

24. A NOTE regarding field 24 (A-J) and multi-page claim submissions:

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-6) under field 24 (A-J) must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines*

will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-4 filled out, but lines 5 and 6 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

24. Service line (shaded area) **Required if applicable**

Enter the NDC Qualifier N4 in the first 2 positions. Next, enter the 11-digit NDC *immediately* after the NDC Qualifier N4, with no dashes or spaces separating them. Follow this with a space, followed by the NDC Unit of Measure Qualifier, followed by the NDC quantity *administered* to the patient.

Example: N400074115278 ML10

NDC Unit of Measure:

- F 2 International Unit
- G R gram
- M L milliliter
- U N unit (each)

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
N400074115278 ML10									
07	01	13	07	01	13	11		J1642	

Note: Enter in only 1 NDC per service line/HCPCS code.

24A. Date(s) of Service **Required**

Enter the beginning and ending service dates.

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
N400074115278 ML10									
07	01	13	07	01	13	11		J1642	

24B. Place of Service **Required**

Enter the two-digit code that describes the place of service.

Refer to the Current Procedural Terminology (CPT) manual for a complete listing of places of service.

24. A						B	C	D	
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES	
From			To			of	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER
N400074115278 ML10									

07	01	13	07	01	13	11		J1642		

24C. EMG – Emergency Indicator **Required if applicable**

Mark this box with a "Y" if the service was an emergency service, regardless of where it was provided.

24. A						B	C	D			
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES			
From			To			Of	EMG	(Explain Unusual Circumstances)			
MM	DD	YY	MM	DD	YY	Service		CPT/HCPCS	MODIFIER		
							Y				

24D. Procedures, Services, or Supplies **Required**

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the **Units** field to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT coding manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provided and avoid delay or denial of payment.

24. A		B	C	D
DATE(S) OF SERVICE		Place		PROCEDURE, SERVICES, OR SUPPLIES
From	To	of	EMG	(Explain Unusual Circumstances)

MM DD YY	MM DD YY	Service		CPT/HCPCS	MODIFIER			
				71010	26			

24. F $ Charges	G Days Or Units	H EPSDT Family Plan	I ID Qual.
	3		

24E. Diagnosis Pointer **Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the letter of the appropriate diagnosis. Enter only the reference letter from Field 21 (A - L), not the diagnosis code itself. If more than one letter is entered, they should be in descending order of importance. Do not separate letters with commas.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan

			A				
			AB				

24F. $ Charges **Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units.

For example, if each unit is billed at $50.00 and three units were provided, enter $150.00 here and three units in Field 24G.

D		E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
			150 00		
			79 00		

24G. Days or Units **Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS coding manuals.

D	E	F	G	H
PROCEDURE, SERVICES, OR SUPPLIES			DAYS	EPSDT

(Explain Unusual Circumstances)		DIAGNOSIS	$ CHARGES	OR	Family
CPT/HCPCS	MODIFIER	CODE		UNITS	Plan
				3	
				1	

24H. EPSDT/Family Planning **Not required**

24I. ID Qualifier **Required**

Enter in the qualifier identifying if the number is a non-NPI. The Other ID# of the rendering provider should be reported in 24J in the shaded area. ZZ should be entered to indicate a Taxonomy Code.

E	F	G	H	I	J
DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID QUAL	RENDERING PROVIDER ID #
				ZZ	Taxonomy Code
					NPI Rendering Provider NPI ID #

24J. Rendering Provider ID # Required if applicable

(SHADED AREA) – Use for Taxonomy Code Reporting

Use this SHADED field to report the provider's 10 digit alpha-numeric Taxonomy Number.

NOTE: Previously this section was used to report Medicare and/or other insurance information. This does not need to be reported on the CMS 1500. Instead, always attach a copy of the Medicare or other insurer's EOB to the claim.

See Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual for details on billing claims with Medicare and other insurance.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
					NPI Rendering Provider NPI ID #

24J. Rendering Provider ID # Required

(NON SHADED AREA) – RENDERING PROVIDER ID #

The Rendering Provider's 10 digit NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used unless the provider has chosen to obtain an NPI and has provided this NPI to AHCCCS.

E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
					Taxonomy Code
				NPI	0000000000

25. Federal Tax ID Number **Required**

Enter the tax ID number and mark the box labeled "EIN." If the provider does not have a tax ID, enter the provider's Social Security Number and mark the box labeled "SSN."

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
861234567	☐	☑	

26. Patient's Account Number **Required if applicable**

This is a number that the provider has assigned to uniquely identify this claim in the provider's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider's own accounting or tracking system.

27. Accept Assignment **Not required**

28. Total Charge **Required**

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
☐ YES ☐ NO	$ 179	00	$		$	

29. Amount Paid **Required if applicable**

Enter the total amount that the provider has been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. Reserved for NUCC Use **Not required**

31. Signature and Date **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable. Enter the date on which the claim was signed.

The signature may be handwritten, but it must be done in black pen.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse

apply to this bill and are made a part thereof.) SIGNED John Doe DATE 03/01/13

32. Service Facility Location Information **Required if applicable**

32a. Service Facility NPI # **Required if applicable**

32b. Service Facility AHCCCS ID # (Shaded Area) **Required if applicable**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) Arizona Hospital 123 Main Street Phoenix, AZ 85XXX a. NPI | b. AHCCCS ID

33. Billing Provider Name, Address and Phone # **Required**

Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI # **Required if applicable**

33b. Other ID – AHCCCS ID # (Shaded Area) **Required if applicable**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Doc Holliday 123 OK Corral Drive Tombstone, AZ 85XXX	
a. NPI	b. Taxonomy Code

Revision History

Date	Description of changes	Page(s)
11/23/2018	Clarification added to the following field's on the CMS 1500 form: • 24I – Qualifier ZZ if a Taxonomy Code is entered • 24J – Shaded Section – Taxonomy Code • 24J – Unshaded Section – NPI • 33a – NPI • 33b – Taxonomy Code Note: The previous instruction to include the COB information in the shaded section of 24 J has been removed.	80-82 84 84
All below rows have the individual chapter's page number indicated. All rows above have the page number within the master document indicated.		
10/1/2018	Field 21 has been updated to include additional information regarding the necessity for the ICD Indicator to be filled out.	7
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	All
7/3/2018	Field 28 was updated. It now reads as: "Enter the total for all charges for all lines on the claim."	14
4/20/2018	Clarifications added regarding the need to have lines 1-6 filled out (under field 24 A-J) in entirety before proceeding to the second page.	2 & 8
3/23/2018	Clarification added to the General Information on the CMS-1500 & Claim Submission section, including that this chapter applies to paper claims only, the preferred font type and size, the preferred methods of claims submissions (HIPAA-Compliant 837 transaction process and AHCCCS Online provider portal), and information on what can make a claim deny. Clarification added to fields 3, 4, 5, and 6. Clarification added to field 12.	1-2 3 5

	Clarification added to field 13. 7Field 19 was updated to include a new standard format, that will allow providers to indicate if services were at an FQHC, along with any additional information that may be needed. Clarification added to field 22. Clarification added to field 23. Clarification added to fields 24 A and B (graphs add). Clarification added to field 24D (graph added). Clarification added to field 24 J (graph also added) Multi-page claim clarification added to field 28. Clarification that only ICD-10 codes will be accepted added. Field names matched to the updated CMS-1500 Claim Form version 02/12. Formatting	5 6-7 7-8 8 8-9 10 11-13 13-14 All All All
10/15/2015	Correction for fields 17, 17a, 17b, 19 and 24	4, 6
09/14/2015	New format "ICD-9" replaced with "ICD"	All multiple
04/02/2014	Replaced CMS 1500 "08/05" with new version 02/12	multiple

CHAPTER 6 ~ BILLING ON THE UB-04 CLAIM FORM

Chapter 6 ~ Billing on the UB-04 Claim Form

REVISION DATES: 11/23/2018; 10/1/2018; 7/10/2018; 7/3/2018; 6/27/2018; 4/20/2018; 4/13/2018; 10/15/2015; 09/15/2015; 10/01/2014

GENERAL INFORMATION ON THE UB-04 CLAIM FORM & CLAIM SUBMISSIONS

Please read the below section in full, prior to proceeding to the section called *Completing the UB-04 Claim Form*.

The following instructions explain how to complete the UB-04 Claim Form and whether a field is "Required," "Required if applicable," or "Not required." These instructions are to be supplemented with the information and codes in the *Uniform Billing Manual for the UB-04*.

These instructions are only applicable to filling out a **paper UB-04 claim form, *for DRG-excluded facilities*.**

- NOTE: The preferred method of claims submission remains the HIPAA-compliant 837 transaction process. If a provider is not set up to perform the 837 transaction process, then submission of a claim via the AHCCCS Online Provider Portal is the preferred method of claim submission.

  For information on how to submit claims using the HIPAA-compliant 837 transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate Implementation Guides. Companion documents for 837 transactions are available on the AHCCCS website at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

THE UB-04 CLAIM FORM IS USED TO BILL FOR ALL HOSPITAL INPATIENT, OUTPATIENT, AND EMERGENCY ROOM SERVICES. DIALYSIS CLINICS, NURSING HOMES, FREE-STANDING BIRTHING CENTERS, RESIDENTIAL TREATMENT CENTERS, AND HOSPICE SERVICES ALSO ARE BILLED ON THE UB-04 CLAIM FORM. CLAIMS FOR IHS AND TRIBALLY OWNED AND/OR OPERATED 638 FACILITIES, REQUESTING REIMBURSEMENT AT THE ALL-INCLUSIVE RATE (AIR) ARE ALSO SUBMITTED ON THE UB-04.
Revenue codes:

- Are used to bill line-item services provided in a facility,
- Must be valid for the service provided, and
- Must be valid for the bill type on the claim.

ICD-10 codes are required. AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

All claims must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

ICD-10 codes must be used to identify surgical procedures billed on the UB-04.

CPT/HCPCS codes and modifiers must be used to identify other services rendered.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 53.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-22) under fields 42-48 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

Refer to Chapter 11, Hospital Services APR-DRG, of the Fee-For-Service Provider Billing Manual for facilities excluded from the APR-DRG reimbursement methodology.

> **Note:** Effective October 1, 2014, AHCCCS determines Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology.
>
> Refer to FFS Chapter 11 Hospital Services APR-DRG for specific billing requirements of the DRG reimbursement methodology.

For the purposes of this chapter the term "member" refers to an AHCCCS eligible member.

COMPLETING THE UB-04 CLAIM FORM

1. Provider Data — Required

Enter the name, address, and phone number of the provider rendering the service.

1
Arizona Hospital

123 Main Street Scottsdale, AZ 85252

2. Billing Provider's Designated Pay-to Address **Required if applicable**

Report this only when it is different from the address reported in Field 1.

3.a PAT CNTL # (Patient Control No.) **Required**

This is a number that the facility assigns to uniquely identify a claim in the facility's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

3.b MED REC. # (Medical/Health Record No.) **Required if applicable**

4. Type of Bill **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See the *UB-04 Manual* for codes. Note: Do not add an extra zero to the 3 digit number. Adding a 4th digit will result in the claim to deny.

2.	3a PATIENT CONTROL NO.	4. TYPE OF BILL
	3b MED REC #	111

5. Fed Tax No. **Required**

Enter the facility's federal tax identification number. This should be a 9 digit number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM THROUGH	7. COV D

861234567		

6. Statement Covers Period **Required**

Enter the beginning and ending dates of the billing period.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM THROUGH	7. COV D
	MM/DD/CCYY MM/DD/CCYY	

Or

	MM/DD/CCYY MM/DD/CCYY	

7. Blank Field **Not Required**

8. Patient Name/Identifier **Required**

Enter the member's last name, first name, and middle initial as they appear on the AHCCCS ID card.

8a. Enter the member's identification number, from their AHCCCS ID card.
8b. Enter the member's name.

8 Patient Name	a
b	

9. Patient Address **Required**

9a. Enter the member's street number and street address.

9b. Enter the member's city.
9c. Enter the member's State
9d. Enter the member's zip code.
9e. Enter the member's country.

9 Patient Address	a		
b	c	d	e

10. Birthdate **Required**

Member's date of birth.

11. Sex **Required if applicable**

Member's sex, if applicable.

12. Date (Admission Start of Care Date) **Required**

This is the admission start of care date.

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CCYY			

13. HR (Admission Hour) **Required if applicable**

Enter the hour in which the patient is admitted for inpatient or outpatient care, using Military Standard Time (00-23) in top-of-hour times only.

Note: **Admission hour requires a 2 digit number.** See example times under field 16, DHR (Discharge Hour).

Admission			
12 Date	13 HR	14 Type	15 SRC

MM/DD/CCYY	08		

14. Type (Priority of Admission/Visit) Required

This is required for all claims. Enter the code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.

- 1 for Emergency
- 2 for Urgent
- 3 for Elective
- 4 for Newborn
- 5 for Trauma

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CCYY	08	1	

15. Point of Origin for Admission or Visit Required

This indicates the point of patient origin for the admission or visit. It is the source of referral for the admission or visit, and will always be entered in as 1 character. (Example: 1 will be 1, not 01.)

Admission			
12 Date	13 HR	14 Type	15 SRC
MM/DD/CCYY	08	1	8

16. DHR (Discharge Hour) Required if applicable

Enter the time (two digits), which best indicates the member's time of discharge. This is required for inpatient claims when the member has been discharged. See the *UB-04 Manual* for code structure.

12:00 a.m. = 00	6:00 a.m. = 06	12:00 p.m. = 12	6:00 p.m. = 18
1:00 a.m. = 01	7:00 a.m. = 07	1:00 p.m. = 13	7:00 p.m. = 19
2:00 a.m. = 02	8:00 a.m. = 08	2:00 p.m. = 14	8:00 p.m. = 20
3:00 a.m. = 03	9:00 a.m. = 09	3:00 p.m. = 15	9:00 p.m. = 21
4:00 a.m. = 04	10:00 a.m. = 10	4:00 p.m. = 16	10:00 p.m. = 22
5:00 a.m. = 05	11:00 a.m. = 11	5:00 p.m. = 17	11:00 p.m. = 23

17. STAT (Patient discharge status) **Required**

Required for all claims. Enter the 2 digit code that best describes the member's status for this billing period. See the *UB-04 Manual* for codes.

18-28 Condition Codes Required if applicable

Enter the appropriate condition codes that apply to this bill. See the *UB-04 Manual* for codes.

Examples:
In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering “61” in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter “73” in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day facilities must enter “GO”.

29. ACDT State (Accident State) **Required if applicable**

31-34 Occurrence Codes and Dates **Required if applicable**

35-36. Occurrence Span Codes and Dates **Required if applicable**

38. Responsible Party Name and Address **Required if applicable**

39-41 Value Codes and Amounts **Required if applicable**

Value codes identify special circumstances that may affect the processing of the claim. See the NUBC manual for specific codes.

42. Revenue Code — Required

Enter the appropriate 4 digit revenue code(s) that describe the service(s) provided. See the *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

If this field is left blank the claim will be returned to the provider.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0132		
2	0251		
3	0258		
4			

43. Revenue Code Description/NDC (effective 7/1/12) — Required/NDC if applicable

Enter the description of the revenue code billed in Field 42. See the *UB-04 Manual* for the descriptions of revenue codes.

*To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier*
    - UN = Unit
    - ML = Milliliters
    - GR = Gram
    - F2 = International Unit
- The NDC Unit Quantity is the amount of medication administered. **If** it includes a decimal point, a decimal point **must** be used and a blank space cannot be left in

place of the decimal point. There is a **limit** of 3 characters to the right of the decimal point. (i.e. 1234.456). Any unused spaces are left blank.

IMPORTANT NOTE: If the NDC Unit Quantity has a space in it, it can result in errors.

Example 1 (Incorrect Example): A provider is attempting to bill for 20 milliliters, and enters the following on their claim:

N412345678901ML20 500

This would be read as **20500**.000 and not as **20**.**5**00

To correct the above example, the provider would enter:
N412345678901ML20.500

Example 2 (Incorrect Example):
A provider is attempting to bill for 1 unit, and enters the following on their claim.

N412345678901ML1 000

This would be read as **1000**.000 and not as **1**.000

To correct the above example, the provider would enter:
N412345678901ML1.000 *or* **N412345678901ML1**

Example 3 (Correct Example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N40007411527ML10	J1642	2.00
2				
3				

Example 4 (Correct Example):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278ML10.000	J1642	2.00
2				
3				

NOTE: The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

*Refer to the AHCCCS Pharmacy webpage for billing details at:
https://azahcccs.gov/Resources/GuidesManualsPolicies/pharmacyupdates.html

44. HCPCS/Rates — Required if applicable

Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes (See Chapter 15, Dialysis Services). Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services (See Chapter 11, Hospital Services).

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1			95901
2			85595
3			9590025
4			

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2.00
2				
3				

45. Service Date **Required**

The dates indicated that outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

46. Service Units **Required**

Number of units for ALL services must be indicated.

If accommodation days are billed, the number of units billed must be consistent with the patient discharge status field (Field 17, STAT) and statement covers period (Field 6). If the member has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the member expired or has not been discharged, AHCCCS covers the admission date through last date billed.

46. SERV. UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
2			
3			
30			

- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0250	N400074115278 ML10	J1642	2
2				
3				

47. Total Charges **Required**

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99.

In line 23, the total charges are represented by revenue code 0001. In Field 47, the total charges must be the last entry. Total charges on one claim cannot exceed $999,999,999.99.

On the UB-04 form also indicate the corresponding page number of the claim.

> Note: For multi-page claims, **all lines (1-22) must be completed on the first page, before proceeding to the second page** of the claim. AHCCCS has received claims where page 1 has had lines (for example) 1-20 filled out, but lines 21 and 22 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and filled in first.**

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0250	N400074115278 ML10	J1642	MM/DD/CCYY	2	589 : 20	:		1
2						:	:		2
3						:	:		3
4						:	:		4
5						:	:		5
6						:	:		6
7						:	:		7
8						:	:		8
9						:	:		9
10						:	:		10
11						:	:		11
12						:	:		12
13						:	:		13
14						:	:		14
15						:	:		15
16						:	:		16
17						:	:		17
18						:	:		18
19						:	:		19
20						:	:		20
21						:	:		21
22						:	:		22
23	0001	PAGE 2 OF 2	CREATION DATE		TOTALS	20102 : 29	0 : 00		23

46. SERV. UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
	2,176	00			
	104	26			
	529	92			

48. Non-Covered Charges **Required if applicable**

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 0001. Do not subtract this amount from total charges.

50. (A–C) Payer Name **Required**

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the member and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

	50. PAYER NAME	51. Health Plan Identification.	52. REL INFO		53. ASG BEN
A	AHCCCS				
B	Medicare Part B				
C					

51. (A–C) Health Plan Identification No. **Required**

Enter the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility's six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

	50. PAYER NAME	51. Health Plan Identification No.	52. REL INFO		53. ASG BEN
A		654321			
B					
C					

52. (A–C) REL INFO (Release of Information) Not required

53. (A–C) ASG BEN (Assignment of Benefits) Not required

54. (A–C) Prior Payments Required if applicable

Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If the member has other insurance but no payment was received, enter "Ø." The " Ø " indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

55. (A–C) Est. Amount Due Not required

56. NPI - National Provider Identifier - Billing Provider Required

57. Other (Billing) Provider Identifier Required if applicable

58. (A–C) Insured's Name Not Required

Enter the name of insured (AHCCCS member) covered by the payer(s) in Field 50.

	58. INSURED'S NAME	59. P.REL.	60. INSURED'S UNIQUE ID
A	Doe, John		
B			
C			

59. (A–C) P Rel. (Patient's Relationship To Insured) Not required

60.A. Insured's Unique ID Required

Enter the member's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Member Eligibility and Enrollment).

Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

	58. INSURED'S NAME	59. P.REL.	60. CERT. –SSN - HIC. - ID NO.
A			A99999999
B			
C			

61. (A–C) Group Name **Not required**

60. CERT. –SSN - HIC. - ID NO.	61. GROUP NAME	62. INSURANCE GROUP NO.

62. (A–C) Insurance Group Number **Not required**

63. (A–C) Treatment Authorization **Not required**

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process. See Chapter 8, Authorizations, of the Fee-For-Service Provider Billing Manual for information on prior authorization.

64. Document Control Number **Required if applicable**

If the claim is a replacement or void, the original CRN shall be entered in this field.

65. (A–C) Employer Name **Not required**

66. DX (Diagnosis and Procedure Code Qualifier) **Required**

Note: ICD Ind. Field: Enter the applicable ICD indicator to identify which version of ICD codes is being reported.

0 = ICD-10-CM

9 = ICD-9-CM (no longer accepted)

- If this field is left blank the claim will be returned to the provider for correction. Please ensure it is filled out correctly.

66. DX	67	A	B	C	D	E	F	G	H
X	I	J	K	L	M	N	O	P	Q

67. Principal Diagnosis Code **Required**

Enter the **principal** *ICD diagnosis code*.

Behavioral health providers must **not** use DSM-4 diagnosis codes.

Note: In each diagnosis code box there is a grayed out area. This is the diagnosis indicator area. If a diagnosis code is entered in, please enter in the appropriate diagnosis indicator (i.e. Y or N).

66. DX	67	A	B	C	D	E	F	G	H
	I	J	K	L	M	N	O	P	Q

69. Admitting Diagnosis **Required**

This field is required for inpatient bills. Enter the ICD diagnosis code that represents the significant reason for admission.

70. Patient Reason DX (Patient's Reason for Visit) **Required if applicable**

71. PPS Code **Required if applicable**

Enter the DRG diagnosis code for the claim in this field.

72 ECI (E-Codes) **Required if applicable**

Enter the trauma diagnosis code, if applicable.

74. Principal Procedure Code and Dates **Required if applicable**

Enter the principal ICD procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/CCYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

For fields concerning provider information:

After January 1st, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny. 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. This applies to *all* providers, including attending providers.

For additional information on this requirement, refer to Chapter 3, Provider Records and Registration, of the Fee-For-Service Provider Billing Manual.

76. Attending Provider name and identifiers **Required if applicable**

NPI, ID (QUAL), First and Last name.

77. Operating Physician Name and Identifiers **Required if applicable**

NPI, ID (QUAL), First and Last name.

78. Referring Provider **Required if applicable**

NPI, ID (QUAL), First and Last name.

79. Other Physician **Not required**

NPI, ID (QUAL), First and Last name.

80. Remarks **Required if applicable**

This field is required on replacements, adjustments, and voids.

Enter the CRN of the claim that is being replaced by this resubmission, adjustment, or void. For resubmissions of denied claims, write “Resubmission” in this field.

81. a Other Procedure Codes **Required if applicable**

Enter taxonomy code

81. b-d Other Procedure Codes **Not required**

Revision History

Date	Description of changes	Page(s)
11/23/2018	The order of the examples in Field 16 was updated, so that midnight (12 a.m.) is now first. Field 43 comprehensively updated to clarify how the unit quantity should be entered.	92-93 94-96
Please note: All below page numbers correspond to the page numbers in the individual chapters and *not* the Master PDF file.		
10/1/2018	Field 66 updated to add clarifying information regarding diagnosis code qualifiers.	16-17
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	All
7/3/2018	A multi-page requirement was removed from Field 47 in regards to total charges.	12-13
6/27/2018	The following clarification was added to field 13: "Note: **Admission hour requires a 2 digit number.** See example times under field 16, DHR (Discharge Hour)." Correction to DHR example.	6 7
4/20/2018	Clarifications added regarding the need to have lines 1-22 filled out (under fields 42-48) in entirety before proceeding to the second page.	2 & 12-13
4/13/2018	Clarification added to the General Information on the UB-04 Claim Form & Claim Submissions section, including that this chapter applies to paper claims only, the preferred font type and size, the preferred methods of claims submissions (HIPAA-Compliant 837 transaction process and AHCCCS Online provider portal), and information on what can make a claim deny. Clarification added to Fields 3a, 3b, 4, 5, and 7-12. Clarification added to Field 13, including examples on the use of military standard time. Clarification added to Field 14, including examples of the admission type codes. Clarification added to Field 15, including examples of how the point of origin code should be entered. Clarification added to Field 16, including examples on the use of military standard time. Clarification added to Field 17.	1-2 3-6 6 6-7 7 7

	Clarification added to Field 29. Clarification added to Fields 39-42, and revenue codes updated to a 4 digit format. Clarification added to Field 43, including examples of the accepted abbreviations for the NDC Unit of Measurement Qualifier. Clarification added to Field 44. Clarification added to Fields 46-51. Clarification added to Fields 52 and 53. Clarification added to Fields 63 and 64. Example and clarification added to Field 67. Clarification added to Fields 70, 71, 72, 76, 77, 78, and 79. Clarification on provider registration requirements added to field 76. Clarification that only ICD-10 codes will be accepted added. Field names matched to the updated UB-04 Claim Form. Formatting	7-8 8 8-9 9 10 11-14 15 16 17 17-18 18 All All All
10/15/2015	Field 43: added AHCCCS Pharmacy website address for NDC billing information Correction to fields: 60 - Required 71 – added 78, 79 split into 2 separate items 81 split into 2 separate items	7 13 14 15 15
09/15/2015	New format "ICD-9" replaced with "ICD"	All multiple
10/01/2014	APR-DRG effective	All

CHAPTER 7 ~ BILLING ON THE ADA 2012 CLAIM FORM

Chapter 7 ~ Billing on the ADA 2012 Claim Form

REVISION DATE: 7/10/2018; 7/3/2018; 4/20/2018; 3/23/2018; 10/15/2015; 9/21/2015; 5/27/2014

GENERAL INFORMATION ON THE ADA 2012 CLAIM FORM & CLAIM SUBMISSIONS

Please read the below section in full, prior to proceeding to the section called *Completing the ADA 2012 Claim Form*.

The following instructions explain how to complete the revised American Dental Association (ADA) 2012 claim form and whether a field is "Required," "Required if applicable," or "Not required."

These instructions are only applicable to filling out a **paper ADA 2012 claim form.**

- Note: The preferred method of claims submission remains the HIPAA-compliant 837D transaction process.

  If a provider is not set up to perform the 837D transaction process, then submission of a claim via the AHCCCS Online Provider Portal is the preferred method of claim submission.

  For information on how to submit claims using the HIPAA-compliant 837D transaction process or the AHCCCS Online Provider Portal please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual and the appropriate implementation guides. Companion documents for 837 transactions are available on the AHCCCS website at **www.azahcccs.gov**. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.

Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim. However, stamped provider signatures will be accepted in field 53.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

When submitting claims via fax it is recommended to fax in the following order: ADA 2012 claim form first, the Explanation of Benefits (EOB) second (if applicable), and any applicable medical documentation third.

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page cannot be submitted unless all lines on page 1 are utilized and completely filled in first.**

AHCCCS will only accept the ADA 2012 claim form. Other ADA forms received will be returned to the provider. Timely filing will not begin until a claim is submitted that is compliant.

> Note: Effective 8/1/2014, the ADA 2012 claim form became mandatory and the old ADA 2006 claim form was no longer accepted by AHCCCS. There was a grace period between 6/1/2014 and 7/31/2014 where both forms were accepted. Since 8/1/2014 AHCCCS has only accepted the 2012 claim form.

When an applicable dental claim requires a diagnosis code, it must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.

For the purposes of this chapter the term "member" refers to an AHCCCS eligible member.

Completing the ADA 2012 Claim Form

Header Information Section

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

1	**Type of Transaction**	**Required**

Mark an **X** in the Statement of Actual Services box when submitting a claim.

Mark an **X** in the Statement of Actual Services and EPSDT/Title XIX if the claim is for a member under the age of 21.

If requesting a predetermination or pre-authorization, mark an **X** in the Request for Predetermination/Preauthorization box.

2 Predetermination/Preauthorization Number — Not Required

The AHCCCS claims system will automatically match claims to approved prior authorization (PA) requests when the claim is submitted. The preauthorization number is not to be confused with the CRN. The CRN **should not** be entered under Field 2.

This means that if there is an existing PA on file, when the claim is submitted it will automatically match and process.

Insurance Company/Dental Benefit Plan Information Section

Sections 3 – 11 are to be completed when there is other coverage (TPL) for the member.

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. Company/Plan Name, Address, City, State, Zip Code

3 Company/Plan Name, Address, City, State, Zip Code — Required if applicable

This is the address of the primary payer.

Other Coverage Section

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)		
4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender ☐ M ☐ F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		

4 (Other) Dental or Medical Coverage **Required**

Mark the appropriate box to indicate if the member has third party coverage.

5 Name of Policyholder/Subscriber in #4 **Required if applicable**

6 Date of Birth **Required if applicable**

7 Gender **Required if applicable**

8 Policyholder/Subscriber ID (SSN or ID#) **Required if applicable**

9 Plan/Group Number **Required if applicable**

10 Patient's Relationship to Person named in #5 **Required if applicable**

What is the member's relationship to the primary policyholder?

11 Other Insurance Company/Dental Benefit Plan Name, Address, City State, Zip Code **Required if applicable**

Policyholder/Subscriber Information Section

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender ☐ M ☐ F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	

12 Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code **Required**

13 Date of Birth (MM/DD/CCYY) **Required**

Enter the member's date of birth in MM/DD/CCYY format.

14 Gender **Required if applicable**

15 Policyholder/Subscriber ID (SSN or ID#) **Required**

Enter the AHCCCS member's 9 digit *AHCCCS ID number (example: A99999999).* Contact the AHCCCS Verification Unit if there are questions about eligibility or the AHCCCS ID number. For additional information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual.

16 Plan/Group Number **Not required**

17 Employer Name **Not required**

Patient Information Section

PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other		19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender ☐ M ☐ F	23. Patient ID/Account # (Assigned by Dentist)

18	**Relationship to Primary Subscriber** in field # 12	**Required**
19	**Reserved for Future Use**	**Not Required**
20	**Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code**	**Required**
21	**Date of Birth (MM/DD/CCYY)**	**Required**
22	**Gender**	**Required if applicable**
23	**Patient ID/Account Number (Assigned by Dentist)**	**Required**

This is a number that you have assigned to uniquely identify this claim in your records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and your own accounting or tracking system.

Record of Services Provided Section

A NOTE regarding multi-page claims and fields 24-31:

If a claim will be submitted with multiple pages (a multi-page claim) then **all lines (1-10) under fields 24-31 must be completed on the first page, before proceeding to the second page** of the claim. (Please note that only the required fields on *all lines* will need filled in.) AHCCCS has received claims where page 1 has had lines (for example) 1-8 filled out, but lines 9 and 10 are skipped. Then a second page is incorrectly submitted. This is an incorrect submission, because **a second page**

cannot be submitted unless all lines on page 1 are utilized and completely filled in first.

24 Procedure Date **Required**

Enter the date of service in MM/DD/CCYY format.

25 Area of Oral Cavity **Not Required**

Enter the code for the area of the oral cavity. Consult ANSI/ADA/ISO Specification No. 3950 *Designation System for Teeth and Areas of the Oral Cavity* for codes.

Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as D4263 bone replacement graft-first site in quadrant.

Do not report the applicable area of the oral cavity when the procedure either:

1) Incorporates a specific area of the oral cavity in its nomenclature, such as D5110 complete denture-maxillary; or
2) Does not relate to any portion of the oral cavity, such as D9220 deep sedation/general anesthesia for the first 30 minutes.

26 Tooth System **Required**

Enter "JP" when designating teeth using the ADA's Universal/National Tooth Designation system. Enter "JO" when using ANSI/ADA/ISO Specification No. 3950.

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)
1	11/01/2017		JO	01
2	11/01/2017		JO	01
3	11/01/2017		JO	11
4	11/01/2017		JO	03
5	11/1/2017		JO	
6	11/1/2017		JO	
7	11/1/2017		JO	
8	11/1/2017		JO	
9	11/1/2017		JO	
10	11/1/2017		JO	

27 Tooth Number(s) or Letter(s) **Required**

Enter the tooth number when the procedure directly involves a tooth

If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines of the claim form. There are 10 lines on the ADA claim form and multiple pages of the ADA 2012 claim form may be used if needed.

When using "JP" (ADA's Universal/National Tooth Designation system) use only 1 letter to indicate the tooth.

When using "JO" (ANSI/ADA/ISO Specification No. 3950) use **two** digits to indicate the tooth system. If a procedure is done to tooth 1 enter in 01. If a procedure is done to tooth 2, enter 02. Failure to list the tooth number in a two digit format can result in return of the claim to the provider or denial.

28 Tooth Surface **Required**

Designate tooth surface(s) when the procedure directly involves one or more tooth surfaces.

The following single letter codes are used to identify surfaces: **B** for buccal; **D** for distal; **F** for facial; **I** for incisal; **L** for lingual; **M** for mesial and **O** for occlusal.

Multiple areas/surfaces of the same tooth can be submitted on the same claim.

27. Tooth Number(s) or Letter(s)	28. Tooth Surface
01	
01	
11	
03	

29 Procedure Code **Required**

Enter the appropriate procedure code from the *CDT-4 Manual*.

29a Diagnosis Code Pointer **Required if applicable**

Enter the letter(s) from Field 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.

29b Quantity **Required**

Enter the number of times (01 – 99) the procedure code in Field 29 is delivered to the patient on the date of service shown in Field 24. The default value is “01”.

29. Procedure Code	29a. Diag. Pointer	29b. Qty.

30 Description **Required if applicable**

Enter the description of the procedure code billed in Field 29.

31 Fee **Required**

Enter the fee for the procedure code billed in Field 29. This field cannot be left blank, but a 0 can be entered in.

We cannot accept negative numbers in any fees. Claims with negative fees listed will be returned to the provider.

31a. Other Fees **Not required**

30. Description	31. Fee

32 Total Fee **Required**

Enter the sum of all fees from lines in item #31, plus any fee(s) entered in Item #31a.

33 Missing Teeth **Required**

Place an "X" on each missing tooth.

33. Missing Teeth Information (Place an "X" on each missing tooth.)															
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

34 Diagnosis Code List Qualifier **Required**

Enter the qualifier ("B" for the ICD-9; "AB" for the ICD-10) when diagnosis codes are entered in Field 34a.

<u>When an applicable dental claim requires a diagnosis code, it must be submitted using an ICD-10 diagnosis code. Claims with an ICD-9 diagnosis code will be denied.</u>

34a Diagnosis Code(s) **Required if applicable**

Enter up to 4 applicable diagnosis codes after each letter (A – D). The principal diagnosis code is entered in field "A".

Per the ADA 2012 manual, this is "required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions."

34. Diagnosis Code List Qualifier	(ICD-9 = B; ICD-10 = AB)		31a. Other Fee(s)	
34a. Diagnosis Code(s)	A _____	C _____		
(Primary diagnosis in "**A**")	B _____	D _____	32. Total Fee	Leave blank. The total will go on page 2 of the claim.

35 Remarks **Required if applicable**

Any additional information required for the processing of a claim that is not found in another field shall be entered under remarks.

The standard format is as follows (with parentheses removed):

(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Indicator)\(Any other additional information)

Enter the appropriate code ("7" or "8") to indicate whether the claim is a replacement (resubmission/7) of a denied or paid claim, an adjustment of a previously paid or denied claim (7), or a void (8) of a paid claim. Enter the AHCCCS Claims Reference Number (CRN) for the denied or paid claim that you want to replace.

Claims that are being submitted for the first time (original submissions) will not have any number or CRN entered here.

Any claim that is submitted with **only** a CRN number and no indication of whether it is a replacement or void (with a 7 or 8) will be processed as an **original** claim submission, which can cause the claim to deny as a duplicate.

See Chapter 4, General Billing Rules, for information on replacements, adjustments, and voids.

If the claim is a replacement of a previously submitted claim or a request to void a claim, has a previous CRN number, or is a claim for emergency dental than the remarks section should *begin* with the following standard format, separated by backslashes:

7 or 8 to indicate if the claim is a replacement or void (enter 7 for a replacement and 8 for a void), followed by the CRN, followed by a Y (to indicate emergency dental) or N (to indicate it was *not* emergency dental).

For example, if a provider was submitting:

- A replacement claim for an emergency dental visit, for a member over 21 years of age, the remarks section would begin with **7\CRN\Y**.
- A request to void a previous claim, that was for a non-emergency dental visit, for a member under 21 years of age, then the remarks section would begin with **8\CRN\N**.
- An original claim for an emergency dental visit, for a member over 21 years of age, would have the remarks section **begin** with **Y**. There would be no number (7 or 8) or CRN since it would be an **original claim.**

The CRN and the original reference number are the same.

If the provider is an FQHC and the claim is for a professional practitioner it must be indicated here. To indicate this in a manner that will allow the claims system to read it, it must be entered in **after the CRN format described above and separated by a backslash** in the following format (with the parentheses removed):

(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC Information in the Standard FQHC Format)

In the remarks section, for FQHC professional claims, the claims processing system is only able to accept *one* provider name at a time. If two providers are providing services to a member at the FQHC, please see Chapter 10, Addendum FQHC/RHC, for additional information. The standard FQHC format is as follows:

- If the provider has a NPI: XXNPIProviderName; *or*
- If the provider does not have a NPI: 999999999ProviderName
  - Example: XX1234567890Smith, Hillary

For additional information on how to indicate that the provider is an FQHC please see Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Any additional information should be entered in **after** this standard format of (with parentheses removed):

(Replacement/Void Indication Status)\(CRN)\(Emergency Status Indication of Y for Yes or N for No)\(FQHC)\(Additional information here)

Examples:

- An FQHC provider is submitting an original claim that is not a dental emergency.
  N\XX1234567890Smith, Andrew

  If this provider had additional information to add after the FQHC indicator, then another backslash would be needed after the provider name.
  N\XX1234567890Smith, Andrew\Additional information here

- An FQHC provider is billing for a replacement claim of a previous submission. It was for a dental emergency
  7\CRN\Y\XX1234567890Smith, Hillary

  If this provider had additional information to add after the FQHC indicator, then another backslash would be needed after the provider name.
  7\CRN\Y\XX1234567890Smith, Stacy\Additional information here

For questions on this field please outreach the provider training e-mail inbox at ProviderTrainingFFS@azahcccs.gov.

35. Remarks

Authorizations Section

AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X _____ Patient/Guardian Signature Date
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. X _____ Subscriber Signature Date

36 Parent/Guardian Signature and Date **Not required**

If a signature is on file, stating that the signature is on file is acceptable.

37 Subscriber Signature and Date **Required**

If a signature is on file, stating that the signature is on file is acceptable.

Ancillary Claim/Treatment Information

ANCILLARY CLAIM/TREATMENT INFORMATION		
38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")		39. Enclosures (Y or N) ☐
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment	43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)	44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident		
46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State

38 Place of Treatment **Required**

Enter the appropriate 2 digit Place of Service Code for professional claims. Refer to the CPT Manual for a complete listing of Place of Service Codes.

39 Enclosures **Required if applicable**

Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g. radiograph, oral images, or models).

40 Is Treatment for Orthodontics? **Required if applicable**

Mark the appropriate box. If "Yes" is marked, complete Fields 41 and 42. If "No" is marked, skip to 43.

41 Date Appliance Placed **Required if applicable**

42 Months of Treatment **Required if applicable**

Enter the total number of months required to complete the orthodontic treatment.

Note: This is the total number of months from the start of the treatment to the end of the treatment. Some versions of the claim form incorrectly include the word "Remaining" at the end of this data element's name, however the true number of months to be entered in this field is the total from start to finish.

43 Replacement of Prosthesis **Required if applicable**

Mark the appropriate box. If "Yes" is marked, complete Field 44. This item applies to crowns and all fixed or removable prostheses (e.g., bridges and dentures).

44 Date of Prior Placement **Required if applicable**

If "Yes" is checked in Field 43, enter the date of prior placement in MM/DD/CCYY format.

45 Treatment Resulting From **Required if applicable**

Mark the appropriate box, as applicable.

46 Date of Accident **Required if applicable**

Enter the date in MM/DD/CCYY format.

47 Auto Accident State **Required if applicable**

Enter the 2 character abbreviation of the state where the accident occurred.

Billing Dentist or Dental Entity

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)		
48. Name, Address, City, State, Zip Code		
49. NPI	50. License Number	51. SSN or TIN
52. Phone Number ( ) -	52a. Additional Provider ID	

48 Billing Dentist/Dental Entity Name and Address **Required**

Enter the full name, address, city, state and zip code of the billing dentist or dental entity.

49 NPI **Required**

Enter the NPI of the billing dentist or dental entity.

50 License Number **Required if applicable**

If the billing dentist is an individual, then enter the dentist's license number in this field. If the billing entity (e.g. corporation) is submitting the claim, then this field can be left blank.

51 SSN or TIN **Required**

Enter the Social Security Number (SSN) or Tax ID Number (TIN) of the billing dentist or group entity.

52 Phone Number **Not required**

Enter the business phone number of the billing dentist or group entity.

52a Additional Provider ID **Required if Applicable**

Treating Dentist and Treatment Location Information

TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed. X_____ Signed (Treating Dentist) Date	
54. NPI	55. License Number
56. Address, City, State, Zip Code	56a. Provider Specialty Code
57. Phone Number ( ) -	58. Additional Provider ID

53 Signature of Treating Dentist **Required**

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable. Enter the date on which the claim was signed.

The signature may be handwritten, but it must be done in black pen.

54 NPI **Required**

Enter the NPI of the treating dentist.

55 License Number **Required**

Enter the license number of the **treating dentist**. This may differ from that of the *billing* dentist or dental entity.

56 Address, City, State, Zip Code (Treating Dentist) **Required**

56a Provider Specialty Code **Required**

Enter the specialty code that indicates the type of dental professional rendering the treatment (e.g., 1223X0400X for Orthodontics, 1223P0221X for Pediatric Dentistry). The general code listed as "Dentist" may be used instead of other dental practitioner codes.

57 Phone Number (Treating Dentist) **Not required**

58 Additional Provider ID **Required if Applicable**

Revision History

Date	Description of changes	Page(s)
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	All
7/3/2018	Field 32 was updated. It now reads as: "Enter the sum of all fees from lines in item #31, plus any fee(s) entered in Item #31a."	9
4/20/2018	Clarifications added regarding the need to have lines 1-10 filled out (under fields 24-31) in entirety before proceeding to the second page.	2 & 6
3/23/2018	Completing the ADA 2012 Claim Form introduction updated to include information on the 837 D transaction process, the use of labels and stamps on claim forms, the preferred font and faxing order for claims forms, and the use of ICD-10 codes. Field 1 – Clarification added. Field 2 – Clarification added regarding the non-use of the predetermination/preauthorization number. Field 10 – Clarification added. Field 15 – Clarification added. Field 25 – The Area of Oral Cavity field was updated with examples. Field 27 – The Tootle Number or Letter section was updated to clarify the needed formats for claims processing. Field 28 – Clarification added to the Tooth Service section. Field 31 – Clarification added that the field cannot be left blank. Field 34 – Clarification added. Field 35 – Remarks field extensively updated to clarify how it is to	1-2 1 2 2-3 4 5 6 6-7 7 8-9

	be used and what format should be used when indicating voids, replacements, original submissions, emergency dental visits, claims associated with a previous CRN, and FQHC professional claims. Field 36 – Clarification added. Field 37 – Clarification added. Field 39 – Enclosures description added. Field 40 – Clarification added. Field 42 - Description added to clarify that it is the total months of treatment from start to finish and not the number of months remaining. Field 43 – Examples added to lend further clarity. Field 49 - The field was updated to reflect that it is a field for the NPI requirement and not for the provider ID. Field 50 – Clarification added to describe license number field. Field 52 – Description added to clarify what phone number is needed. Field 52a – Description added to explain what the additional provider ID is. Field 53 – Clarification added to signature requirement. Field 55 – Clarification added to field 55. Field 56a - Description added to explain what a specialty code is, with examples. Field 58 – Description added to explain what the additional provider ID is. Clarification that only ICD-10 codes will be accepted added. Field names matched to the updated ADA 2012 Claim Form Formatting	9 9-11 12 12 13 13 13 13 14 14 14 14 15 15 15 6 All All All
10/15/2015	Correction for field 35: Required if applicable	4
09/21/2015	"ICD-9" replaced with "ICD" ADA Form *Correction* for field 34a: based on ADA manual, ICD diagnosis codes and related fields are "Required if Applicable"	multiple 4
05/27/2014	New format Update language for new ADA 2012 form	All

CHAPTER 8 ~ PRIOR AUTHORIZATIONS

Chapter 8 ~ Prior Authorizations

Revision Dates: 3/25/2019; 10/1/2018; 4/26/18; 2/15/18; 10/01/2015, 08/01/2015, 08/14/2014, 08/07/2014

GENERAL INFORMATION

Prior authorization (PA) is not required for emergency services.

The following **do not** require Prior Authorization:

- **Emergency services;**
- IHS or Tribal 638 services for Fee-for-Service, Title XIX members;
- IHS or Tribal 638 non-pharmacy services for Title XXI (KidsCare) members;
- The member has Medicare, third party liability (TPL), or commercial insurance coverage *and* the services are covered by Medicare, TPL, or commercial insurance; or
- Services provided prior to the posting of the member's retroactive eligibility.

Note: PA should not be requested for services rendered to FESP members. Please refer to chapter 1100 of the AMPM regarding extended services eligibility for outpatient dialysis services. All emergency services under the Federal Emergency Services Program (FESP), in any setting, are subject to retrospective review to determine if an emergency did exist at the time of service.

Many non-emergent services require prior authorization from the prior authorization Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU) for acute care services or from the member's Tribal ALTCS case manager for long term care services.

Note: The Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU) is DFSM's prior authorization unit, and will be referred to as **DFSM** in the rest of this chapter.

Receiving an authorization approval does not guarantee payment. The medical treatment for which the authorization was issued must be supported by medical documentation establishing medical necessity. In addition, the claim must meet all AHCCCS criteria including, but not limited to, clean claim and timely filing.

Prior authorization (PA) for services is also based on other factors including:

- The member's eligibility status at the time of service,
- The provider's status as an AHCCCS-registered Fee-for-Service provider, and
- Whether or not the service is an AHCCCS-covered service that requires PA.

Refer to the Prior Authorization webpage for the most up-to-date information regarding covered services and services requiring prior authorization at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

PRIOR AUTHORIZATION PROCEDURES

For complete information regarding how to request for prior authorization and what is needed with a prior authorization request please refer to the following AMPM Chapters:

- AMPM 820, Prior Authorization; and
- AMPM 810, Utilization Management.

The AMPM can be found at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/

AHCCCS Online Provider Portal

The preferred method of PA submission is via the AHCCCS Online Provider Portal. This is the quickest way to submit for PA and to check the status of a PA request, and it can be accessed on the AHCCCS website at:

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

Prior Authorization Mandatory Fax Forms:

https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

A pended PA number may be assigned to prior authorization requests after they are reviewed. Once reviewed either an approval or a denial will be issued, or the authorization will be pended for additional information to substantiate compliance with AHCCCS criteria.

AHCCCS generates a PA confirmation letter with appropriate approval, denial, or pending information. The letter is mailed to the provider by the next working day.

When a PA is denied concurrently, AHCCCS also generates a Notice of Action letter that is mailed to the member within three working days of the request. No denial letters are sent to members for services that are denied retrospectively.

Per A.A.C. R9-22-703 (D)(3) all services reimbursed, whether prior authorized or not, are subject to post-payment audit and recoupment if DFSM determines that the services were not medically appropriate.

CLAIM SUBMISSION DIRECTIONS

It is not necessary for the provider to enter the PA number on the claim form. If a valid PA exists for the service, the AHCCCS claims system will automatically match the claim information against established PA files and choose the correct one.

The information entered on the claim form must match what has been prior authorized and listed on the PA confirmation letter. If there are any discrepancies the system will not find the appropriate PA and the claim will be denied. Any known PA discrepancies should be corrected prior to submitting a claim.

If a PA discrepancy is discovered after the claim has been paid, then the provider must submit a PA correction request with supporting documentation. PA correction requests should be entered using the web portal. The FFS Correction Form can be uploaded as an attachment to ensure prior authorization staff can accurately identify which corrections need to be made. The correction form can be found on the PA website.

Once the PA correction request has been reviewed and approved, then a replacement claim can be submitted. This process is also followed for Tribal ALTCS requests that were authorized by prior authorization staff. PA status can be verified by using the AHCCCS Online Provider Portal.

For correction of authorizations that were entered by the member's Tribal ALTCS Case Manager, if the claim has already been paid then the provider must submit a PA correction request with supporting documentation.

> Note: PA correction requests for long term care services authorized by a Tribal ALTCS member's Tribal ALTCS Case Manager are called "open line requests." These open line requests may be faxed in using the FFS Medical Documentation Form, and should be labeled as an "open line request." Once the PA open line request has been reviewed and approved, then a replacement claim can be submitted.

Prior Authorization of Acute Services

Pursuant to Arizona Administrative Code the following list identifies acute services requiring prior authorization. (ALTCS authorization requirements are discussed in Chapter 21, ALTCS Services.)

A.A.C. R9-22-204 (A)(1) advises that providers shall obtain PA from AHCCCS for the following inpatient services:

- Nonemergency and elective admission, including psychiatric hospitalization;
- Non-emergency/Elective surgery; and
- Services or items provided to cosmetically reconstruct or improve personal appearance after an illness or injury.

A.A.C. R9-22-211(G) (1) advises that providers shall obtain PA from AHCCCS for any medically necessary nonemergency transportation services when the distance traveled exceeds 100 miles one-way or round trip.

For additional information on other services that require PA, please refer to AMPM 820, Prior Authorization Requirements, and to the Fee-For-Service Prior Authorization web page at: https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

A.A.C. R9-22-215 B (1 – 14) advises the following acute services do not require PA:

- Voluntary sterilization;
- Dialysis shunt placement;
- Arteriovenous graft placement for dialysis;
- Angioplasties or thrombectomies of dialysis shunts;
- Angioplasties or thrombectomies of arteriovenous grafts for dialysis;
- Eye surgery for the treatment of diabetic retinopathy;
- Eye surgery for the treatment of glaucoma;
- Eye surgery for the treatment of macular degeneration;
- Home health visits following an acute hospitalization (limited up to five visits);
- Hysteroscopy (up to two, one before and one after) when associated with a family planning diagnostic code and done within 90 days of hysteroscopic sterilization;
- Occupational therapy (see the Rehabilitative Services section for information on limitations);
- Physical therapy (see the Rehabilitative Services section for information on limitations);
- Facility services related to wound debridement;
- Apnea management and training for premature babies up to the age of one;
- Hospitalization for vaginal delivery that does not exceed 48 hours;
- Hospitalization for cesarean section delivery that does not exceed 96 hours; and
- Other services identified by the Administration through the Provider Participation Agreement.

Note: As of 10/1/2017 outpatient occupational therapy is a covered service, and no prior authorization is required for Acute members.

Please refer to the AHCCCS Medical Policy Manual (AMPM) at https://www.azahcccs.gov/shared/MedicalPolicyManual/ for additional information on covered services.

AUTHORIZATION REQUIREMENTS FOR SPECIFIC SERVICES

Abortions

All medically necessary abortions require PA, except in cases of medical emergency.

In the event of a medical emergency, all documentation of medical necessity must accompany the claim when it is submitted for reimbursement.

The request for PA must be accompanied by a completed AHCCCS Certificate of Medical Necessity for Pregnancy Termination, which is available as Attachment C under

AMPM 410, Maternity Care Services in the AMPM. For additional information regarding coverage requirements for pregnancy terminations please refer to AMPM Policy 410, Maternity Care Services.

DFSM will review the request and the certification for medical necessity prior to issuing an authorization decision.

Ambulatory Surgery Center (ASC)

Ambulatory surgical facilities furnishing non-emergency surgical services must obtain a PA number for scheduled ambulatory surgery, except voluntary sterilization procedures and dialysis related services, including FES on Extended Services.

The facility's PA number is separate from the surgeon's PA number and PA requirements may differ for these providers.

Apnea Management and Training

No PA is required for the first 12 months of life.

Apnea management, training, and use of the apnea monitor must be billed using procedure code E0618 or E0619 and the proper modifier, and must be prior authorized.

The NU, LL, and RR modifiers are all permitted.

- RR – Rental of DME
- NU – Purchase of DME
- LL – Lease/Rental of DME

PA requests must include the charge for the service, including the charges for management, training, and use of the apnea monitor.

Behavioral Health Services

Prior Authorization is required for acute, non-emergency psychiatric hospitalizations.

- PA requests for AIHP members enrolled in a Regional Behavioral Health Authority (RBHA) are submitted to the RBHA,
- PA requests for AIHP members enrolled in a Tribal Regional Behavioral Health Authority (TRBHA) are submitted to DFSM,
- PA requests for AIHP members, who are not enrolled with a RBHA or TRBHA, are submitted to DFSM, and
- PA requests for Tribal ALTCS members are submitted to DFSM.

For further information regarding behavior health services refer to Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual, and AMPM 820, Prior Authorization.

Dental Services

PA is not required for preventive/ therapeutic dental services for EPSDT members except for:

- Removable dental prosthetics, including complete dentures and removable partial dentures;
- Cast crowns;
- Medically necessary dental surgery services;
- Orthodontia services; and
- Medically necessary pre-transplant dental services. PA is given by the AHCCCS transplant coordinator and reviewed by the AHCCCS Dental Director or Designee.

PA is required for:

- Medically necessary pre-transplant dental services for adults. PA is given by the AHCCCS transplant coordinator and reviewed by the AHCCCS Dental Director or Designee.
- Surgical services provided by a dentist to an adult age 21 years and older, only to the extent that such services may be performed under State law by either a physician or a dentist, and the services would be considered physician services if furnished by a physician.

Dialysis

PA is not required for monthly dialysis supervision or services. For additional information on dialysis services please refer to Chapter 15, Dialysis, of the Fee-For-Service Provider Billing Manual and for information on covered dialysis services for members *not* in FESP please refer to AMPM Policy 310-E.

FES members are required to have a Monthly Certification of Emergency Medical Condition kept on file in the physician's office, and this can be found as Exhibit 1120-2 in the AMPM.

Prior authorization for outpatient dialysis for FESP members is met when:

- The treating physician has submitted the completed and signed Initial Dialysis Case Creation Form to AHCCCS; and
- When the treating provider has completed and signed a Monthly Certification of Emergency Medical Condition for the month in which outpatient dialysis services are received.

For information on FESP dialysis services please refer to AMPM 1120 for FESP and to Chapter 18, FES, of the Fee-For-Service Provider Billing Manual.

Home Health Services

All home health services for acute care members require prior authorization, except for the first 5 visits following discharge from an acute hospital stay.

All home health services for ALTCS members require prior authorization from the case manager.

Hospital Admissions

All non-emergency and elective admissions, including all organ and tissue transplantation services require prior authorization.

Notification to DFSM *must* be provided within 72 hours of a behavioral health emergency hospitalization. (This does not apply to FES inpatient admissions.)

- If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
- If approved, the CMSU nurse will authorize the admission.
- Continued authorization/approval of services may be determined through concurrent review.

Note: Notification of an emergent physical health admission must be provided when the member remains inpatient 72 hrs or more. (This does not apply to FES inpatient admissions.)

When a member's eligibility is posted after the beginning date of service and prior to the end date of service on the claim:

- Notification must be provided no later than 72 hours after the eligibility posting date.
- If the required notification day falls on a weekend or state holiday, notification must be provided no later than the next working day.
- If notification is not provided as required, AHCCCS may deny any portion of the stay, dependent on medical review.

Hysterectomy Services

Non-emergency and medically necessary hysterectomy services require PA.

The member must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. Please refer to AMPM 820, Exhibit 820-1 for the AHCCCS Hysterectomy Consent and Acknowledgement Form.

Exceptions:

The member was already sterile before the hysterectomy. The physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility.

The member requires a hysterectomy because of a life threatening emergency situation, in which the physician determines that the prior acknowledgement is not possible. The physician must certify in writing that the hysterectomy was performed under a life threatening emergency situation, in which the physician determined that prior acknowledgement was not possible.

In a life-threatening emergency PA is not required.

Medical Equipment, Medical Appliances, Medical Supplies, and Orthotic and Prosthetic Devices

Certain EPSDT medical equipment, appliances, and supplies and orthotic/prosthetic services may require PA. Refer to AMPM 430, EPSDT Services for further information about required PA documentation, coverage limitations and exclusions.

The purchase of medical equipment and appliances requires PA when the purchase price for the item exceeds $300.00 for acute members and $500.00 for ALTCS members.

Consumable medical supplies (supplies which have limited potential for re-use) require PA when the cost exceeds $100.00 per month. For members 21 years of age and older, PA is required for medically necessary incontinence supplies.

For additional information regarding coverage and limitations of medical equipment, appliances and supplies refer to AMPM 310-P.

PA is required for the purchase of orthotic/prosthetic devices for adult members 21 years and older, when the purchase price exceeds $300.00. For additional information regarding coverage of orthotic and prosthetic devices refer to AMPM 310-JJ, Orthotic and Prosthetic Devices. Refer to Chapter 13, DME, Orthotics, Prosthetics, and Medical Supplies, of the Fee-For-Service Provider Billing Manual for additional information regarding the required PA documentation, coverage, limitations and exclusions. For information on criteria related to coverage of incontinence briefs for members under the age of 21, please refer to AMPM 430, EPSDT Services.

All rental equipment and equipment repairs require PA.

For acute members prior authorization should be sent to DFSM.

For ALTCS and Tribal ALTCS members, prior authorization requests for long term care services should be sent to the Tribal ALTCS Case Manager. For and Tribal ALTCS members, prior authorization requests for *acute* care services should be sent to DFSM.

Non-Emergency Medical Transportation (NEMT)

All NEMT services provided by air transport require PA.

Non-emergency transportation provided by ground ambulance and non-ambulance vehicles requires PA over 100 miles.

Only codes for the base rate, mileage, and waiting time (not covered under 100 miles) will be prior authorized.

For additional information please refer to Chapter 14, Transportation Services, of the Fee-For-Service Provider Billing Manual.

Nursing Facilities

PA must be obtained before admission of an acute care member unless another insurance or Medicare is primary, or the member becomes retroactively eligible for AHCCCS.

No PA is required during the retrospective eligibility period, but the stay is subject to medical review.

Initial authorization will not exceed the member's anticipated Fee-for-Service enrollment period or a medically necessary length of stay; whichever is shorter (not to exceed 90 days).

Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.

AHCCCS will allow up to 90 days (including Medicare days) of nursing facility care in a contract year (10/01 – 09/30).

As a part of discharge planning, prior authorization staff may request hospital personnel to initiate an ALTCS application for potentially eligible members.

For Tribal ALTCS members, PA must be obtained before admission to a nursing facility, even if the member has other insurance or Medicare as the primary insurance.

- The Tribal ALTCS Case Manager must coordinate and provided service authorization for members who need a lower level of care at a nursing facility.

- For nursing facility specialty rates (that are above level of care facility rates), the Tribal ALTCS Case Manager must assist in obtaining any needed documentation and must coordinate with DFSM for approval *prior* to the Tribal ALTCS Case Manager entering the service authorization.

Pharmacy

For information regarding pharmacy services and prior authorization, please refer to Chapter 12, Pharmacy Services, of the Fee-For-Service Provider Billing Manual.

Rehabilitative Services

Outpatient speech therapy is not covered for non-ALTCS members age 21 years or older.

Outpatient physical and occupational therapy visits do not require prior authorization, but are subject to the following limitations:

Effective 1/1/2014, outpatient physical therapy for adults (age 21 years or older) is limited to:

a. 15 visits per contract year to restore a particular skill or function the individual previously had but lost due to injury or disease and to maintain that function once restored; and
b. 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and to maintain that function once acquired.

Effective 10/1/2017, outpatient occupational therapy for adults (age 21 years or older) is limited to:

c. 15 visits per contract year to restore a particular skill or function the individual previously had but lost due to injury or disease and to maintain that function once restored; and
d. 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and to maintain that function once acquired.

The above limitations are not applicable to EPSDT members. For members under 21 years of age, AHCCCS covers medically necessary inpatient and outpatient physical therapy, occupational therapy and speech therapy. Authorization is not required for rehabilitation therapies for members under 21 years of age.

For additional information please refer to Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual and to AMPM 310-X, Occupational, Physical and Speech Therapies, for further information.

Surgeons

Surgeons must obtain a separate and distinct PA from that of the facility for:

- Elective or non-emergency surgery, except voluntary sterilization;
- Both the primary surgical procedure and any surgical procedure designated in the *CPT Manual* as a separate procedure;
- Surgeries scheduled more than 72 hours after initial emergency admission of a continuous hospitalization; and
- Organ transplantation not covered by Medicare.

Assistant surgeons and anesthesiologists do not require separate PAs.

Total Parenteral Nutrition (TPN)

Facilities and agencies furnishing outpatient TPN services must obtain PA at least one working day prior to initiation of services.

Telephone requests are assigned an authorization number and pended until required documentation is received and reviewed.

The following documentation must be received by DFSM at the time of the initial TPN authorization request:

- History and physical, which describe member's condition and diagnosis;
- Physician's orders;
- Dietary assessment, including member's weight;
- Any pertinent progress notes (nursing/physician) which reflect the member's dietary, eating, and functional status;
- Physician progress notes indicating expected outcome of treatment;
- Nursing home records showing the percentage of each meal's consumption by the member; and
- Current laboratory data.

TPN is covered for members over 21 years of age when it is medically necessary and the only method to maintain adequate weight and strength. To obtain prior authorization this must be reflected in the provided documentation with the PA request.

TPN is also covered for EPSDT and KidsCare members when medically necessary. To qualify for coverage TPN does not have to be the sole source of nutrition for EPSDT and KidsCare members. To obtain prior authorization medical necessity must be shown.

For additional information on TPN please refer to AMPM 310-AA, Total Parenteral Nutrition.

AMERICAN INDIAN HEALTH PROGRAM (AIHP)

AHCCCS members who are enrolled with the American Indian Health Program (AIHP) may receive services from Indian Health Services (IHS), a tribally operated 638 facility, or AHCCCS Fee-For-Service providers.

Non-IHS/638 providers must obtain authorization from DFSM before they can provide certain medically necessary services to American Indian Health Program members. For additional information in regards to what services require prior authorization when provided at a non-IHS/638 facility, please refer to the FFS prior authorization list in this chapter and to AMPM 820, Prior Authorization.

References

Refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process and services that require PA, which can be found at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

Refer to AMPM 820, Prior Authorization Requirements for further information regarding covered services and those services requiring prior authorization.

Refer to the Fee-For-Service Provider Billing Manual, Chapter 12, Pharmacy Services, for additional information about prior authorization for pharmacy services.

Refer to Exhibit 12-1 in the Fee-For-Service Provider Billing Manual, under the Pharmacy Services chapter, for the prior authorization form for OptumRx.

Refer to the IHS/Tribal Provider Billing Manual, Chapter 6, Authorizations, for additional information about prior authorization when services are rendered by or at an IHS/638 provider or facility.

Refer to the Fee-For-Service Provider Billing Manual, Chapter 15, Dialysis Services, and AMPM 1120, Federal Emergency Services Program Dialysis and its exhibits for additional information on prior authorization of dialysis services for Federal Emergency Services Program (FESP) members.

Revision History

Date	Description of changes	Pag

		e(s)
3/25/2019	Observation Services section removed as it is no longer applicable.	10
10/1/2018	Clarifying language was added to the General Information section. Clarifying language was added to the Prior Authorization Procedures section. The following was added: *AHCCCS Online Provider Portal* *The preferred method of PA submission is via the AHCCCS Online Provider Portal. This is the quickest way to submit for PA and to check the status of a PA request, and it can be accessed on the AHCCCS website at:* *https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f* Clarifying language was added to the Claim Submission Directions section The Prior Authorization of Acute Services section was updated. • The second bullet point under A.A.C. R9-22-204 (A)(1) was updated to read as "non-emergent/elective surgery." • A.A.C. R9-22-211(G)(1) was updated to have "one way or round trip" added to it for clarification. • The reference to A.A.C. R9-22-215(B) was removed and instead the following was added: For additional information on other services that require PA, please refer to AMPM 820, Prior Authorization Requirements, and to the Fee-For-Service Prior Authorization web page at: https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html Clarifying language added to the Ambulatory Surgery Center section. The Behavioral Health Services section was updated with integration information (changed "Acute FFS" to "AIHP") Clarifying language added to Hospital Admissions section, including: *Note: Notification of an emergent physical health admission must be provided when the member remains inpatient 72 hrs or more. (This does not apply to FES inpatient admissions.)* Medical equipment section updated – "ALTCS" was removed and only "Tribal ALTCS" was kept. "Retro eligibility" changed to "retrospective eligibility" Added clarification regarding surgeons obtaining PA. It was changed to "elective or non-emergency surgery, except *voluntary* sterilization;" Updated reference to 310-AA Total Parenteral Nutrition policy and added clarifying language.	1 2 2 2-3 3-4 5 5 7 8 9 11

		11
4/26/18	The link to the FFS Prior Authorization webpage was added.	1-2; 12
2/23/18	Updated verbiage for the prior authorization department from the AHCCCS Administration to DFSM	All
2/15/2018	General Information section updated Prior Authorization Procedures section updated Prior Authorization of Acute Services section updated Behavioral Health Services section updated Dental Services section updated Dialysis section updated Medical Equipment, Appliances, Supplies, and Orthotics and Prosthetics section updated (formerly it was called DME) NEMT section updated Observation Services updated with recovery room extension information. Rehabilitative Services section updated with OT information Total Parenteral Nutrition section updated American Indian Health Program section updated References section added Phone numbers & fax numbers updated Formatting	1 2-3 3-4 5 5-6 6 8 8-9 9 10 11 12 12 All All
10/1/2015	Replace “ICD-9” with “ICD”	3
08/1/2015	Orthotics benefit changes effective 08/01/2015	6

CHAPTER 9 ~ MEDICARE/OTHER INSURANCE LIABILITY

Chapter 9 ~ Medicare/Other Insurance Liability

REVISION DATES: 1/11/2019; 4/13/2018; 3/20/2018; 3/12/2014; 2/21/2014

General Information

Federal law 42 USC 1396a (a)(25)(A) requires Medicaid to take all reasonable measures to determine the legal liability of third parties for health care items and services provided to Medicaid members.

AHCCCS has liability for payment of benefits after Medicare and all other first- and third-party payer benefits have been paid. Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

Providers who qualify for Medicare payment, but have not applied to Medicare, must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

AHCCCS maintains a record of each member's coverage by Medicare and Other coverages. If a member's record indicates first- third-party coverage but no Medicare and/or insurance payment is indicated on the claim, the claim will be denied.

Timely Filing

The initial claim *must be submitted to AHCCCS within six months of the date of service*, even if payment from Medicare or Other Insurance has not been received.

If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim with the Medicare/Other Insurance payment Remit/EOB/EOMB. This must occur within 12 months of the date of service, which is the clean claim time frame.

Refer to Chapter 4 General Billing Rules, of the Fee-For-Service Provider Billing Manual for timely filing requirements and instructions for *replacing* (resubmitting) a claim. Failure to replace a claim correctly may result in a “timely filing” denial.

Definitions

In addition to the definitions in A.R.S. §36-2901, 36-2923 and 9 A.A.C. 22 Article 1, the following definitions apply to this Article:

Absent Parent	An individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child, as defined by A.A.C. R9-22-1001.
Coordination of Benefits (COB)	The activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
Cost Avoidance	To deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C. R9-22 Article 10.
First Party Liability	The obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member. Refer to A.A.C. R-9-22-1001 Definitions.
Post-Payment Recovery	Subsequent to payment of a service by a Contractor, efforts by that Contractor, to retrieve payment from a liable third-party. "Pay and Chase" is one type of post-payment recovery.
Third-Party	An individual, entity or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.
Third Party Liability	Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan."

Acronyms

For purposes of this chapter the following abbreviations are defined:

EOMB The EOMB is an Explanation of Medicare Benefits.
EOB The EOB is an Explanation of Benefits by First- and Third-Party payers (i.e. Other Payers).
RA The RA stands for Remittance Advice.

First- And Third-Party / Other Coverage

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted per A.R.S. §36-2946.

Under state and federal law and R9-22-1003 (E), AHCCCS must pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement from the First- or Third-Party payer (Post-Payment Recovery) when the claim is for:

1. Preventive pediatric services, including EPSDT services and administration of vaccines under the Vaccines For Children (VFC) Program; or
2. The liability is from an absent parent whose obligation to pay support is being enforced by Division of Child Support Enforcement; or

Per R9-22-1002, AHCCCS is not the payer of last resort (AHCCCS will be the primary payer) when the following entities are the third-party:

1. The payer is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

Coordination of Benefits (COB)

For information on Medicare COB please refer to the Medicare heading within this chapter.

Coordination of benefits with a First-Party Payer includes, but is not limited to the following:

- Private health insurance;
- Employment-related disability and health insurance;
- Long-term care insurance;
- Other federal programs not excluded by statute from recovery;
- Court ordered or non-court ordered medical support from an absent parent;
- State worker's compensation;
- Automobile insurance, including underinsured and uninsured motorists insurance;
- Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
- First-party probate estate recovery; and/or
- Adoption-related payment.

Coordination of benefits with Third-Party Payers includes, but is not limited to the following:

- Motor vehicle injury cases,
- Other casualty cases,
- Tortfeasors,

- Restitution recoveries, and/or
- Worker's compensation cases.

The AHCCCS Administration's reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the first- or third-party liability.

An AHCCCS registered provider agrees to accept the Capped Fee-For-Service schedule as payment in full.

If the first- or third-party coverage paid more than the Capped Fee-For-Service scheduled amount then no further reimbursement is made by AHCCCS.

For example, a provider bills $4,500.00 for a surgical procedure:

- The first-party plan allowed $1,388.23, paid $1,110.58 and shows a 20% coinsurance amount of $277.65;
- The AHCCCS Capped Fee-For-Service schedule allows $753.21 for the surgery

There will be no AHCCCS payment, as the provider has already been paid more than the Capped Fee-For-Service scheduled amount. The provider must accept the $1,110.58 as payment in full and cannot balance bill the member for any amount.

When the first-party payer is an HMO-type health plan, the same coordination of benefits process would apply.

For example, a contracted HMO provider bills $150.00 for an office visit.

- The HMO plan benefit has a member co-pay of $30.00 and the plan pays the contracted provider $50.00.
- The AHCCCS Capped FFS schedule allows $41.39 for the office visit.

There will be no AHCCCS payment, as the provider has already been paid more than the AHCCCS Capped FFS rate. The provider must accept the $50.00 as payment in full. AHCCCS does not reimburse co-pays, deductibles or coinsurance amounts.

Should more than one coverage plan make payment and the <u>total</u> paid by the multiple coverage plans is more than the AHCCCS Capped Fee-For-Service schedule then there will be no AHCCCS payment. The provider cannot balance bill the member for any amount.

If the first- or third-party payer denies a covered service the provider must follow the payer's appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

<u>A.A.C. R-22-1003 Cost Avoidance</u>:

- Section A advises that the Administration's reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability.
- Section C advises that the requirement to "cost avoid" applies to all AHCCCS-covered services under Article 2 of the A.A.C. chapter. The only exception provided by Rule is that the Administration shall pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement when:
    1. The claim is for labor and delivery and postpartum care; or
    2. The liability is from an absent parent, and the claim is for prenatal care or EPSDT services.

AHCCCS shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is submitted (see exceptions 1 – 5 on page 3) without the required other coverage payment EOB/remit/information.

If the probable existence of a First- or Third-party's liability cannot be established or if Post-Payment Recovery is required then the claim will be adjudicated and AHCCCS will follow the Post-Payment Recovery process (Pay and Chase).

Medicare

AHCCCS Medicare Eligibility Definitions

In reference to QMB claims: If a Medicare provider is not an AHCCCS registered provider, AHCCCS will permit the provider to register as an AHCCCS registered provider for the adjudication of the claim for the QMB cost-sharing amount. AHCCCS will notify the provider of the process for registering. If a provider is unwilling to become an AHCCCS registered provider then no payment can be made.

QMB Only – a **Q**ualified **M**edicare **B**eneficiary under the Federal QMB program. This is a person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.

AHCCCS can reimburse the provider for the Medicare deductible, coinsurance, and copay.

If Medicare denies the service and upholds the denial upon the provider's appeal, then AHCCCS *makes no payment.* Refer to Arizona Administrative Code (A.A.C.) R9-29-301.

Balance billing of **QMB**s is prohibited by Federal Law. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost sharing.

QMB Dual – this individual qualifies under the federal QMB program and Medicaid (AHCCCS).

Per A.A.C. R9-29-302:

1. AHCCCS will pay the following costs for FFS members when the services are received from an AHCCCS registered provider *and* the service is covered:

    a) By Medicare only, then AHCCCS pays only the Medicare deductible/coinsurance/copay;
    b) By Medicaid only, then AHCCCS pays the FFS rate; or
    c) By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible/ coinsurance/copay.

2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

A.A.C. R9-29-302.E. advises: "A QMB Dual eligible member who receives services under 9, A.A.C. 22, Article 2 or 9, A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges."

Non-QMB Dual – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as "Dual Eligible").

Per A.A.C. R9-29-303:

1. AHCCCS will pay the following costs for FFS members when services are received from an AHCCCS registered provider *and* the service is covered:
    a) By Medicare only, then AHCCCS shall *not* pay the Medicare deductible or coinsurance or copay;
    b) By Medicaid only, then AHCCCS pays the FFS rate; or
    c) By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible, coinsurance or copay.

2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

Guidelines for "Dual Eligible" Members

A Medicare provider must accept Medicare allowable as the total compensation for services rendered. Based on the member's eligibility, when appropriate, AHCCCS may reimburse up to the Medicare deductible, coinsurance or copay for services, including members enrolled with a Medicare Advantage plan. Contact the Medicare Advantage HMO plan for information regarding covered services and prior authorization requirements.

Services that are not Medicare covered, but are AHCCCS covered, may be reimbursed by AHCCCS if the service is medically necessary and meets the AHCCCS eligibility and reimbursement requirements.

If Medicare denies a covered service based on medical necessity or if the service was not delivered in the appropriate setting, the service will not be paid by AHCCCS.

If Medicare denies a covered service the provider must follow the Medicare appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of Medicare's final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

If a member is *eligible* for Medicare Part D then AHCCCS does not cover prescription medications or Part D copay amounts.

AHCCCS will not pay for more than the member's financial responsibility for the service (e.g., any deductible, coinsurance, and/or co-pay as indicated above).

Medicare Crossover Claims

AHCCCS has established an automated crossover process for fee-for-service claims.

When a provider submits a claim to Medicare for an AHCCCS member the claim is automatically crossed over to AHCCCS when Medicare issues payment. Providers should not submit claims to AHCCCS for paid Medicare claims for Dual eligible AHCCCS members or QMB members. For information on the FQHC/RHC exception, refer to FFS Chapter 10 Addendum – FQHC/RHC.

All crossover claims are identified on the provider's Medicare Remittance Advice (RA).

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within the timely filing requirements. A copy of the Remittance Advice (RA)/Explanation of Medical Benefits (EOMB) must accompany the claim to AHCCCS. Refer to Chapter 4, General Billing, of the Fee-For-Service Provider Billing Manual for timely filing requirements and the claim replacement process.

Filing Paper or Online Claims After Medicare / First- and Third-Party Payer Payments

The EOMB, EOB, and RA show payment/denial details of a provider's claim for services.

Denied Medicare claims are not automatically crossed over to AHCCCS. Read the Medicare RA/EOMB carefully to determine if the claim crossed over to AHCCCS *or* if the provider must submit the claim and the Medicare RA/EOMB to AHCCCS. Read the Medicare reason codes carefully to determine if the Medicare appeal process must be followed before AHCCCS can determine reimbursement.

Adjusted Medicare claims are not automatically crossed over to AHCCCS at this time. The provider must submit a replacement claim to AHCCCS with a copy of the original Medicare RA/EOMB *and* the adjustment RA/EOMB with all of the reason codes displayed. For additional information on replacing (resubmitting) a claim, please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual.

Claims submitted with only the Medicare adjustment RA/EOMB may be denied by AHCCCS as incomplete. If the Medicare RA/EOMB is submitted to AHCCCS without the reason code page(s) the claim may be denied as incomplete.

Providers *must* submit a *separate RA/EOMB/EOB with each claim*. If a provider submits multiple claims for a member but includes only one copy of the RA/EOMB or EOB, the payment document will be attached to the claim with highest coinsurance and deductible amount. The other claims in the package will be denied for lack of a Medicare RA/EOMB or Other Payer's RA/EOB.

Always attach a copy of the Medicare EOMB / Third Party Payer's RA/EOB to each claim submitted.

Always include the Medicare Remittance Advice Reason Code (RARC)/ Claim Adjustment Reason Code (CARC) key page(s) for the RA/EOMB.

Always include the Remark/Reason Code key page(s) for the Other Payer's RA/EOB.

Never submit double-sided pages, as the back side of the page will not be scanned and the claim will be denied as incomplete.

> Note: Failure to submit the remark/reason code key page(s) with the RA/EOMB/EOB are considered incomplete claims and will result in claim denial.

UB-04 Claims with Medicare and/or Other Payer

When a provider finds it necessary to file a UB-04 claim with AHCCCS for a member who also is covered by Medicare and/or other payer, the provider must report Medicare and/or other payer information on the claim to AHCCCS.

For members and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill AHCCCS for the coinsurance/copay and deductible as shown on the Medicare RA/EOMB. Providers must attach a copy of the Medicare RA/EOMB to the UB-04 claim.

1. Medicare Part A
    a. Report the Part A deductible and coinsurance (if applicable) amounts and appropriate value codes in fields 39A and 40A.
    b. Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance.

Example: Provider reports Medicare Part A deductible of $812 and no coinsurance.

	39 VALUE CODE			40 VALUE CODE			41 VALUE CODE		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A1	812	00						
b									
c									
d									

2. Medicare Part B - Inpatient

   a. Report Medicare Part B as the payer in Field 50A and the Part B paid amount in Field 54A.

   NOTE: Please note that field 50 is to be used for the reporting of TPL. If there is a Third Party Payer *and* Medicare Part B, the TPL can be reported in Field 50A and Medicare Part B can be reported in Field 50B.

Example: Provider reports Medicare Part B Inpatient payment of $312.

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
A MEDICARE PART B				312	00		
B							
C							

3. Medicare Part B - Outpatient

   a. Report the Part B deductible (if applicable) and coinsurance amounts and appropriate value codes in Fields 39B and 40B.

   b. Use value code B1 to indicate Part B deductible and B2 for Part B coinsurance.

Example: Provider reports outpatient Part B coinsurance of $125.

	39 VALUE CODE			40 VALUE CODE			41 VALUE CODE		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a									

b	B2	125	00						
c									
d									

4. First- and Third-Party Payers

   a. Report the Other Payer's name(s) in Fields 50A and (if needed) 50B and the payment amount(s) in Fields 54A and (if needed) 54 B. (List all First- and Third-Party payers & payments)

   b. Attach a copy of the payer's RA/EOB to the UB-04 claim. If more than one Other Payer is listed, then include RA/EOB for each Other Payer listed.

Example: Provider reports a first- and third-party payment total of $1,275.00.

50 PAYER		51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
A	XYZ Insurance				1,225	00		
B	Acme Benefits				50	00		
C								

Do **not** "zero fill" the payment amount fields on hospital inpatient and outpatient claims, dialysis facility claims, and hospice claims. If a claim is denied by Medicare or Other Payer, providers must submit documentation of the denial with the UB-04 claim to AHCCCS.

Nursing Facility Claims with Medicare/Other Insurance

AHCCCS is responsible for reimbursement of Medicare coinsurance minus any Other Payer payment, minus the member's share of cost (SOC).

When a nursing facility submits a claim to Medicare Part A intermediaries for an AHCCCS member who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment.

Nursing facilities should not submit claims to AHCCCS for paid Medicare claims for Dual eligible AHCCCS members or QMB members. All Medicare crossover claims are identified on the provider's remittance advice.

When a member has exhausted the Medicare benefit for nursing facility coverage, the nursing facility must submit a claim to AHCCCS. The facility should bill with the appropriate Value Code, "zero fill" the Medicare fields, and submit the claim within the appropriate time frame. Leaving the fields blank will cause the claim to be denied. Zeros indicate that no payment was received.

Example: The provider reports that no payment was received from Medicare.
Value Code A2 = Medicare Part A Coinsurance

	39 VALUE CODES			40 VALUE CODES			41 VALUE CODES		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A2	00	00						
b									
c									

If payment from Medicare or Other Payer is received later, the provider must submit an adjustment claim with the RA/EOMB/EOB reflecting the payment. Refer to Chapter 4 of the Fee-For-Service Provider Billing Manual, General Billing Rules, for additional information on how to submit claim adjustments.

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within the timely filing requirements.

A copy of the Medicare RA/EOMB and/or the Other Payer's RA/EOB must be submitted with the claim to AHCCCS.

FQHC/HRC Claims with Medicare/Other Insurance

Refer to the Chapter 10 Addendum FQHC/RHC for specific Fee-for-Service (FFS) billing instructions.

RETROACTIVE POSTING OF MEDICARE ELIGIBILITY

Occasionally, AHCCCS learns that a member is eligible for Medicare after payment has been made to the provider. When that happens, AHCCCS recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

AHCCCS contracts with Health Management Systems, Inc. (HMS) to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

AHCCCS will systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. With retroactive Medicare postings AHCCCS may recoup overpayments where Medicare information was not previously reported.

When AHCCCS recoups, providers should bill Medicare and follow the procedures outlined earlier in this chapter.

References

The following references pertain to QMB Payments:

- 42 USC 1396a(a)(10)(E)
- 42 USC 1396d(p)
- 42 USC 1396(a)(n)(2)
- CMS –MMCO – CM Informational Bulletin – Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs) dated June 7th, 2013
- Center for Medicaid and CHIP Services MMCO – CMCS Informational Bulletin on Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs) dated January 6th, 2012
- CMS QMB FAQs dated September 9th, 2017
- Additional CMS QMB Program information can be found at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html
- From Medicare.gov- Medicare Savings Program Overview https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#collapse-2614
- From CMS January 2012 QMB Informational Bulletin, Background on QMBs and Benefits http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-06-12.pdf
- From Qualified Medicare Beneficiary Program – FAQ on Billing Requirements (July 2018) https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf
- From CMS Medicare Learning Network Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
- https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-07-2013.pdf

Revision/Update History

Date	Description of changes (All page numbers reflect the page number in the individual chapter and not the master pdf document.)	Page(s)
1/11/2019	The AHCCCS Medicare Eligibility definition section was updated with the following: "In reference to QMB claims: If a Medicare provider is not an AHCCCS registered provider, AHCCCS will permit the provider to register as an AHCCCS registered provider for the adjudication of the claim for the QMB cost-sharing amount. AHCCCS will notify the provider of the process for registering. If a provider is unwilling to become an AHCCCS registered provider then no payment can be made." QMB Only definition updated to include copays (see definition for details).	5 5

	References for copay payment added. QMB Dual definition updated to include copays (see definition for details) Non-QMB Dual definition clarified (no changes, just re-ordered for clarity) The following clarification was added: "With retroactive Medicare postings AHCCCS may recoup overpayments where Medicare information was not previously reported." References section added Professional Claims section deleted	5 5-6 6 11 11-12
4/13/18	The Timely Filing section was updated. The Third-Party definition was updated to match the updated rule reference and R9-22-1001 changes. The Third Party Liability definition was updated to match the updated rule reference and R9-22-1001 changes. An acronyms section was added. Clarification was added to the First-And Third Party /Other Coverage section. The reference to R9-22-1002 was updated to match the updated rule. An updated reference to the updated rule R9-22-1003 on Cost Avoidance was added. Clarifications and examples were added to the Professional Claims section. Clarifications and examples were added to the UB-04 Claims with Medicare and/or Other Payer section. Retroactive Posting of Medicare Eligibility section updated. Formatting	1 2 2 2 2-3 3 4-5 9-11 10-12 13-14 All
08/1/2015	New layout and formatting For clarification: Added section of Definitions Removed paper claim instructions	All pages 2, 3 All pages
3/12/2014	Removed existing ambiguous language; replaced with A.A.C. Rule and A.R.S. language	All pages
2/21/2014	Clarification language to section "Filing Paper or Online Claims" Formatting changes	5, 6 All pages

CHAPTER 10 ~ INDIVIDUAL PRACTITIONER SERVICES

Chapter 10 ~ Individual Practitioner Services

Revision Dates: 4/12/2019; 11/1/2018; 4/5/2018; 2/9/2018; 1/05/18; 12/29/17; 10/01/2017; 10/05/2016; 03/30/2016; 12/21/2015; 11/13/2014; 09/30/2014; 04/07/2014

General Information

Within limitations, AHCCCS covers medically necessary medical and surgical services performed in offices, clinics, hospitals, homes, or other locations by licensed physicians, dentists, and mid-level practitioners.

Cosmetic surgery, experimental procedures, and unproven procedures are not covered.

Physicians and mid-level practitioners must bill for services on the CMS 1500 claim form. Services must be billed using appropriate CPT and HCPCS codes and procedure modifiers, if applicable. Dentists must bill for services on the ADA 2012 form using CDT-4 codes. The range of procedure codes that may be used by each provider type is listed in the provider type profile maintained by AHCCCS.

Providers should contact the Claims Customer Service Unit to determine if a procedure is covered by AHCCCS or if a specific code can be billed on a fee-for-service claim.

Phoenix area: (602) 417-7670 (Option 4)
All others: 1-800-794-6862 (In state)
1-800-523-0231, Ext. 7670 (Out of state)

The covered services, limitations, and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM) and Arizona Administrative Codes (A.A.C.) R9-22-201 et. seq. Please direct questions to the AHCCCS Office of Medical Policy, Analytics and Coding.

The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at www.azahcccs.gov.

For information on Title XIX and Title XXI (KidsCare) member claims for professional services done at an IHS/638 facility, please see Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual.

Correct Coding Initiative

AHCCCS follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on Fee-For-Service claims for the same provider, same member, and same date of service.

Correct coding means billing for procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code.

Some examples of **incorrect** coding include:

- Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service and clinically justified as demonstrated in the medical record. Claims submitted to AHCCCS utilizing modifier 59 will be subject to Medical Review. **Documentation in the medical record must satisfy the criteria required for appropriate use of the modifier.** Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

To align with Medicare billing rule, bilateral procedures are to be billed on one line with the "50" modifier and the appropriate number of units. The rate valuation is 150% of the capped fee schedule.

Separate services during the post-operative period may be billed with modifier 58 or 78.

Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

CCI edits and audits are run on a prepayment basis. The CCI edit results are:

L140.1 - Invalid Coding Combination; Mutually Exclusive Code Paid (Deny)
L140.2 - Invalid Coding Combination; Component Previously Paid (Deny)
L140.3 - Invalid Coding Combination; Comprehensive Previously Paid (Deny)
L140.4 - Invalid Coding Combination; Multiple Component Codes (Deny)
L140.5 – Invalid Coding Combination; Ventilator Management with E/M Code (Deny)
L140.6 - Invalid Coding Combination; Discharge Management with E/M Code (Deny)

To meet CCI requirements, billers should follow these steps:

1. Determine if the code to be billed is a mutually exclusive code.

   Mutually exclusive procedures are those that cannot reasonably be performed in the same session (e.g., codes for “initial” and “subsequent” services).

   If a mutually exclusive code and its “partner” are billed on the same claim, the system will allow the code with the lowest capped fee. If the “partner” code has been paid, the system will deny the billed code.

2. Determine if the code to be billed is a component of a comprehensive code that also will be billed or that has been billed.

   The comprehensive code must be billed, if applicable. Claims for component codes that describe services distinct or separate from the services described by the comprehensive code may be reimbursed when billed with NCCI associated modifiers, if appropriate. CMS updates this modifier list quarterly. For current information please use the following link:

   https://www.cms.gov/medicare/coding/nationalcorrectcodinited/version_update_changes.html

3. Determine if the code to be billed is a comprehensive code.

   If it is a comprehensive code and one of its components has been billed and paid, that claim for the component code must be voided before the comprehensive code can be billed.

   Component codes cannot be billed if the comprehensive code is the most appropriate code.

Social Determinants

Social determinants of health are the conditions in which a person is born, grows, lives, works and ages. ICD-10 codes have been created to correspond with these social determinants.

Social determinants of health take into account factors like the member’s education, employment, physical environment, socioeconomic status, and social support network. The use of social determinants allows a provider to identify things such as illiteracy, unemployment, a lack of adequate food and safe drinking water, social exclusion and rejection, homelessness, alcoholism, and many other factors that could affect a member’s overall health and wellbeing.

Beginning with dates of service on and after **April 1st, 2018**, AHCCCS will begin to monitor all claims for the presence of social determinant ICD-10 codes.

As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about the social determinant should be included in the member's chart.

Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for AHCCCS members, in order to comply with state and federal coding requirements.

> Note: Social determinants are ***not*** the primary ICD-10 code. They are secondary ICD-10 codes.

Dental providers will be **exempt** from the use of social determinants.

For a list of ICD-10 codes relevant to social determinants of health, please see Exhibit 4-1, Social Determinants of Health ICD-10 Code List in the Fee-For-Service Provider Billing Manual. The list of social determinants of health codes may be added to or updated on a quarterly basis. Providers should remain current in their use of these codes.

Anesthesia Services

Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).

Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of MINUTES in Field 24G of the CMS 1500 claim form.

The begin and end time of the anesthesia administration must be entered on the claim on the line immediately below Field 24D/ ASA code.

The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim.

AHCCCS uses the limits and guidelines as established by ASA for base and time units. Every 15 minutes or any portion thereof is equal to one unit of time. The AHCCCS system will calculate units based on minutes billed for most anesthesia procedures.

The AHCCCS system adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established FFS rate to obtain the allowed amount.

<u>Billing for labor and delivery</u>

Providers should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes the repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural is used. Providers may bill for a maximum of 180 minutes (three hours).

If labor results in a Cesarean section, add-on code 01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added. Providers should bill for the time of the Cesarean section portion of the service only. A base of 5 units is added for the ASA code 01967, and a base of 3 units is added for 01968.

For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.

Providers who bill other CPT codes for additional procedures performed during anesthesia administration must use the units field to indicate the number of times the procedure was performed.

Providers should not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

For example:

A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.
Billing the Basic Unit Value of four would indicate placement of four catheters.

Reimbursement is based on capped fee schedule.

Anesthesia Medical Direction

The following modifiers are to be used for anesthesia medical direction:

QK- Medical direction of two, three or four concurrent anesthesia procedures
QX- Anesthesia, CRNA medically directed
QY- Medical direction of one CRNA by anesthesiologist

Reimbursement of each provider will be at 50% of the AHCCCS capped fee schedule.

Effective 05/01/2015 modifier AD – Medical supervision by a physician: more than four concurrent anesthesia procedures will be reimbursed at 50% of the AHCCCS capped fee schedule.

<u>Two separate claims must be filed for medically directed anesthesia procedures</u>- one for the anesthesiologist and one for the CRNA. Medical direction can occur in several different

scenarios. When billing for the anesthesia services, please refer to the following examples for appropriate modifier usage:

- An anesthesiologist is medically directing one CRNA. The anesthesiologist should bill with the QY modifier and the CRNA should bill with the QX modifier.
- An anesthesiologist is medically directing two, three or four CRNAs. The anesthesiologist should bill with the QK modifier and the CRNA should bill with the QX modifier.

The following anesthesia services are not covered:

- 00938 (Insertion of penile prosthesis)
- Qualifying circumstances codes
- Physical status codes

Peripheral Nerve Blocks for Postoperative Pain Management on the Date of Surgery

A peripheral nerve block (CPT codes 64400-64530) may be billed separately when the following conditions are met:

- The peripheral nerve block was performed for the purpose of postoperative pain management; *and*
- The operative anesthesia was general anesthesia, subarachnoid injection or epidural injection; *and*
- The adequacy of the operative anesthesia was not dependent on the peripheral nerve block; *and*
- A procedure note is included in the medical record.

Modifier 59 may be used to indicate that a separate peripheral nerve block injection was performed for postoperative pain management, rather than for intraoperative anesthesia.

Modifier 51 does not apply if one surgical code for a peripheral nerve block for postoperative pain management is reported in addition to the anesthesia code; however, if more than one surgical code is reported, then modifier 51 applies to the additional surgical code(s).

Please see the section (below) on Multiple Surgical Procedures for additional information on the use of Modifier 51.

Dental Services

In accordance with Arizona Administrative Code (A.A.C.) R9-22-207, AHCCCS covers limited dental services for adult members (21 years of age and older).

For adult members (21 years of age and older), effective date of service 10/1/17, in accordance with A.R.S. 36-2907, an emergency dental benefit has been granted in an annual amount not to exceed $1,000 per member per contract year (October 1st to September 30th) for emergency dental care and emergency extractions.

A dental emergency covered by this benefit is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

The emergency dental benefit is in addition to the services that may be furnished by a dentist under specified circumstances, which are already covered by AHCCCS. For further details regarding covered dental emergencies please see AMPM 310–D1 Dental Services for Members 21 Years of Age and Older.

The emergency dental benefit is in addition to the non-emergency dental services for ALTCS members age 21 years and older, as specified in AMPM Policy 310-D2.

ALTCS Dental Services

Effective date of service 10/01/2016, the dental benefit for ALTCS members has been restored. Refer to FFS Chapter 21 ALTCS Services for coverage and billing information.

Dental Services for Members under Age 21: EPSDT Services

AHCCCS covers comprehensive health care for members under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT covers all medically necessary services described in federal law 42 USC 1396d to treat or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening, whether or not the service is described in the State Plan.

Covered EPSDT dental services for members under age 21 and KidsCare members include, but are not limited to:

- Screening and preventive services as specified in the dental periodicity schedule;
- Emergency dental services; and
- All medically necessary therapeutic dental services.

Prior Authorization Requirements for Dental Services

PA is not required for emergency dental services, preventative or for medically necessary therapeutic dental services for EPSDT and KidsCare members.

Dental surgery services for EPSDT and KidsCare members require PA.

Pre-transplant dental services that are medically necessary in order for the member to receive the major organ or tissue transplant do require prior authorization from the AHCCCS transplant case manager.

Billing Requirements

Dentists must bill on the ADA 2012 claim form using CDT-4 codes.

Only oral surgeons registered as Provider Type 07 (Dentists) may use CPT Evaluation and Management (E/M) codes on the CMS 1500 claim form to bill AHCCCS for office visits.

Dentists who are not oral surgeons must use one of the following codes to bill for office visits and evaluation services:

- D0120 - Periodic oral exam
- D0140 - Limited oral evaluation -- problem focused
- D0150 - Comprehensive oral evaluation
- D0160 - Detailed and extensive oral exam -- problem focused
- D9430 - Office visit for observation (during regularly scheduled hours) – no other
- services performed
- D9440 - Office visit -- after regularly scheduled hours

Dentists may use appropriate E/M codes for hospital consultation, emergency room services, and hospital visits.

Effective 4/1/2014, AMPM Policy 431 EPSDT Oral Health Care advises that the physician, physician's assistant or nurse practitioner must perform an oral health screening as part of the EPSDT physical examination.

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for members who are at least 6 months of age, with at least 1 tooth eruption. Additional applications occurring every 6 months during an EPSDT visit, up until the member's 2nd birthday, may be reimbursed according to the AHCCCS fee schedule. Refer to AMPM Policy 431 for further details regarding fluoride varnish application and the AHCCCS recommended training information.

PCPs and attending physicians must refer EPSDT members to a dentist for appropriate services based on the needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 431-1). Evidence of the referral must be documented on the ESPDT Tracking Form and in the member's medical record.

Members must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS EPSDT Periodicity Schedule. The physician may refer EPSDT members for a dental assessment at an earlier age, if their oral

health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to physician referrals, EPSDT members are allowed self-referral to an AHCCCS registered dentist.

Refer to AMPM Policy 431 for covered services, provider requirements, informed consents and treatment plans.

Informed Consent

Please refer to AMPM 310-D1 Dental Services for Members 21 Years of Age and Older for further information regarding informed consent requirements.

Notification Requirements for Charges to Members

Please refer to AMPM 310-D1 Dental Services for Members 21 Years of Age and Older for further information regarding notification requirements for charges to members.

Billing for Dental Services

Please refer to AMPM 310-D1 Dental Services for Members 21 Years of Age and Older for further information regarding informed billing requirements for dental services.

Discharge Management

Physicians and mid-level practitioners who bill Evaluation and Management (E/M) codes 99238 and 99239 for discharge management should not bill any other evaluation and management code for the same date when submitting claims to AHCCCS.

The E/M codes for hospital discharge day management are used to report all services provided on the date of discharge, including final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.

If a provider submits a claim for discharge management and another E/M code for the same date, the E/M code will be paid, but the discharge management code will be denied.

EPSDT Program Services

AHCCCS covers comprehensive health care for members under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

EPSDT also covers all medically necessary services to treat or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the service is covered under the State Plan.

KidsCare (Title XXI) members are eligible for nearly the same services as ESPDT members eligible under Title XIX. However, KidsCare members are not eligible for licensed midwife services and home births.

EPSDT screening services are to be provided in compliance with AHCCCS medical policy, including the periodicity schedule, which meet reasonable standards of medical practice and specified screening services at each stage of a child's life. **Refer to AMPM Policy 430 for comprehensive changes effective 4/1/2014 for EPSDT** and Exhibit 430-1 for the updated EPSDT Periodicity Schedule.

The EPSDT screening requirements are:

- Comprehensive health, nutritional and developmental history
- Comprehensive unclothed physical examination
- Screening for immunizations appropriate to age and health history.
- Laboratory tests
- Health education
- Vision, speech and hearing assessment
- Age appropriate dental screening
- Behavioral health services
- Oral health screening
- Tuberculin skin testing

Effective 4/1/2014 EPSDT/Well Child visits are all-inclusive visits. The payment for the EPSDT is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1). Refer to AMPM Policy 430 for exceptions to the all-inclusive visit global payment rate.

Claims must be submitted on CMS 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventative medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in AMPM Policy 430. No additional reimbursement is allowed.

Providers must use an EP modifier to designate all services related to the EPSDT well child check-up, including routine vision and hearing screenings.

Providers must be registered as **Vaccines for Children (VFC) Program** providers and VFC vaccines must be used. Under the federal VFC program, providers are paid a capped fee for administration of vaccines to members 18 years old and younger.

For VFC claims incurred prior to 1/1/2013**,** providers must bill the appropriate CPT code for the immunization with the "SL" (State supplied vaccine) modifier that identifies the immunization as part of the VFC program.

Providers must *not* use the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.

Because the vaccine is made available to providers free of charge, providers must not bill for the vaccine itself.

For VFC services incurred on/after 1/1/2013**,** Section 1202 of the Patient Protection and Affordable Care Act (ACA) requires AHCCCS to modify how providers submit claims for vaccine administration services.

Beginning with dates of service 1/1/2013, AHCCCS will require all providers to submit two CPT codes for VFC program services, both billed with modifier SL**:**

- One code will identify the vaccine administrative service as described by codes 90460, 90461, 90471, 90472, 90473 and 90474 and *billed with SL modifier.*
- The second code, with the SL modifier, will identify the actual vaccine administered.

24. A	B	C	D	E	F
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges
1/1/13-1/1/13	11		90460 **SL**	1	$xx.xx
1/1/13-1/1/13	11		90700-SL	1	0.00

Follow CPT guidelines for the appropriate administration code usage.

No payment will be made for the vaccine provided through the VFC program. Payment will be made for the administration at the rates in effect for that service at the time the VFC immunization was administered.

For a list of vaccines covered under the VFC program refer to Chapter 2 of the Vaccines for Children Operations Guide found at http://azdhs.gov/preparedness/epidemiology-disease-control/immunization/index.php#vaccines-children-guide.

REMINDER: these billing instructions are ONLY for vaccines through the VFC program administered to members 18 years or younger.

Family Planning Services

Family planning services are provided to eligible members who voluntarily choose to delay or prevent pregnancy and include covered medical, surgical, pharmacological and laboratory benefits.

Family planning services includes the provision of accurate information and counseling to allow eligible members to make informed decisions about the specific family planning methods available.

For further information regarding family planning services and contractor requirements please see AMPM 420, Family Planning Services.

Covered services include:

- Contraceptive counseling, medications, supplies and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, long-acting reversible contraceptives (LARC), subdermal implantable contraceptives, diaphragms, condoms, foams, and suppositories;
- Voluntary sterilization (male and female);
- Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning;
- Treatment of complications resulting from contraceptive use, including emergency treatment;
- Natural family planning education or referral to qualified health professionals;
- Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse;
- Pregnancy screening; and
- Screening and Treatment for Sexually Transmitted Infections (STI).

Limitations and exclusions:

- Services for the diagnosis or treatment of infertility are not covered.

- Abortion counseling is not covered.
- Pregnancy terminations are not covered unless:
    1) The pregnancy termination is necessary to protect the life of the mother,
    2) The pregnancy termination is medically necessary to prevent a serious physical or mental health problem for the pregnant mother, or
    3) The pregnancy is the result of a rape or incest.
- Sterilization services are not covered for Federal Emergency Services (FES) members, and claims for sterilization services for FES members will be denied.

AHCCCS requires a completed Federal Consent Form to be submitted with all claims for voluntary sterilization procedures. This form is available in AMPM Exhibit 420-1.

Federal consent requirements for voluntary sterilization are:

- The member to be at least 21 years of age at the time consent is signed.
- The member to be mentally competent.
- Consent to be voluntary and obtained without duress.
- Thirty days, but not more than 180 days, to have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- At least 72 hours to have passed since the member gave informed consent for the sterilization if the member is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
- The informed consent to have been given at least 30 days before the *expected* date of delivery in the case of premature delivery.
- The person securing the informed consent and the physician performing the sterilization procedure to sign and date the consent form.
- A copy of the signed Federal Consent Form to be submitted by each provider involved with the hospitalization and/or the sterilization procedure. Please refer to AMPM Attachment 420-1 for the form.
- The sterilization consent may not be obtained when an eligible member:
    - Is in labor or childbirth,
    - Is seeking to obtain or obtaining an abortion, or
    - Is under the influence of alcohol or other substances that affect that member's state of awareness.

Providers must bill for IUDs on the CMS 1500 claim form using the following codes:

- J7300 Intrauterine copper contraceptive (Paraguard)
- J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
- S4989 Contraceptive intrauterine device (e.g. progestacert IUD), including implants and supplies

Prior to 1/1/2013 providers must bill for Depo-provera injections on the CMS 1500 claim form using HCPCS code J1055 - Depo-provera (150 mg). Effective 1/1/2013 the Depo-provera injections should bill billed with HCPCS code J1050 (1 mg).

Norplant insertion is no longer an AHCCCS-covered service because the manufacturer, Wyeth, is no longer distributing Norplant in the United States.

Do not bill for CPT codes:

- 11975 - Insertion, implantable contraceptive capsules; and
- 11977 - Removal with reinsertion, implantable contraceptive capsules.

Essure insertion must be billed on a CMS 1500 claim form using CPT code 58565.

Foot and Ankle Care

Effective date of service 10/1/2017 and later, in accordance with A.R.S. 32-801, podiatric physicians and surgeons may perform amputations of the partial foot and toe, but are excluded from performing an amputation of the leg or entire foot, and are excluded from administering an anesthetic other than local.

Effective date of service 10/1/2016 and later, medically necessary foot and ankle care is covered for persons age 21 and older when provided by a podiatrist or podiatric surgeon, when ordered by the primary care provider, attending physician or practitioner, for AHCCCS eligible members. The member's medical record must document the order for the podiatrist service. The podiatrist or podiatric surgeon must be an AHCCCS registered provider.

When billing for a podiatrist's services, the CMS 1500 field 17 must have Qualifier DK and the ordering provider's name. Field 17b must have the ordering provider's NPI. Podiatrist claims will be denied if these fields are blank or the ordering provider is not an AHCCCS registered provider.

Prior to date of service 10/1/2016

In accordance with Arizona Administrative Code A.A.C. R9-22-21, AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, when ordered by a member's primary care provider, attending physician or practitioner for eligible members. The ordering provider must be indicated on the podiatrist's CMS 1500 claim. The podiatrist and the ordering provider must be active AHCCCS registered providers.

Foot and ankle services are not covered for adults (age 21 and older) when provided by a podiatrist or podiatric surgeon. ‘

Routine foot care is designated as those services performed in the absence of localized illness, injury or symptoms involving the foot. Routine foot care is considered medically necessary in very limited circumstances as described below. These services include:

- The cutting or removal of corns or calluses,
- The trimming of nails (including mycotic nails), and
- Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the feet, and the use of skin creams to maintain skin tone of both ambulatory and bedfast patients).

Coverage includes medically necessary foot and ankle care such as wound care and treatment of pressure ulcers.

Foot and ankle care also includes fracture care, reconstructive surgeries, and limited bunionectomy services.

Routine foot care is considered medically necessary when the member has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional person would be hazardous.

Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include but are not limited to:

- Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger’s disease (thromboangiitis obliterans)
- Chronic thrombophlebitis
- Diabetes mellitus
- Peripheral neuropathies involving the feet
- Member receiving chemotherapy
- Pernicious anemia
- Hereditary disorder, i.e. hereditary sensory radicular neuropathy, Fabry’s disease
- Hansen’s disease or neurosyphilis
- Malabsorption syndrome
- Multiple sclerosis
- Traumatic injury
- Uremia (chronic renal disease)
- Anticoagulant therapy

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered in the following circumstances:

- A systemic condition, and
- Clinical evidence of mycosis of the toenail, and
- Compelling medical evidence documenting the member either:
    - Has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or
    - In the case of a non-ambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Foot and Ankle Care Limitations

Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to EPSDT members). A "contract year" is defined as October 1-September 30.

Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT members).

Neither general diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitation injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnosis under which routine foot care is covered.

Bunionectomy is covered only when the bunion is present with overlying skin ulceration, or neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Foot and Ankle Care Prior Authorization Requirements

Prior to service date 10/1/2016 all foot and ankle services not covered by Medicare require Prior Authorization.

After service date 10/1/2016, PA is not required for evaluation and management services. Elective surgical services are subject to PA requirements. Please refer to AMPM Chapter sections K and Q for those PA requirements.

Health Care Acquired Conditions & Provider Preventable Conditions

Section 2702 of the Affordable Care Act (ACA) prohibits Medicaid programs from reimbursing certain providers for services resulting from a "provider preventable condition" (PPC). PPCs are comprised of two categories:

1) health care acquired conditions (HCACs), and

2) other provider preventable conditions (PPCs).

Beginning July 1, 2012, AHCCCS will implement policies that conform to the federal requirements regarding HCACs and PPCs.

HCAC

For Medicaid, HCACs are defined as conditions identified by Medicare as Hospital Acquired Conditions (HACs) occurring in the inpatient hospital setting, which includes any of the following:

- Retained foreign object following surgical procedures;
- Air embolism;
- Blood incompatibility;
- Stage III and IV pressure ulcers;
- Injuries resulting from falls and trauma;
- Catheter associated urinary tract infections;
- Vascular catheter associated infections;
- Manifestations of poor glycemic control;
- Mediastinitis following coronary artery bypass graft (CABG) procedures;
- Surgical site infections following orthopedic surgery procedures involving spinal column fusion or re-fusion, arthrodeses of the shoulder or elbow, or other procedures on the shoulder or elbow;
- Surgical site infections following bariatric surgery procedures;
- Deep vein thrombosis or pulmonary embolism following total hip or knee procedures, except in pediatric or obstetrical patients.

Inpatient hospitals will not be paid any incremental or additional fees for treating an HCAC that is not present on admission to the facility, regardless of the cause of the HCAC. No reduction in payments will be assessed if the HCAC is present on admission or if the identification of the HCAC would not otherwise result in additional payments to the provider. The amount not paid to the facility is limited to the additional payments that would otherwise be paid for the treatment of and related to the HCAC.

For Medicaid, HCACs are defined as conditions identified by Medicare as Hospital Acquired Conditions (HACs) occurring in the inpatient hospital setting which includes any of the following diagnosis codes E870-E876.9.

PPC

Unlike HCACs, PPCs are not confined to conditions occurring in the inpatient hospital setting, but may occur in either the inpatient or outpatient setting. In this case, “outpatient” is not limited to hospital outpatient departments, but may include other outpatient settings, such as a clinic, Ambulatory Surgical Center (ASC), Federally Qualified Health Center, or physician’s office.

State Medicaid programs have significant flexibility to define conditions they consider to be PPCs, but at a minimum must identify any of the following three occurrences as a PPC:

- Wrong surgical or other invasive procedure performed on the patient;
- Surgical or other invasive procedure performed on the wrong body part; or
- Surgical or other invasive procedure performed on the wrong patient.

At this time AHCCCS will adopt the minimum list of procedures above as PPCs for purposes of implementing Section 2702 of the ACA. When a PPC occurs in either the inpatient or outpatient setting, payments for the services resulting in the PPC will not be made to either the facility in which the PPC occurred or to the professionals involved in performing the procedure that resulted in the PPC.

Reporting PPCs
Under the federal rule implementing Section 2702, providers must affirmatively report the occurrence of any PPC in a Medicaid member, regardless of whether the provider has submitted a claim for payment for the services that resulted in the PPC. Providers should report these occurrences through the use of the appropriate codes on the UB04 claim form in the case of a hospital or the CMS 1500 claim form for professionals.

AHCCCS will utilize the following modifiers to define conditions they consider to be PPCs:

PA: Surgery wrong body part
PB: Surgery wrong patient
PC: Wrong surgery on patient

Health Risk Assessment and Screening Tests

For adults (age 21 years old and older) AHCCCS covers health risk assessment and screening tests pursuant to A.A.C. R9-22-205 provided by a physician, primary care provider or other licensed practitioner within the scope of his/ her practice under State law for all members.

These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status.

For adults (age 21 years and older) well exams are not covered. Well exams are physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. Effective with date of service 10/1/2013 adult (age 21 years and older) well visits and well exam coverage will be re-instated.

Certain preventive services such as immunizations, PAP smears, colonoscopies, and mammograms are covered for adults (age 21 and older). (For adult immunizations, refer to AMPM Policy 310-M.)

Health risk assessment and screening tests are also covered for members (under age 21) through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program and KidsCare Program.

Preventive health risk assessment and screening tests services for non-hospitalized adults (age 21 and older) include, but are not limited to:

- Hypertension screening (annually)
- Cholesterol screening (once; additional tests based on history)
- Mammography (annually after age 40; recommended annually for younger females who are at high risk due to immediate family history)
- Cervical cytology (annually for a sexually active woman; after three successive normal exams the test may be less frequent)
- Colon cancer screening (digital rectal exam and stool blood test, annually after age 50 as well as baseline colonoscopy after age 50)
- Sexually transmitted disease screening (at least once during pregnancy; other, based on history)
- Tuberculosis screening (once; additional testing based on history or for AHCCCS members residing in a facility, as necessary per health care institution licensing requirements)
- Immunizations (refer to AMPM 310-M Immunizations for details)
- HIV-screening
- Prostate screening (annually after age 50; recommended annually for males 40 and older who are at high risk due to immediate family history)
- Physical examinations, periodic health examinations or assessments, diagnostic work ups or health protection packages designed to: provide early detection of disease; detect the presence of injury or disease; establish a treatment plan; evaluate the results or progress of treatment plan or the disease; or to establish the presence and characteristics of a physical disability which may be the result of disease or injury.

Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

Physical examinations performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

- Qualification for insurance
- Pre-employment physical examination
- Qualification for sports or physical exercise activities (does not apply to EPSDT members)
- Pilots examinations (FAA)
- Disability certification to establish any kind of periodic payments
- Evaluation for establishing third party liability
- In accordance with A.A.C. R9-22-205 preventive examination in the absence of any known disease or symptom for members 21 years of age or older

Prior Authorization requirements:

Prior Authorization for medically necessary health risk assessment and screening services is not required.

Hysterectomy Services

AHCCCS covers medically necessary hysterectomy services.

AHCCCS does not cover a hysterectomy service if it is performed solely to render the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical) which was proven unsatisfactory.

Hysterectomy services may be considered medically necessary without a trial of therapy in the following cases:

- Invasive carcinoma of the cervix
- Ovarian carcinoma
- Endometrial carcinoma

- Carcinoma of the fallopian tube
- Malignant gestational trophoblastic disease
- Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
- Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio

Hysterectomy services require prior authorization. In a life-threatening emergency, PA is not required, but the physician must certify in writing that an emergency existed.

All claims for hysterectomy services are subject to medical review.

A hysterectomy consent form (See AMPM Chapter 800 Exhibit 820-1), or a hospital consent form that contains the same information as the Exh. 820-1 hysterectomy consent form, must be submitted with the claims. The consent form must state that the patient will be permanently incapable of having children.

The consent form must be signed by the member, the physician who performs the hysterectomy, the person who obtains the member's consent and, if applicable, an interpreter.

Licensed Midwife Services

A licensed midwife is an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to ARS §36-751 and AAC Title 9, Chapter 16, Article 1.

This provider type does not include certified nurse midwives licensed by the Arizona Board of Nursing as nurse practitioners or physician assistants licensed by the Arizona Board of Medical Examiners.

Labor and delivery services provided by licensed midwives generally are provided in the member's home. Licensed midwife services cannot be provided to AHCCCS members in ahospital, free-standing birthing center, or other licensed health care institution.

Licensed midwives must obtain prior authorization from AHCCCS CMSU. Documentation certifying risk status of the member's pregnancy must be submitted prior to providing licensed midwife services.

Licensed midwife services may be provided only to pregnant AHCCCS members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated.

- The age of the member must be a consideration in the risk status evaluation.

- Risk status must be determined at the time of the first visit and each trimester thereafter.
- Members initially determined to have a high-risk pregnancy or members whose physical condition changes to high risk during the course of the pregnancy must immediately be referred to an AHCCCS-registered physician or practitioner.

Upon delivery of the newborn, the licensed midwife is responsible for conducting the newborn examination and for referring the mother and newborn to a physician for follow-up care of any assessed problematic conditions.

The licensed midwife also must notify the AHCCCS Administration's Newborn Reporting Line no later than three days after the birth in order to enroll the newborn with a health plan.

Licensed midwives must bill for delivery using CPT-4 code 59400 - Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care.

Reimbursement is the lesser of billed charges or the AHCCCS capped fee.

If complications arise during the pregnancy and the woman must be referred to a physician, the licensed midwife may bill for prenatal care only using CPT code 99212 - Office or other outpatient visit for the evaluation and management of an established patient. Each visit date should be billed on a separate line of the CMS 1500 claim form.

Naturopathic Physicians

Naturopathic physicians blend natural medicine with conventional diagnosis and treatment. They treat the cause of illness, work to prevent disease whenever possible and teach patients how to live healthy lives using tools including nutrition, lifestyle medicine, physical medicine and herbal therapies.
As of 3/1/2019, AHCCCS members under the Early Periodic Screening Diagnostic and Treatment (EPSDT) program may be treated by Licensed Naturopathic Physicians. This AHCCCS provider type is active and is designated as 17-Naturopath in the AHCCCS Provider Enrollment system.
In order to submit claims for AHCCCS Fee for Service Programs, an active AHCCCS provider registration is required. In order to submit claims for AHCCCS managed care organizations (MCOs), Naturopathic physicians will need to be credentialed and contracted with the MCO(s) in addition to having an active AHCCCS provider registration.
Naturopathic physicians will be paid at 100% of the physician fee schedule rate.
AHCCCS will pay retroactive claims and encounters for registered, eligible providers who provide medically necessary EPSDT services subject to timeliness rules.

Nutritionist Services

Nutritionists can bill for services covered under codes B4034-B9999, G0270, G0271, S9470, 97802-97804.

Nutritional evaluations are covered under the following circumstances:

- Hospice services
  Dietary services which include a nutritional evaluation and dietary counseling when necessary

- Total Parenteral Nutrition (TPN)
  AHCCCS follows Medicare guidelines for the provision of TPN services. TPN is covered for members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

  AHCCCS covers TPN for members receiving EPSDT and KidsCare members when medically necessary and not necessarily the sole source of nutrition. Refer to Chapter 400 of the AHCCCS Medical Policy Manual for complete information.

- Transplant Services
  Nutritional assessments - Refer to Chapter 310 of the AHCCCS Medical Policy Manual for complete information.

REMINDER: Diabetic Education services are NOT an AHCCCS covered service.

Obstetrical Services

Refer to AMPM Chapter 400 Medical Policy for Maternal and Child Health for federal and state regulatory requirements. AMPM Exhibit 410-3 pages 1-5 provides Initial Screening and Antepartum Risk Assessment Tools that can be used as a guide. AMPM Chapter 410-D1 states "Physicians and practitioners must follow the American College of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment."

The AHCCCS global obstetrical (OB) package includes ***all*** OB visits prior to the delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital for delivery.

Evaluation and management (E/M) codes for office and/or hospital visits may not be unbundled from the global OB code and billed separately. Claims for these services will be denied when billed in addition to the global OB code.

The global OB package includes:

1 visit/month for the first 28 weeks gestation	7 visits
Biweekly visits to 36 weeks gestation	4 visits
1 visit/week up to delivery date (39 weeks gestation)	3+ visits

All inpatient visits including admit and discharge from the hospital
All postpartum visits for 60 days following discharge from the hospital, including family planning

Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother.

Medical complications of pregnancy *may* require additional resources outside the global OB care package as outlined above and may be reported separately. The medical complication(s) must be present as supported by the medical documentation, including but not limited to, maternal medical history & physical, lab results and imaging reports.

The global OB package does not include:

- Consultation by a specialist other than OB/G when referred by the treating physician or practitioner;
- Consultation by an OB/G specialist physician not affiliated with the treating physician or practitioner;
- Other services as supported by medical necessity with documentation.

Providers *must* bill the global OB code if the member is seen five or more times prior to delivery.

Physicians, practitioners and certified nurse practitioners in midwifery (CNMs) may not bill the global OB package if the member has been seen for less than 5 visits prior to delivery.

If a CNM refers a member to a *non-affiliated* physician for on-going OB care, that physician may bill for the visits plus the delivery, unless the requirements for billing the global OB code are met.

The CNM who referred the member may bill for the visits that occurred prior to referring the patient to the *non-affiliated* physician for on-going OB care.

The CNM may not bill for the delivery or global OB code if the delivery is billed by another provider.

<u>Billing for other than total care</u>

- A provider may not bill the global OB code or codes for postpartum care if the delivery is the only service provided.

- A provider who performs a *delivery and subsequent postpartum care only* should consult the CPT code book for the appropriate CPT codes.

- A provider billing for *postpartum care only* should use CPT code 59430.

- A provider billing for *antepartum care only* should use CPT codes 59425 (4 - 6 visits and services) or 59426 (7 or more visits and services).
- For 1 - 3 antepartum care visits, a provider should use the appropriate E/M Codes.

Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother, including instances of multiple gestations.

The global code includes delivery services for one baby.

When billing delivery services for twin births, providers should bill only one global obstetric care code. Delivery of the second baby should be billed using the appropriate code for delivery only.

Obstetrical Services for Members with Hospital Presumptive Eligibility (HPE)

Members eligible under Hospital Presumptive Eligibility (HPE), when providers are billing for prenatal services, should bill the AHCCCS Administration for prenatal visits utilizing the appropriate E&M code performed during the HPE period.

Global obstetric billing for total OB care is only applicable for the plan in effect on the date of delivery and is only applied if global delivery guidelines are met (i.e. 5 or more visits performed while member is eligible under the plan). If guidelines are not met services should be billed as Fee-For-Service.

Opioid Use Disorder and Medication Assisted Treatment

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat Opioid Use Disorder (OUD). For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

For further information regarding MAT please refer to AMPM 510, Primary Care Providers.

Ordering Provider

Effective 1/1/2012 for FFS the following services require the submission of an ordering provider:

Laboratory
Radiology
Medical and Surgical Supplies
Respiratory DME
Enteral and Parenteral Therapy
Durable Medical Equipment
Drugs (J-Codes)
Temporary K and Q codes
Orthotics
Prosthetics
Vision codes (V-codes)
97001-97546

Ordering providers can only be one of the following provider types:

M.D.
D.O.
Optometrist
Physician Assistant
Registered Nurse Practitioner
Dentist
Podiatrist
Psychologist
Certified Nurse Midwife

Claims submitted without the ordering provider listed will be denied.

Pathology and Laboratory Services

Diagnostic testing and screening are covered services.

Pass-through billing by which the physician pays the laboratory for tests and then bills AHCCCS for the lab services is not allowed.

AHCCCS follows Medicare guidelines that specify which codes may be billed using the professional (26) and/or technical lab component (TC) modifiers.

When the procedure code for the test is for the technical component only or the professional component only, the procedure should be billed without a modifier.

Laboratory tests with automated results do not have a professional component, and claims for the professional component should not be billed for those laboratory services.

Laboratory services for hospitalized members must be included on the UB-04 inpatient claim. These services may not be unbundled and billed as -TC separately from the inpatient claim.

In accordance with Medicare guidelines, physicians may bill only a limited number of CPT codes for pathology services performed in a hospital setting.

- AHCCCS follows Medicare guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital.
- AHCCCS does not reimburse physicians for the technical portion of tests performed at hospitals or for any indirect costs, such as supervising the laboratory.
  - The hospital is reimbursed for the technical component of the test performed in its facility.
  - The hospital is also responsible for compensating employees that may be supervising the lab.

Pregnancy Terminations

AHCCCS does not cover abortion counseling and pregnancy terminations unless:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated, or
- The pregnancy is a result of rape or incest, or
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
  - Creating a serious physical or mental health problem for the pregnant member, or
  - Seriously impairing a bodily function of the pregnant member, or
  - Causing dysfunction of a bodily organ or part of the pregnant member, or
  - Exacerbating a health problem of the pregnant member, or
  - Preventing the pregnant member from obtaining treatment for a health problem.

All medically necessary abortions require prior authorization (PA) except in cases of medical emergency.

In the event of a medical emergency, all documentation of medical necessity must accompany the claim when submitted for reimbursement.

The request for PA must be accompanied by a completed *Certificate of Medical Necessity for Pregnancy Termination (See the AHCCCS Medical Policy Manual (AMPM), Exhibit 410-4).*

The AHCCCS Care Management Services Unit (CMSU) will review the request and the Certificate of Medical Necessity for Pregnancy Termination and may authorize the procedure if medically necessary.

Refer to the AHCCCS Medical Policy Manual (AMPM) Chapter 410 Section 8 for further criteria and additional required documentation

Radiology and Medical Imaging Services

Diagnostic testing, imaging and MRI are covered services.

Positron emission tomography (PET) scans are covered only at PET imaging centers with PET scanners that have been approved by the FDA.

No PA is required for medically necessary radiology and medical imaging services.

Radiology services provided to hospitalized members must be included on the UB-04 claim.

- These services may not be unbundled and billed separately from the inpatient claim.
- The professional services of a radiologist may be billed separately with a 26 modifier.

Occupational, Physical and Speech Therapies

AHCCCS covers physical, occupational, speech and respiratory therapy services that are ordered by a primary care provider (PCP), or attending physician for FFS members, including ALTCS members when approved by the ALTCS Case Managers, and provided by, or under the direct supervision of a licensed therapist. Refer to AMPM Chapter 300 Section 310-X and AMPM Chapter 1200 for additional information regarding ALTCS covered rehabilitation services. Refer to AMPM Chapter 820 for Prior Authorization requirements.

Outpatient rehabilitation therapy services are *NOT* covered for FESP members.

Occupational Therapy

Occupational Therapy (OT) services are medically ordered treatments to restore a skill or level of function and maintain that skill or level of function once restored, or to acquire a new skill or a new level of function and maintain that skill or level of function once acquired. OT is intended to improve the member's ability to perform those tasks required for independent functioning.

Occupational Therapists must be licensed by the Arizona Board of Occupational Therapy Examiners, or governing Board of the State where the therapist practices or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of Occupational Therapy Examiners.

Effective date of service 10/1/2017 and later, occupational therapy is covered for acute and ALTCS members 21 years of age and older in accordance with AMPM Policy 310-X. Benefit limits for acute care members are as follows:

A. 15 visits per contract year (October 1-September 30) to restore a particular skill or function the member previously had but lost due to injury or disease and maintain that function once restored; and
B. 15 visits per contract year (October 1-September 30) to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

Outpatient OT services are covered when medically necessary for EPSDT, KidsCare, and ALTCS members.

AHCCCS covers medically necessary OT services provided to all members in an inpatient or outpatient setting, when services are ordered by the member's PCP/attending physician as follows:

A. Inpatient OT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility).
B. Outpatient
    a. Outpatient OT services are covered for EPSDT and KidsCare members when medically necessary.
    b. Outpatient OT services are covered for acute care members, 21 years of age and older, in accordance with AMPM Policy 310-X.
    c. Outpatient OT services are covered for ALTCS members in accordance with AMPM Policy 310-X, as authorized by the ALTCS Case Manager.

Therapy services may include, but are not limited to:

- Cognitive training
- Exercise modalities
- Hand dexterity
- Hydrotherapy
- Joint protection
- Manual exercise
- Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
- Perceptual motor testing and training
- Reality orientation
- Restoration of activities of daily living
- Sensory reeducation, and

- Work simplification and/or energy conservation.

Outpatient settings include, but are not limited to: occupational therapy clinics, outpatient hospital units, FQHCS, home health settings and physician offices.

Occupational therapy maintenance, not associated with maintenance following restoration or acquisition of a newly acquired skill or level of function, is excluded.

Service limits will be applied to outpatient occupational therapy CPT codes 97001 – 97546 for AHCCCS enrolled members as follows:

- Services occurring on the same day with either the same or different providers will count as a single visit.
- Multiple services provided on the same day will be counted as a single visit.

An outpatient OT visit is defined as service(s):

- Identified by CPT codes 97001-97546,
- Received on one date of service,
- Billed on form types 1500 and UB-04,
- By any provider type except 14 – Physical Therapist, or 22 – Nursing Home; and
- Billed with any place of service except 31 – Nursing Home, 32 – Nursing facility, or 33 – Custodial facility.

Prior Authorization

No PA is required for covered outpatient occupational therapy services. Refer to AMPM Policy 310-X for limitations.

The PA for inpatient occupational therapy services is included in the PA for facility services.

For Tribal ALTCS members that receive therapies in an outpatient, skilled nursing or inpatient setting, please contact the tribal case manager for PA requirements.

Physical Therapy

Physical therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.

Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices. A Physical Therapy Assistant (under the supervision of the PT according to A.A.C. 24, Article 3) must be certified by the Arizona Physical Therapy Board of Examiners. Out of state physical therapists providing services to AHCCCS members outside the State of Arizona must meet applicable State and/or Federal requirements.

AHCCCS covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's PCP/attending physician as follows:

1. Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility).
2. Outpatient
    a. Outpatient PT services are covered for EPSDT and KidsCare members when medically necessary.
    b. Outpatient PT services are covered for acute care members, 21 years of age and older, in accordance with AMPM Policy 310-X.
    c. Outpatient PT services are covered for ALTCS members in accordance with AMPM Policy 301-X as authorized by the ALTCS Case Manager.

Outpatient settings include, but are not limited to: physical therapy clinics, outpatient hospital units, FQHCS, home health settings and physician offices.

Physical therapy prescribed only as a maintenance regimen is excluded.

An outpatient PT visit is defined as service(s):

- Identified by CPT codes 97001-97546,
- Received on one date of service,
- Billed on form types 1500 and UB-04,
- By any provider type except 13 – Occupational Therapist, or 22 – Nursing Home; and
- Billed with any place of service except 31 – Nursing Home, 32 – Nursing facility, or 33 – Custodial facility.

Benefit limits apply to outpatient physical therapy CPT codes 97001 – 97546 for acute and ALTCS members 21 years of age and older as follows:

- Services occurring on the same day with either the same or different providers will count as a single visit.

- Multiple services provided on the same day will be counted as a single visit.

For ALTCS PT limits please refer to Chapter 21.

Service limits prior to service date 01/01/2014

In accordance with Arizona Administrative Code A.A.C. R9-22-215, outpatient PT services are covered for adult members, 21 years of age and older (ACUTE and ALTCS), as follows:

A. AHCCCS members who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the member changes Contractors. (Contract year is defined as October 1-September 30.)

B. For AHCCCS members, who are also Medicare members, refer to AMPM Chapter 300, Exhibit 300-3A regarding Medicare cost sharing and the outpatient physical therapy limit.

Dual Eligible refers to a member with income above 100% FPL who is Medicare and AHCCCS eligible (also known as Medicare Primary, non-QMB dual). The member does not qualify for the Federal QMB program. The health plan is responsible for the Medicare cost sharing amount (Medicare's deductible, copay and coinsurance) up to 15 PT visits.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will pay the Medicare cost sharing up to the 15 visit limit per contract year.
As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; however the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the member's responsibility.

Should the member exhaust their Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the health plan.

QMB Dual refers to a member with income not exceeding 100% FPL who qualifies for Medicare under the Federal QMB program and is enrolled in Medicaid. The health plan is responsible for the Medicare cost sharing amount (Medicare deductible and coinsurance) up to the Medicare maximum dollar amount.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

Should the member exhaust their Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the health plan.

Effective service date 1/1/2014 and later, service limits for medically necessary outpatient physical therapy for adults (age 21 years and older) are as follows:

A. 15 visits per contract year (October 1-September 30) to restore a particular skill or function the member previously had but lost due to injury or disease and maintain that function once restored; and
B. 15 visits per contract year (October 1-September 30) to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

Refer to AMPM Exhibit 300-3A for more detail regarding Medicaid only members, QMB Dual and Medicare Primary (non-QMB Dual).

Covered physical therapy treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment,

2. The administration, evaluation and modification of treatment methodologies and instruction, and

3. The provision of instruction or education, consultation and other advisory services.

Prior Authorization

No PA is required for covered outpatient physical therapy services. Refer to AMPM Policy 310-X for limitations.

The PA for inpatient physical therapy services is included in the PA for facility services.

For Tribal ALTCS members that receive therapies in an outpatient, skilled nursing or inpatient setting, please contact the tribal case manager for PA requirements.

Speech Therapy

Speech therapy is the medically ordered provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

A qualified Speech-Language Pathologist (SLP) must be licensed by the Arizona Department of Health Services (ADHS) or a Speech-Language Pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be

under the direct supervision of an ASHA certified Speech-Language Pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed.

A qualified Speech-Language Pathology Assistant (SLPA) must be licensed by the Arizona Department of Health Services (ADHS). The SLPA must be identified as the servicing provider and bill for services under his/her individual NPI number. (A group ID number can be utilized to direct payment). SPLA's may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members.

Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

Speech therapy by qualified professionals may include the services listed below:

Articulation training	Language treatment
Auditory training	Lip reading
Non-oral language training	Cognitive training
Oral-motor development	Esophageal speech training
Swallowing training	Fluency training

Prior Authorization

The PA for inpatient speech therapy services is included in the PA for facility services.

For Tribal ALTCS members that receive therapies in a skilled nursing or inpatient setting, please contact the tribal case manager for PA requirements.

Respiratory Therapy

Respiratory therapy is an AHCCCS covered treatment service, ordered by a primary care provider for members or attending physician for Fee-For-Service (FFS) members, to restore, maintain or improve respiratory functioning.

Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures, observing and monitoring signs and symptoms, general behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response exhibits abnormal characteristics; and implementing appropriate reporting referral, and respiratory care protocols or changes in treatment based on observed abnormalities and pursuant to a prescription by a physician.

AHCCCS covers medically necessary respiratory therapy services for all members on both an inpatient and outpatient basis.

Respiratory therapists must bill with code S5180-Home health respiratory therapy, initial evaluation.

Physicians and hospitals may use CPT codes 94010 - 94799.

Refer to AMPM Chapter 310-T for further information.

Rehabilitative Services Documentation Requirements

The following written documentation must be in the member's medical records and available upon request for audit:

- Nature, date, extent of injury/illness and initial therapy evaluation,
- Treatment plan, including specific services/modalities of each therapy, and
- Expected duration and outcome of each therapy provided.

Outpatient rehabilitation services are *NOT* covered for FES members.

Residents, Interns, Students, Teaching Physicians and Dentists

A hospital may not submit a claim for professional services rendered unsupervised by a resident or intern using the hospital's provider ID, the attending/teaching physician's provider ID, or the chief of staff's provider ID number.

Patient services rendered by the attending/teaching physician solely in the capacity of teaching are excluded from reimbursement.

The attending/teaching physician may submit a claim for professional services if:

1. The attending/teaching physician is present for a key portion of the time the service being billed was performed.

   For deliveries, the attending/teaching physician must be present for the requisite number of prenatal visits and the delivery in order to bill the global OB code.

   If the attending/teaching physician is present only for the delivery, he/she must bill the "delivery only" code. (See obstetrical services, this chapter)

2. For surgery or dangerous/complex procedures, the attending/teaching physician is present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

   If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

3. For inpatient and outpatient evaluation and management (E/M) services, the attending/teaching physician is present during the key portion of the visit and participates in the management of the patient.

Documentation substantiating the above criteria must be available for audit purposes.
All claims are subject to post-payment review and recovery per A.R.S. §36-2903.01 L.

Hospital Outpatient department setting or other ambulatory entity

Consistent with Medicare, AHCCCS permits an exception to the direct supervision rule for certain primary care residency programs. The exception rule allows specific low level E&M codes to be billed by the teaching physician for services rendered by the residents without the presence of the teaching physician. The permitted codes are limited to:

New Member	Established Member
99201	99211
99202	99212
99203	99213

Additionally, AHCCCS allows for the reimbursement of Preventative Medicine CPT codes for members under 21 years of age.

All codes under the exception for E/M services should be used with the “GE” modifier to designate the claim as a teaching physician billing exception claim.

For the above primary care exceptions to apply, the residency program must attest in writing that the following conditions are met:

1. Services must be furnished in a primary care center located in the outpatient department of a hospital or other ambulatory entity, in which the time spent by residents in patient care activities is included in determining GME payments to a teaching hospital.
2. Residents furnishing services, without the physical presence of a teaching physician, must have completed at least six months (post graduate) of a Graduate Medical Education (GME) approved residency program.

3. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.
4. The members seen must consider the center to be their primary location for health care services. . The residents must generally follow the same group of members throughout the course of their residency program.
5. The range of services furnished by the residents includes all of the following: acute and chronic care, care coordination, and comprehensive care not limited by organ system or diagnosis.
6. The types of residency programs most likely to quality for the primary care exception rule include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology. Certain GME programs in psychiatry may also qualify, in special situations, such as when the residency program furnishes comprehensive care for chronically mentally ill patients.

Note: This is an abbreviated summary. Refer to Medicare Part B News, Issue #192 October 22, 2001, "Supervising Physicians in Teaching Settings" for complete details.

Teaching physicians are instructed to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective 11/22/2002, which describes clarification to "Supervising Physicians in Teaching Settings – Documentation."

Nursing Facility Setting

AHCCCS permits the billing of the following low level E&M nursing facility CPT codes by the teaching physician for services rendered by the residents <u>without</u> the presence of the teaching physician:

New Member	Established Member
99301	99311

All codes should be used with the "GE" modifier to designate the claim as a teaching physician billing exception claim.

For the nursing facility exception to apply, the residency program must attest <u>in writing</u> that the following conditions are met:

1. Services must be furnished in a nursing facility.
2. Residents furnishing service without the presence of a teaching physician must have completed more than twelve months (post graduate) of an approved residency program.
3. The teaching physician in whose name payment is sought may not supervise more than four residents at any given time and must be immediate available via telephone.

4. The members seen must be an identifiable group of individuals who consider the setting and residency program to be the continuing course of their health care. The residents must generally follow the same group of members through the course of their residency program.
5. The range of services furnished by the residents includes all of the following: acute and chronic care, care coordination, and comprehensive care not limited by organ system or diagnosis.
6. The types of residency programs most likely to quality for the primary care exception rule include: family practice, general internal medicine, geriatric medicine, pediatrics and obstetrics/gynecology.

Teaching physicians are instructed to follow the documentation guidelines as outlined by Noridian, the Medicare intermediary in Arizona, in Transmittal 1780, CR 2290, effective 11/22/2002, which describes clarification to "Supervising Physicians in Teaching Settings – Documentation."

Dental Students/Dental Residents

AHCCCS permits billing for dental services provided by dental students or dental residents when the following conditions are met:

1. Services must be furnished at the dental school clinic or other dental treatment facility identified by the dental school and permitted by the Dental Practice Act.
2. All dental services must be provided under the direct supervision of a teaching dentist certified as either faculty or adjunct faculty by the dental school.
3. The teaching dentist must be an AHCCCS registered provider in order to bill for services.
4. All treatment notes written by the dental students or residents must be counter-signed by a teaching dentist.

Supplies, Materials, Injectable Drugs

AHCCCS does not reimburse providers on a fee-for-service basis for services billed using procedure code 99070 (Supplies and materials, except spectacles, provided by the physician over and above those usually included with the office visit or other services rendered).

Providers must bill the J Codes for injectable drugs and HCPCS codes for durable medical equipment and supplies.

Surgeon billing

Multiple Surgical Procedures

Multiple surgical procedures performed on the same member on the same day must be billed using modifier 51. Typically these are done during the *same session.*

Providers should list the principal procedure on the first line of the CMS 1500 claim form and list the secondary surgeries on subsequent lines with modifier 51.

- The principal procedure is reimbursed at 100 percent of the capped fee or billed charges, whichever is less.
- Each secondary surgical procedure is reimbursed at 50 percent of the capped fee or billed charges, whichever is less.

If a claim is received without modifiers to indicate secondary procedures, the AHCCCS system identifies the first procedure on the claim as the principal procedure and prices it accordingly.

For information on the use of modifier 51 and anesthesia, please see the section on Anesthesia and Modifier 51 in this chapter. All other surgical procedure are identified as secondary and priced at 50 percent of the capped fee or billed charges, whichever is less.

Claims with more than four secondary surgical procedures are subject to medical review.

Certain modifiers indicate less than comprehensive surgical care.

54 Surgical care only
55 Post-operative management
56 Pre-operative management

Bilateral procedures performed during the same session are identified by using modifier 50 with the CPT code for the second (bilateral) procedure.

When a procedure is repeated, use of the appropriate modifier reduces the likelihood that the claim will be denied as a duplicate:

76 Repeat procedure or service by same physician
77 Repeat procedure or service by another physician
78 Indicates an unplanned return to the operating/procedure room by the same physician following the initial procedure for a related procedure during the postoperative period

Multiple Surgeons/Assistants

If multiple surgeons participate in a surgery, the appropriate modifier is necessary to ensure proper payment of claims.

80 Assistant Surgeon
81 Minimum Assistant Surgeon
82 Assistant Surgeon (when qualified resident surgeon not available)
62 Two Surgeons

66 Surgical Team
AS PA, NP, or CNS served as the assistant at surgery

If multiple providers bill for the same procedure without modifiers, all but the first claim received will be denied as duplicates.

Assistant surgeon services shall be identified by adding modifier 80 to the procedure.

Minimum assistant surgeon services shall be identified by adding modifier 81 to the procedure, and it is only submitted with surgical codes.

Assistant surgeon services, when a qualified resident surgeon is not available, shall be identified by adding modifier 82 to the procedure. Documentation must include information relating to the unavailability of a qualified resident in this situation. Only teaching hospitals may submit this modifier.

Use the modifier "AS" for assistant at surgery services, when services are provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS). The provider must accept assignment. If modifier AS is used, modifiers 80, 81, or 82 must also be submitted with it. Submitting modifiers 80, 81 or 82 without modifier AS indicates that a physician served as the surgical assistant.

A Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO) should not submit the "AS" modifier. This modifier is only valid for use by non-physician practitioners (NPP) when billing under their own provider number.

Assistant surgeons must bill with modifier 80. Non-physician practitioners providing surgical assist services should bill with modifier AS.

AHCCCS accepts modifiers:
22 – Increased procedural services; or
52 - Reduced services.
These modifiers do not impact reimbursement.

Fee Schedule for Physician Services - Assistant at Surgery

- Indicators for services where an assistant at surgery is allowed:
  0 = Payment restrictions for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 = Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at Surgery may not be paid.
2 = Payment restrictions for assistants at surgery does not apply to this procedure. Assistant at Surgery may be paid.

When billing multiple surgical procedures, the secondary procedures should be billed with the appropriate surgical assist modifier (80 or AS) and modifier 51.

When assistant surgeons are billing for Cesarean delivery assist, they must bill the code for delivery only with the appropriate assist modifier.

Telemedicine

AHCCCS covers medically necessary services provided via telemedicine.

Service delivery via telemedicine can be in one of two modes:

- *Real time* means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and the spoke site.
  - Hub site means the location of the telemedicine consulting provider, which is considered the place of service.
  - Spoke site means the location where the member is receiving the telemedicine service.

    Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication.
- *Store-and-forward* means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

The following medical services are covered, both real time and store-and-forward:

Cardiology	Oncology/radiation
Dermatology	Ophthalmology
Endocrinology	Orthopedics
Hematology/Oncology	Pain clinic
Home Health	Pathology & Radiology
Infectious Diseases	Pediatrics and Pediatric Subspecialties
Neurology	Rheumatology

Obstetrics/Gynecology Surgery Follow-Up and Consultations

Non-emergency transportation to and from the spoke site to receive a medically necessary consultation or treatment is covered for Title XIX members only.

Behavioral health telemedicine services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) members.

Covered behavioral health services include (real time only):

- Diagnostic consultation and evaluation
- Psychotropic medication adjustment and monitoring
- Individual and family counseling
- Case management

For real time behavioral health services, the member's physician, case manager, behavioral health professional, or tele-presenter may be present with the member during the consultation.

Telemedicine Conditions and Limitations:

At the time of service delivery via real time telemedicine, the member's PCP, attending physician, or other medical professional employed by the PCP or attending physician who is familiar with the member's condition may be present with the member (telepresenter).

Other medical professionals include registered nurses; licensed practical nurses; clinical nurse specialists; registered nurse midwives; registered nurse practitioners; physician assistants; physical, occupational, speech, and respiratory therapists; or a trained tele-presenter familiar with the member's medical condition.

All services provided via telemedicine must be reasonable, cost effective and medically necessary for the diagnosis or treatment of a member's medical or behavioral health condition.

Services must be billed on a CMS 1500 claim form using the "GT" modifier to designate the service being billed as a telemedicine service.

Services are billed by the consulting provider. Telepresenter services are not billable.

Unlisted or Unspecified Services

Procedure codes for unspecified or unlisted procedures (identified by CPT codes ending in "99") should only be billed in situations where no other code adequately describes the service performed.

Providers who bill procedure codes for unspecified or unlisted procedures must describe the service rendered and identify the service in the procedure or operative report.

Claims with such procedure codes are subject to Medical Review.

Ventilator Management

Providers should not bill AHCCCS for any E/M service when submitting claims for global ventilator management services.

CPT Codes 94002 (Ventilation assist and management, first day); 94003 (Ventilation assist and management, subsequent days) and 94004 (Ventilation assist and management, nursing facility, per day) are global procedure codes.

Claims with an E/M code in addition to a ventilator management code are subject to denial during Medical Review.

Vision

AHCCCS covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Routine and medically necessary vision services, including examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening Diagnosis and Treatment Program and the KidsCare Program. Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service. Refer to AMPM 430, EPSDT Services, and the EPSDT Periodicity Schedule found in AMPM Exhibit 430-1 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

For members who are 21 years of age or older, examination and treatment of medical conditions of the eye are covered.

Routine eye examinations for prescriptive lenses and the provision of prescriptive lenses are **not** covered for adults. The provision of prescriptive lenses is considered medically necessary for adults **only** when used as the sole prosthetic device following cataract surgery. Refer to AMPM 310-G, Eye Examination/Optometry Services, for detailed information regarding coverage of eye exams and prescriptive lenses for adults.

REVISION HISTORY

Date	Description of Change(s)	Page(s)
4/12/2019	Naturopathic Physician section added.	22-23

11/1/2018	The following information was added to the Teaching Physicians section: "If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed."	35
4/5/2018	Peripheral Nerve Blocks for Postoperative Pain Management on the Date of Surgery subsection added	6
2/09/2018	Social Determinants of Health added	3-4
1/05/2018	Vision Updates	41-42
12/29/2017	Family Planning Updates Obstetrical Services for Members with Hospital Presumptive Eligibility (HPE) Section Added Medication Assisted Treatment for Opioid Use Disorder (OUD) Section Added Surgeon Billing Updates (Including Modifiers 50, 51, 80, 81, 82 and AS)	11-13 24 25 2; 36-38
10/01/2017	Dental Podiatry Occupational Therapy Formatting Updates	6-8 13-17 25-27 All
10/05/2016	Updated section Pregnancy Terminations to conform to AMPM language Anesthesia modifier AD updated Added reference for ALTCS Dental Restoration Updated section Foot and Ankle Care Correction to section Physical Therapy service limits to conform to AMPM Removed PA section for Rehabilitation Therapies Updated section Telemedicine Conditions and Limitations	4 6 7 16 29-31 32 39
03/30/2016	Updated NCCI associated modifier section with link to CMS for quarterly list updates	3
12/21/2015	Correction to Telemedicine . Conditions and limitations: Remove "must" and replaced with "may" to read "…may be present with the member." to conform to AMPM language	39
12/21/2015	Add Revision History to chapter	40

CHAPTER 10 ADDENDUM ~ FQHC/RHC

Chapter 10 Addendum ~ FQHC/RHC

UPDATE: 5/23/2018; 4/13/2018; 03/01/2017; 10/15/2015; 4/1/2015

Background

Effective for dates of service on and after 04/01/2015 AHCCCS pays the all-inclusive per visit PPS rate on a per claim basis for providers registered as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), replacing the previous method of reimbursing claims reported under individual FQHC/RHC employed practitioners by the capped fee-for-service fee schedule and annually reconciling to the PPS rate. The method for calculating the all-inclusive per visit PPS rates will not change.

AHCCCS will continue to perform annual reimbursement reconciliations. Additionally, AHCCCS anticipates that quarterly supplemental payments will continue, though in amounts appropriate to the expectation that the MCOs will, in most cases, be paying the PPS rate. MCOs may continue to establish sub-capitated reimbursement arrangements.

A provider designated by CMS as an FQHC or FQHC Look-Alike (FQHC-LA) will be registered by AHCCCS with an AHCCCS provider type of C2 (FQHC). A provider designated by CMS as an RHC will be registered by AHCCCS with an AHCCCS provider type of 29 (RHC). To be eligible for the PPS per visit rate claims must be reported under the FQHC or RHC.

Definitions

“FQHC/RHC visit” means: A face-to-face encounter with a licensed AHCCCS registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service. Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

Services “incident to” a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician’s or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services

(Examples: x-ray; medication; laboratory test).

Behavioral Health

- **Case Management**
  - Effective with dates of service on and after 10/01/2015, AHCCCS will not recognize case management as a PPS-eligible service. To the extent that case management services are reimbursable, they will be reimbursed according to the Capped FFS Fee Schedule.
- **Group Therapy**
  - Group therapy does not qualify as an FQHC service, since it is not a face-to-face encounter. For a visit to qualify as a face-to-face encounter the visit must be one-on-one, disqualifying group therapy from being a PPS-eligible service.

Billing Guidelines

Please note: FQHC pharmacy billing will remain under the pharmacy provider type and is not impacted by this change.

For dates of service on and after 04/01/ 2015, in order to qualify for PPS reimbursement all FQHC, FQHC-LA, and RHC providers must utilize the appropriate NPI for the FQHC or RHC as the rendering provider for the claim (Note: PPS reimbursement will only apply to the FQHC or RHC provider). For electronic billing applicable reporting standards apply (Billing Provider Loop – Required, sent for every transaction and Rendering Provider Loop – Situational, sent if the rendering provider is different than the billing provider).

PPS visits must be billed on a Form 1500, 837P professional format, ADA Form or 837D dental format as appropriate to the type of PPS eligible visit and utilize appropriate place of service coding. Place of service codes for inpatient settings are not appropriate for FQHC/RHC billing.

For purposes of reimbursing PPS eligible visits, AHCCCS has adopted the T1015 (Clinic visit/encounter, all-inclusive) procedure code for FQHC physical, behavioral health and dental visits. This procedure code should be reported on all claims to designate an FQHC/RHC visit and receive PPS reimbursement.

Billed charges associated with the T1015 procedure code should reflect the appropriate PPS rate for the FQHC/RHC to ensure full PPS reimbursement. If something less than the PPS rate is used to report billed charges for the T1015 visit code, the AHCCCS “lesser of” reimbursement policy will prevail and cause the claim to be paid a rate less than the PPS rate.

A visit is identified by, and reimbursement for the visit is associated with, the T1015 code; all other covered services reported on the claim are bundled into the visit and valued at $0.00 for reimbursement purposes.

In addition to the T1015 PPS visit code, claims must continue to include all appropriate covered procedure codes (including appropriate E&M codes) describing the services rendered as part of the visit. If no covered procedure codes are reported in conjunction with the T1015 visit code or if there is no T1015 visit code reported, no PPS reimbursement will apply.

For dates of service on and after 04/01/ 2015, traditionally global services such as deliveries and/or surgery pre- and post-op days will no longer be treated as packages; however, they will be eligible for PPS visit reimbursement and, therefore, will require split billing.

Services which do not accompany a visit but are “incident to” that visit based upon the definition (lab, radiology, immunizations or other testing) are not separately reimbursed.

Multiple visits on the same day within the same discipline which are distinct based upon the FQHC/RHC visit definition above must be identified by billing the T1015 visit code for the same-day subsequent visit with a modifier 25 to indicate a distinct and separate visit.

In order to retain information related to the actual professional practitioner (provider) participating in/performing services associated with PPS visits, that professional practitioner (provider) participating in/performing services must also be reported on all claims as outlined below.

Behavioral Health Technician (BHT)

Behavioral Health Technician (BHT) services, excluding case management, may qualify as an FQHC/RHC visit when those services qualify as services incident to the services of an FQHC/RHC practitioner consistent with 42 CFR 405.2462.

Telehealth and Telemedicine

Telehealth and telemedicine may qualify as an FQHC/RHC visit if it meets the requirements specified in AMPM 320-I, Telehealth and Telemedicine.

Instructions for Billing Participating/Performing Professional Practitioner:

CMS Form 1500 (Paper/Web Claim): Field 19 - Additional Claim Information

Format Examples:

One Participating/Performing Provider – XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first, 20 characters) Example – XX1987654321Smitherhouse, Michelle

Two Participating/Performing Providers –
XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
3 blanks XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle XX2123456789Fredricksburg, Cynthia

ADA Form (Paper/Web Claim): Field 35. Remarks

Format Examples:

One Participating/Performing Provider - XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
Example –
XX1987654321Smitherhouse, Michelle

Two Participating/Performing Providers –
XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)
3 blanks XXNPIProviderName (NPI if a registerable Provider) or
9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)

Example –
XX1987654321Smitherhouse, Michelle XX2123456789Fredricksburg, Cynthia

837 Professional (Electronic Claim): 2300 NTE

Format Examples:

One Participating/Performing Provider – XXNPI ProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)

Two Participating/Performing Providers – XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters) 3 blanks XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters)

Loop	Element	Description 837-P 5010 A1 ENC	ID	Min. Max.	Use	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)
2300	NTE	CLAIM NOTE		1	S		

2300	NTE01	Note Reference Code	ID	3-3	R	ADD=Additional Information CER=Certification Narrative DCP=Goals, Rehabilitation Potential, or Discharge Plans DGN=Diagnosis Description TPO=Third Party Organization Notes	Expect 'ADD' – Additional Information
2300	NTE02	Claim Note Text	AN	1-80	R	Expect Claim Note Text	One Participating Provider XXNPIProviderName or 9999999999ProviderName Two Participating Providers or Performing ProvidersXXNPIProviderName or 9999999999ProviderName 3 blanks XXNPIProviderName or 9999999999ProviderNameMITHERHOUSE, MICHELLE XX2123456789FREDRICKBURG, CYNTHIA

<u>837 Dental (Electronic Claim): 2300 NTE</u>

Format Examples:

One Participating/Performing Provider – XXNPI ProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first 20 characters)

Two Participating/Performing Providers – XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters) 3 blanks XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider)(last, first 20 characters)

Loop	Element	Description 837-D 5010 A2 ENC	ID	Min. Max.	Use	Note	AHCCCS Usage/Expected Value (Codes/Notes/Comments)

2300	NTE	CLAIM NOTE		1	S		
2300	NTE01	Note Reference Code	ID	3-3	R	ADD=Additional Information CER=Certification Narrative DCP=Goals, Rehabilitation Potential, or Discharge Plans DGN=Diagnosis Description TPO=Third Party Organization Notes	Expect 'ADD' – Additional Information
2300	NTE02	Claim Note Text	AN	1-80	R	Expect Claim Note Text	One Participating Provider XXNPIProviderName or 9999999999ProviderName Two Participating Providers or Performing Providers XXNPIProviderName or 9999999999ProviderName 3 blanks XXNPIProviderName or 9999999999ProviderName

- Do not enter a space, hyphen, slash or other separator between the qualifier code and the NPI number or between the NPI and the Provider Name.
- When reporting a second item of data, enter three blank spaces and then the next qualifier and number/code/Provider Name.
- XX is the actual Qualifier Code designated by the standards body to indicate an NPI.
- At this time reporting of Participating Providers beyond 2 occurrences is not supported as defined in the standards for these transactions. If Participating Providers beyond 2 occurrences exist for a single claim, only the first two occurrences should be reported.

Billing Examples

Examples 1500:

Example Claim #1 – (based on actual services to a member on the same day) (may be billed on multiple claim forms or a single claim form)

PROC: 99202	PROC: T1015	PROC: 84005
MOD:	MOD:	MOD: 26
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
BILLED CHRGE: 114.00	BILLED CHRGE: 160.00	BILLED CHARGE: 24.00
PAY: 0.00	PAY: PPS Rate *(or Billed Charge if less)*	PAY: 0.00

Example Claims #2 and #3 – (based on actual services for the same member over a period of time) (each claim example may be billed on multiple claim forms or a single claim form)

BEGIN/END DATES OF SERVICE – 5/1/2015

PROC: T1015	PROC: 99213	PROC: 84005
MOD:	MOD:	MOD: 26
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
BILLED CHRGE: 160.00	BILLED CHRGE: 90.00	BILLED CHARGE: 90.00
PAY: PPS Rate *(or* ***Billed Charge if less)***	PAY: 0.00	PAY: 0.00

BEGIN/END DATES OF SERVICE – 6/10/2015

PROC: T1015	PROC: 99213	PROC: 74000
MOD:	MOD:	MOD: 26
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
BILLED CHRGE: 160.00	BILLED CHRGE: 90.00	BILLED CHARGE: 90.00
PAY: PPS Rate *(or Billed Charge if less)*	PAY: 0.00	PAY: 0.00

Example Claim #4 – (No T1015 billed)

PROC: 99213	PROC: 74000
MOD:	MOD:
UNITS: 1.000	UNITS: 1.000
BILLED CHRGE: 114.00	BILLED CHARGE: 124.00
PAY: 0.00	PAY: 0.00

Examples ADA:

Example Claim #1 – (based on actual services to a member on the same day) (may be billed on multiple claim forms or a single claim form)

PROC: D7111	PROC: T1015	PROC: D0220
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
TOOTH NUMBER: J	TOOTH NUMBER:	TOOTH NUMBER: J
SURFACE:	SURFACE:	SURFACE:
ORAL CAVITY:	ORAL CAVITY:	ORAL CAVITY:
BILLED CHRGE: 114.00	BILLED CHRGE: 160.00	BILLED CHARGE: 24.00
PAY: 0.00	PAY: PPS Rate *(or Billed Charge if less)*	PAY: 0.00

Example Claims #2 and #3 – (based on actual services for the same member over a period of time) (each claim example may be billed on multiple claim forms or a single claim form)

BEGIN/END DATES OF SERVICE – 5/1/2015

PROC: T1015	PROC: D2392	PROC: D0220
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
TOOTH NUMBER:	TOOTH NUMBER: 28	TOOTH NUMBER: 29
SURFACE:	SURFACE: O D	SURFACE: O D
ORAL CAVITY:	ORAL CAVITY:	ORAL CAVITY:
BILLED CHRGE: 160.00	BILLED CHRGE: 90.00	BILLED CHARGE: 90.00
PAY: PPS Rate *(or Billed Charge if less)*	PAY: 0.00	PAY: 0.00

BEGIN/END DATES OF SERVICE – 6/10/2015

PROC: T1015	PROC: D2392	PROC: D0220
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
TOOTH NUMBER:	TOOTH NUMBER: 28	TOOTH NUMBER: 29
SURFACE:	SURFACE: O D	SURFACE: O D
ORAL CAVITY:	ORAL CAVITY:	ORAL CAVITY:
BILLED CHRGE: 160.00	BILLED CHRGE: 90.00	BILLED CHARGE: 90.00
PAY: PPS Rate *(or Billed Charge if less)*	PAY: 0.00	PAY: 0.00

BEGIN/END DATES OF SERVICE – 6/10/2015

PROC: D2392	PROC: D0220
UNITS: 1.000	UNITS: 1.000
TOOTH NUMBER: 28	TOOTH NUMBER: 29
SURFACE: O D	SURFACE: O D
ORAL CAVITY:	ORAL CAVITY:

BILLED CHRGE: 90.00	BILLED CHARGE: 90.00
PAY: 0.00	PAY: 0.00

For additional examples related to areas including EPSDT visits; multiple visits on the same date of service; global billing situations; Medicare and OTI primary, please refer to the FQHC/RHC page on the AHCCCS website at the following link: https://www.azahcccs.gov/PlansProviders/Downloads/FFSrates/FQHC/FQHC-RHCAdditionalBillingExamples.pdf

FFS Billing Instructions with a Primary Payer

When Medicare is primary payer
Crossover claims are received electronically from the Medicare plan with Medicare's specified coding, which will not match to AHCCCS coding requirements.

The FQHC/RHC provider must first void the crossover claim and then submit on a 1500 claim form with the AHCCCS specified coding and include a copy of the EOMB.

On the 1500 claim form Medicare's deductible/coinsurance/copay total amounts *must* be reported on the T1015 claim line for reimbursement in the correct Medicare fields. The appropriate EM codes must be billed on successive lines with 0.00 billed amount, while leaving the Medicare fields blank (do *not* enter 0's).

If the Medicare claim did not crossover, the FQHC/RHC must submit the claim with the EOMB, even though the codes billed will not match the EOMB. The Medicare deductible/coinsurance/copay total amounts *must* be reported on the T1015 service line, in the correct Medicare fields, for reimbursement. The appropriate EM codes must be billed on successive lines with 0.00 billed amounts, leaving the Medicare deductible/coinsurance /copay fields blank (do *not* enter 0's).

When other coverage paid as primary
The FQHC/RHC must submit the claim with the total amount paid by the other primary payer entered on the T1015 service line only (in the correct OT fields).

The appropriate EM codes must be billed on successive lines with 0.00 billed amount, leaving the other payer fields blank (do *not* enter 0's). A copy of the primary payer's EOB must be included with the claim. Since AHCCCS specifies the T1015 coding, the billing and the EOB coding will not match.

References
For information on billing with a 638 FQHC please refer to Chapter 20, 638 FQHC, of the IHS/Tribal Provider Billing Manual.

Revision/Update History

Date	Description of changes	Page(s)
5/23/2018	BHT services section added Telehealth/telemedicine services sections added References section added	3 3 10
4/13/2018	Group therapy statement added under Behavioral Health section	2
03/01/2017	Updated Definition to indicated "registered" AHCCCS practitioner Added Behavioral Health Case Management language effective 10/01/2015 Updated Place of Service language Updated directions for covered non-registerable Providers Corrected website link Minor formatting corrections	1 2 2 3 – 6 9 Various
10/15/2015	Correction: Paper/Web Claims For clarification, added new section "FFS Billing Instructions with a Primary Payer"	3 8,9
04/01/2015 Effective	FQHC/RHC Addendum	All

CHAPTER 11 ~ HOSPITAL SERVICES

Chapter 11 ~ Hospital Services

REVISION DATES: 3/25/2019; 2/28/2019; 1/23/2018; 10/01/2015 (EFFECTIVE 10/01/2015), 03/03/2015, 09/17/2014

General Information

The covered services, limitations, and exclusions described in this chapter are global in Nature and are listed here to offer general guidance to acute care hospitals. The *AHCCCS Medical Policy Manual (AMPM)* is available on the AHCCCS website at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/.

Effective 10/1/2014 AHCCCS will determine Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals, and out-of-state hospitals, using a Diagnosis Related Group (DRG) payment methodology. DRG pricing and pricing logic will be based on the date of discharge.

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology.

DRG payment will be applied to all inpatient claims from acute care hospitals except the following:

- Claims from a free-standing rehabilitation facility
- Claims from a free-standing long term acute care facility
- Claims from a free-standing psychiatric facility
- Claims from an Indian Health Service facility or tribally operated 638 facility
- Claims for Tribal Regional Behavioral Health Authorities (TRBHA) and AIHP enrolled members for behavioral health services
- Claims for administrative days only, including psychiatric admissions
- Claims for transplant services
- Claims for which admit and discharge are on the same day and the discharge status does not indicate member expired
- Claim is an interim bill

Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for full details regarding billing instructions and reimbursement methodology.

Inpatient Hospital Services

EFFECTIVE 10/1/2014, THIS SECTION OF THIS CHAPTER IS NO LONGER VALID FOR ALL HOSPITAL PROVIDERS AND IS UNDERGOING REVISION.

AHCCCS covers medically necessary inpatient hospital services provided by or under the direction of a physician which are ordinarily furnished in a hospital, except for services in an institution for tuberculosis or mental diseases.

Inpatient services are covered when the member's condition requires hospitalization because of the severity of illness and intensity of services required.

Coverage for Federal Emergency Services Program (FESP) members is limited to those services that meet the federal Emergency Medical Condition criteria. For additional information on FESP refer to AMPM 1100.

For detailed information on covered hospital accommodation services and ancillary services, refer to the AHCCCS Medical Policy Manual (AMPM), Chapter 310-K, Hospital Inpatient Services.

Exclusions and Limitations

Inpatient dialysis treatments are covered only when the hospitalization is for:

- An acute medical condition requiring hemodialysis treatments.
- A medical condition experienced by a member routinely maintained on an outpatient chronic dialysis program.
- Placement, replacement, or repair of the chronic dialysis route (shunt or cannula).

Blood administration is considered a nursing function and is not included in calculating whether a particular case qualifies as an Outlier nor is it a covered service paid for under the Outlier payment methodology if a case qualifies as an Outlier.
Personal comfort items are not covered.

Inpatient hospital services are subject to the prior authorization, medical and concurrent review requirements for medical necessity for admission and continued stay.

Professional component for services rendered during an inpatient stay must be billed separately on a CMS 1500 claim form.

Health Care Acquired Conditions and Other Provider-Preventable Conditions

Section 2702 of the Patient Protection and Affordable Care Act (ACA) of 2010 prohibits Medicaid programs from reimbursing certain providers for services resulting from a “Provider-Preventable Condition” (PPC). Provider-Preventable Condition means a condition that meets

the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). These terms are defined as follows:

Health Care-Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) which occurs in any inpatient hospital setting and is not present on admission. Refer to the current CMS list of Hospital-Acquired Conditions and the AHCCCS Medical Policy Manual (AMPM) Chapter 900, Policy 960 for additional information on HCAC.
Other Provider-Preventable Condition (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member,
2. Wrong surgery on a member, and
3. Wrong site surgery.
4.

A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.
If it is determined that the HCAC or OPPC was a result of mistake or error by the hospital or medical professional, the AHCCCS Medical Review Department will report the occurrence to the AHCCCS Clinical Quality Management Unit.

Billing Inpatient Hospital Claims

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to the DRG policy, which is available on the AHCCCS website at:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html

Inpatient hospital claims must be submitted to the AHCCCS Administration on UB-04 billing forms (See Chapter 6, Billing on the UB-04 Claim Form, for specific billing requirements.)

The claim form must be completed correctly with valid revenue, ICD diagnosis codes, and ICD procedure codes if applicable in order for the AHCCCS system to qualify the accommodation day(s) at the appropriate reimbursement rate. At least one accommodation revenue code must be billed with associated charges greater than zero for an inpatient claim to qualify for payment. Any accommodation revenue code submitted without charges will not be considered for reimbursement.

AHCCCS will match inpatient and outpatient UB-04 claims for the same member for the same date of service. If a member is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

Same day admit/discharge services are considered outpatient (including maternity and nursery claims), except:

- When the patient expires, provided the hospital bills for the accommodation day.

Reimbursement of Inpatient Hospital Claims

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to the Fee-For-Service Provider Billing Manual, Chapter 11, Hospital Addendum APR-DRG for additional information on reimbursement.

AHCCCS reimburses acute general care hospital providers based upon the services rendered.

The tiered per diem methodology is used to reimburse instate, non-IHS, acute general care hospitals. Rates are set prospectively and adjusted annually. The tiered per diem system consists of seven tiers which are based on level and type of care:

Maternity NICU ICU Surgery
Psychiatric Nursery Routine

The AHCCCS system will classify a fee-for-service acute hospital inpatient claim at the surgical tier for all applicable days if the surgery occurs after the member becomes AHCCCS eligible and the member is fee-for-service eligible. A non-excluded ICD surgical procedure must be billed, and the date of the procedure must be within the member's fee-for-service eligibility period. Revenue code 036X must be billed with charges greater than zero.

The processing of the inpatient claim for payment is hierarchical. Each day is classified into only one tier, based on revenue, procedure, and/or diagnosis codes. An inpatient claim may split across no more than two tier levels. Some splits are either not allowed or are not logical.

The tiered per diem represents payment in full for both accommodation and ancillary services regardless of the billed charges and includes emergency room, observation, and other outpatient hospital services provided before the hospital admission.
.
Exhibit 202-1 identifies the requirements for classification into each tier and the allowed tier splits.

The statewide inpatient cost-to-charge ratio is used to reimburse outlier claims and out-of-state inpatient hospital claims and is computed based on average of all in-state, acute general care hospitals.

Contract/negotiated rates are used to reimburse providers for certain services, such as transplants, or for providers who have negotiated special rates for specific services.

The current published Federal Register per diem rate is used to reimburse Indian Health Service (IHS)/638 facility inpatient claims. This rate is established by the federal Office of Management and Budget (OMB).

When Medicare is the primary payer and has made payment on the inpatient hospital claim, Medicare's coinsurance and/or deductible may be reimbursed (see Chapter 9).

Inpatient Hospital claims shall be paid according to inpatient methodology. Outpatient payment methodology *does not apply* to inpatient claims.

AHCCCS pays for the date of admission up to but not including date of discharge unless the patient expires.

Example 1:

Dates of service: 03/05 through 03/10 Accommodation days billed: 5

Bill type: 111 Patient status: 01

AHCCCS will reimburse five days at the appropriate tier(s). The date of discharge will not be paid when the patient status indicates a status other than expired.

Example 2:

Dates of service: 03/05 through 03/10 Accommodation days billed: 6

Bill type: 112 Patient status: 30

AHCCCS will reimburse six days at the appropriate tier(s). AHCCCS will pay the last accommodation day billed when the patient status is 30 (still a patient).

Example 3:

Dates of service: 03/05 through 03/10 Accommodation days billed: 2

Bill type: 111 Patient status: 01

AHCCCS will reimburse two days at the appropriate tier(s). The provider billed only two accommodation days. AHCCCS will reimburse the number of accommodation days billed up to the maximum allowed for the dates of service.

Reimbursement for the emergency room, observation and other outpatient hospital services provided before the hospital admission are included in the admission and will be paid using inpatient methodology only. A UB-04 outpatient claim will pend for review if the hospital has

previously submitted an inpatient claim for the same member for the same date of service, or vice versa.

When a patient is admitted and discharged on the same day, AHCCCS will reimburse the claim as follows:

Same day admit/transfer

AHCCCS reimburses the transferring hospital's claim by valuing allowed ancillary charges using the AHCCCS Outpatient Hospital Fee Schedule Methodology.

The receiving hospital would be paid the full per diem payment for the date of transfer provided the hospital bills for at least one accommodation day.

Same day admit/discharge

AHCCCS reimburses same day admit/discharge claims by valuing allowed ancillary charges using the AHCCCS Outpatient Hospital Fee Schedule Methodology.

If the hospital bills the claim as an inpatient admission and the AHCCCS system would qualify the claim as Maternity or Nursery, reimbursement will be the per diem rate for the Maternity or Nursery classified tier.

Same day admit/patient expires

AHCCCS will reimburse the facility the appropriate per diem payment for the date of death provided the hospital bills for the accommodation day.

Outliers

EFFECTIVE 10/1/2014 THIS SECTION OF THIS CHAPTER IS NO LONGER VALID FOR ALL HOSPITAL PROVIDERS AND IS UNDERGOING REVISION.

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for outlier billing and reimbursement details.

AHCCCS reimburses in-state, non-IHS hospitals for inpatient claims with extraordinary cost per day as *outliers*. A claim is defined as an outlier if its covered costs per day exceed the statewide average cost thresholds.

In order for claims to be paid at the outlier payment rate, hospitals must enter a Condition Code 61 in any Condition Code field (18 - 28) on the UB-04 claim form. The entire claim for which AHCCCS is responsible must be submitted as one claim. If a claim has been paid and the provider decides to submit an adjustment for outlier consideration, the entire period of

AHCCCS liability must be submitted on one claim form. The claim may not be split billed with a request for outlier reimbursement on the first claim and the remaining hospital stay billed on a subsequent claim. Claims that are identified as outlier with condition code 61 are subject to medical review.

A claim identified as an outlier with condition code 61 will be considered for outlier reimbursement if it is an admit through discharge billing, identified by a bill type 111, or if it is the last bill of interim billings which represents the total AHCCCS liability period of a confinement identified by bill type 114.

Example: Inpatient stay billed on two different claims

Dates of service	January 1 - 10
First claim submitted to AHCCCS	January 1 - 5
Bill Type: 112	Patient status: 30
Second claim submitted to AHCCCS	January 6 - 10
Bill Type: 114	Patient status: 01

After the initial claims have been reimbursed by AHCCCS, the provider decides to request outlier reimbursement. The provider must resubmit the entire stay on a single claim as an adjustment with a Condition Code 61 (See Chapter 4, General Billing Rules, for information on submitting adjustments to UB-04 claims).

Adjustment submitted to AHCCCS	January 1 - 10
Bill Type: 111	Patient status: 01
Condition Code: 61	

AHCCCS will void the original claims and process the adjustment. If the adjustment claim qualifies for outlier payment, the outlier amount will be calculated. If the adjustment claim does not qualify for an outlier payment, the claim will be reimbursed using the tier per diem rates.

If a claim is identified as an outlier with Condition Code 61, but it does not qualify as an outlier and the billed services are covered, that claim will be paid at the appropriate tiered per diem rate.

The hospital-specific fee-for-service rate sheets include hospital-specific billed charges per day (charge thresholds) as a guideline to assist hospitals in identifying claims to flag with the Condition Code 61.

Outlier Calculations:

The steps in the outlier process for claims **classified at one tier** are:

1. [Total charges (-) non-covered charges] (÷) allowed accommodation days (=) covered charges per day.

2. Covered charges per day (x) provider-specific cost-to-charge ratio (=) claim costs per day.

3. If the claim costs per day exceed the qualified tier threshold amount, the claim will pend for outlier medical review. If the costs per day do not exceed the threshold, the claim will pay at the appropriate tier.

4. If the claim is forwarded for outlier medical review, it will be reprocessed through the outlier calculation to determine if any disallowed charges disqualify the claim as an outlier. Although the claim costs per day may have initially exceeded the outlier threshold, upon completion of medical review, the costs per day may no longer exceed the threshold.

5. If the claim is still an outlier, reimbursement is calculated by multiplying the covered claim charges by the statewide inpatient cost-to-charge ratio, subtracting other deductions and applying discounts or penalties.

Outlier example 1 (single tier):

Units (Days)	Revenue code	Description	Hospital charges
3	17X	Nursery	$ 3,000
		Ancillary 1	4,000
		Ancillary 2	1,500
		Ancillary 3	6,000
			$14,500

1. Compute the hospital charges per day:

   Total charges ÷ total days = Hospital charges per day

Total charges	$14,500.00
Total days	3

   Hospital charges per day = 14,500 ÷ 3 = $ 4,833.33

2. Determine the hospital cost per day:

   Charges per day x inpatient cost-to-charge ratio = Hospital cost per day

Hospital charges per day $4,833.33
Hospital-specific inpatient cost-to-charge ratio .3282

Hospital cost per day = $4,833.33 X .3282 = $1,586.30

3. Compare to the outlier threshold.

   Is the cost per day ($1,586.30) greater than the hospital-specific nursery tier threshold? If so, the claim qualifies as an outlier and will be forwarded for medical review. If not, the claim will pay at the appropriate tier.

The steps in the outlier process for claims **classified at more than one tier** are processed with a weighted tier threshold amount:

1. [Total charges (-) non-covered charges] (÷) allowed accommodation days (=) covered charges per day.
2. Covered charges per day (x) provider-specific cost-to-charge ratio (=) claim costs per day.

Tier 1 threshold number of accommodation days classified at Tier 1 x tier threshold amount
+
Tier 2 threshold number of accommodation days classified at Tier 2 x tier threshold amount
÷

3. If the claim costs per day exceed the qualified tier threshold amount (calculated below), the claim will pend for outlier medical review. If the costs per day do not exceed the threshold, the claim will pay at the appropriate tier.

4. If the claim is forwarded for outlier medical review, it will be reprocessed through the outlier calculation to determine if any disallowed charges disqualify the claim as an outlier. Although the claim costs per day may have initially exceeded the outlier threshold, upon completion of medical review, the costs per day may no longer exceed the threshold.

5. If the claim is still an outlier, reimbursement is calculated by multiplying the covered claim charges by the statewide inpatient cost-to-charge ratio, subtracting other deductions and applying discounts or penalties.

Total accommodation days = Weighted threshold amount

<u>Outlier example 2 (two tiers):</u>

An inpatient claim qualifies for five days at the ICU tier and two days at the Routine tier.

Units	Revenue Code	Description	Charges
5	203	ICU	$12,500

2	110	Routine Ancillary 1 Ancillary 2 Ancillary 3 Ancillary 4	2,000 20,000 18,500 15,000 10,000 $78,000

1. Compute the hospital charges per day:

Total charges	$78,000.00
Total days	7

Charges per day = 78,000 ÷ 7 = $11,142.86

2. Determine the hospital cost per day:

Hospital charges per day	$11,142.86
Inpatient cost to charge ratio	.3484

Hospital cost per day = $11,142.86 x .3484 = $3,882.17

3. Since the claim has split across tiers, compute a weighted tier threshold:

Tier	Threshold	Number of Days
ICU	$4,500	5
ROUTINE	$2,000	2

[(Tier 1 threshold x days at Tier 1) + (Tier 2 threshold x days at Tier 2)] ÷ total days

[($4,500 X 5) + ($2,000 X 2)] ÷ 7 = [$22,500 + $4,000] ÷ 7 = $26,500 ÷ 7 = $3,785.71

4. The cost per day ($3,882.17) is greater than the weighted threshold ($3,785.71), and the claim will go to medical review.

5. After medical review, the claim is processed through the outlier calculation again to determine if it still qualifies as an outlier.

6. If it is an outlier, reimbursement is calculated by multiplying covered charges by the statewide inpatient cost-to-charge ratio, subtracting other deductions and applying discounts or penalties.

Discounts and Penalties

Acute care hospital inpatient stays with a date of discharge on or after 10/1/2014 will be priced using the DRG methodology. Refer to FFS Chapter 11 Hospital Services Addendum APR-DRG for discount/penalty details.

AHCCCS calculates quick pay discounts and slow pay penalties on the AHCCCS allowed amount for any in-state, non-IHS/638 general acute hospital inpatient and outpatient claims (including secondary claims) billed on the UB-04 claim form. Quick pay discounts and slow pay penalties are applied to:

- Inpatient claims
- Transplant claims reimbursed at the statewide inpatient cost-to-charge ratio
- Outlier claims reimbursed at the statewide inpatient cost-to-charge ratio
- Outpatient claims for dates of service prior to 7/1/2005, reimbursed at the provider-specific outpatient cost-to-charge ratio
- Outpatient claims for dates of service on or after 7/1/2005, reimbursed using the Outpatient Hospital Fee Schedule Methodology

A 1% quick pay discount is applied to claims paid within 30 days of the clean claim date.

The slow pay penalty is based on a 30 calendar day month, as illustrated below:

Claim paid within 31-60 days of clean claim date:	0% discount/penalty
Claim paid within 61-90 days of clean claim date:	1% penalty
Claim paid within 91-120 days of clean claim date:	2% penalty

The penalty continues to accrue at a rate of 1 per cent per month or partial month until the claim is paid by AHCCCS.

Discount/Penalty Example 1:

A claim is paid within 30 days of the clean claim date, and the quick pay discount is applied.

AHCCCS allowed amount (tier per diem)	$10,000.00	
1% discount applied to AHCCCS allowed amount	-100.00	($10,000.00 x .01)
AHCCCS payment	$ 9,900.00	

Discounts and penalties are applied on the net balance to claims with other insurance primary.

Discount/Penalty Example 2:

A claim for a member with other insurance is paid within 30 days of the clean claim date.

AHCCCS allowed amount (tier per diem)	$10,000.00	
Other insurance payment	- 2,000.00	
Balance	$ 8,000.00	
1% discount applied to balance	- 80.00	($8,000.00 x .01)
AHCCCS payment	$ 7,920.00	

Discount/Penalty Example 3:

Claim is paid 69 days after the clean claim date, and a slow pay penalty is applied.

AHCCCS allowed (tier per diem)	$10,000.00	
1% penalty applied to AHCCCS allowed amount	+ 100.00	($10,000.00 x .01)
AHCCCS payment	$10,100.00	

Discount/Penalty Example 4:

A claim for a member with other insurance is paid 69 days after the clean claim date, and a slow pay penalty is applied.

AHCCCS allowed (tiered per diem)	$10,000.00	
Other insurance payment	- 2,000.00	
Balance	$ 8,000.00	
1% penalty applied to balance	+ 80.00	($8,000 x .01)
AHCCCS payment	$ 8,080.00	

Replacement claims are subject to discounts and penalties with consideration to the original claim. The only replacements that affect payment of an inpatient claim are an increase in the number of days billed or billing a revenue code, procedure code, or diagnosis code that impacts the tiers.

If a replacement is submitted for additional accommodation days where additional payment is due from AHCCCS, a new clean claim date is established.

If the replacement allowed amount is more than the AHCCCS allowed amount of the original claim, a new discount or penalty will be calculated only on the amount of the increase. The original discount or penalty will remain as applied to the initial claim amount.

If the replacement allowed amount is less than the allowed amount of the original claim, the same discount or penalty percentage applied to the original claim will be applied to the adjusted amount, regardless of the processing time.

Discount/Penalty Example 5:

A claim was originally paid within 30 days of the clean claim date, and a 1% discount was applied. The hospital submits an internal adjustment or replacement that increases the AHCCCS allowed amount. The adjusted claim is paid 67 days after the new clean claim date. A 1% penalty is applied to the difference between the original and adjusted allowed amounts.

Original claim paid within 30 days:

AHCCCS allowed amount (tier per diem)	$8,000.00	
1% discount	- 80.00	($8,000.00 x .01)
AHCCCS payment	$7,920.00	

Replacement reimbursed 67 days after the new clean claim date:

New AHCCCS allowed amount (tier per diem)	$12,500.00	
Original AHCCCS allowed amount	- 8,000.00	
Difference between original/new allowed amounts	4,500.00	
1% penalty on difference	+ 45.00	($4,500 x .01)
	$ 4,545.00	
original AHCCCS payment	+7,920.00	
New AHCCCS total payment	$12,465.00	

Discount/Penalty Example 6:

A claim was originally paid 95 days after the clean claim date, and a 2% penalty was applied. The hospital submits an adjustment that increases the AHCCCS allowed amount. The adjusted claim is paid within 30 days of the new clean claim date. A 1% discount is applied to the difference between the original and adjusted allowed amounts.

Original claim paid within 91-120 days of clean claim date:

AHCCCS allowed (tier per diem)	$8,000.00
2% penalty	+ 160.00
AHCCCS payment	$8,160.00

Internal adjustment or replaced claim reimbursed within 30 days of the clean claim date:

New AHCCCS allowed amount	$12,500.00
Original AHCCCS allowed amount	- 8,000.00

Difference original/new	$ 4,500.00	
1% discount on difference	- 45.00	($4,500 x .01)
	$ 4,455.00	
	+ 8,160.00	
New AHCCCS total payment	$12,615.00	

Discount/Penalty Example 7:

A claim was originally paid within 30 days of the clean claim date, and a 1% discount was applied. The hospital submits an internal adjustment or replacement that decreases the AHCCCS allowed amount. The same discount percentage that was applied to the original claim will be applied to the adjusted amount, regardless of the processing time.

Original claim paid within 30 days:

AHCCCS allowed	$8,000.00	
1% discount	- 80.00	($8,000.00 x .01)
AHCCCS payment	$7,920.00	

Replaced claim with decrease in AHCCCS allowed amount**:**

New AHCCCS allowed amount	$7,000.00	
Original 1% discount reapplied	- 70.00	($7.000.00 x .01)
New AHCCCS total payment	$6,930.00	
Original AHCCCS payment	- 7,920.00	
Recoup difference	<$ 990.00>	

Discount/Penalty Example 8:

A claim was originally paid 97 days after the clean claim date, and a 2% penalty was applied. The hospital submits an internal adjustment or replacement that decreases the AHCCCS allowed amount. The same penalty percentage that was applied to the original claim will be applied to the adjusted amount, regardless of the processing time.

Original claim paid within 91-120 days of clean claim date:

AHCCCS allowed	$8,000.00	
2% penalty	+ 160.00	($8,000.00 x .02)
AHCCCS payment	$8,160.00	

Replaced claim with decrease in AHCCCS allowed amount**:**

New AHCCCS allowed amount	$7,000.00	
Original 2% penalty reapplied	+ 140.00	($7,000.00 x .02)

New AHCCCS total payment	$7,140.00
Original AHCCCS payment	- 8,160.00
Recoup difference	<$1,020.00>

Medical Review of Inpatient Hospital Claims

An inpatient claim is considered to be a clean claim, for medical review purposes only, upon initial receipt of the legible, error-free UB-04 claim form by AHCCCS if the claim includes the following error-free documentation in legible form:

- An admission face sheet;
- An itemized statement, submitted by the provider;
- An admission history and physical;
- A discharge summary or an interim summary if the claim is split;
- An emergency record, if admission was through the emergency room;
- Medication Administration Record (MAR);
- Operative report(s), if applicable;
- A labor and delivery room report, if applicable;
- Physician orders;
- Diagnostic test results;
- Progress notes; and/or
- Documentation listed in Exhibit 11-4, Outlier Records Request, for claims qualifying for outlier payments.

Periodically, retrospective review will be conducted by AHCCCS based upon a variety of criteria.

Freestanding Emergency Departments (FrEDs)

Effective with dates of service on and after March 1, 2017, Hospital-based Freestanding Emergency Departments (FrEDs) will be reimbursed by AHCCCS and its Contractors in accordance with the unique reimbursement methodology and rate schedule delineated in A.A.C. R9-22-712.90. A Hospital-Based FrED is an outpatient treatment center that provides emergency department services, is subject to the requirements of 42 CFR § 489.24 (EMTALA), and shares an ownership interest with a hospital.

The new Hospital-based FrED fee schedule requires that AHCCCS and its Contractors be able to differentiate FrEDs from the hospitals with which the FrEDs are licensed. To that end, AHCCCS has established a new, distinct provider type specifically for Hospital-based FrEDs and all Hospital based FrEDs are required to submit separate provider registration.

Reimbursement using the new Hospital-based FrED fee schedule will be tied directly to the use of FrED NPIs for claims with dates of service on and after March 1, 2017. The rendering provider on the claim must be the FrED as indicated by the NPI. Therefore each Hospital-based FrED is required to have a distinct NPI not already associated with an active AHCCCS Provider Identification Number.

Billing FrED Claims

Claims must be submitted to the AHCCCS Administration on UB-04 billing forms (See Chapter 6, Billing on the UB-04 Claim Form, for specific billing requirements.) Bills should include all detail for the services including the correct Revenue Code-to-Procedure Code combinations.

Reimbursement of FrED Claims

For dates of service on and after March 1, 2017, hospital-based FrEDs shall be reimbursed a percentage of the total amount otherwise reimbursable under the AHCCCS Outpatient Capped Fee-For-Service Schedule, depending on the level of service provided:

1. 60% for a level 1 emergency department visit.
2. 80% for a level 2 emergency department visit.
3. 90% for a level 3 emergency department visit.
4. 100% for a level 4 or 5 emergency department visit.

Peer Group Multipliers will not be applied except under specific circumstances.

Hospital-based FrEDs located in a city or town in a county with less than 500,000 residents where the only hospital in the city or town operating an emergency department closed on or after January 1, 2015, shall be reimbursed using the *Outpatient Hospital Reimbursement: Adjustment to Fees* associated with the nearest hospital with which the freestanding emergency department shares an ownership interest.

Services provided by an outpatient treatment center that does not meet the FrED criteria shall be reimbursed based on the non-hospital AHCCCS capped fee-for-service schedule. If the member is admitted directly from a hospital-based FrED to a hospital with an ownership interest in the hospital-based FrED, AHCCCS will not reimburse for the services provided at the hospital-based FrED. The sole reimbursement to the hospital shall be payment for the inpatient stay using the DRG methodology.

Discounts and Penalties

AHCCCS calculates quick pay discounts and slow pay penalties on the AHCCCS allowed amount for any in-state, non-IHS/638 general acute hospital inpatient, outpatient, and freestanding emergency department claims (including secondary claims) billed on the UB-04 claim form. Quick pay discounts and slow pay penalties are applied to:

- Inpatient claims
- Transplant claims reimbursed at the statewide inpatient cost-to-charge ratio
- Outlier claims reimbursed at the statewide inpatient cost-to-charge ratio
- Outpatient claims for dates of service prior to 7/1/2005, reimbursed at the provider-specific outpatient Cost-to-charge ratio
- Outpatient claims for dates of service on or after 7/1/2005, reimbursed using the Outpatient Hospital Fee Schedule Methodology
- Freestanding Emergency Department claims for dates of service 03/01/2017, reimbursed using a percentage of the total amount otherwise reimbursable under the AHCCCS Outpatient Capped Fee-For-Service Schedule

A 1% quick pay discount is applied to claims paid within 30 days of the clean claim date.

The slow pay penalty is based on a 30 calendar day month, as illustrated below:

Claim paid within 31-60 days of clean claim date:	0% discount/penalty
Claim paid within 61-90 days of clean claim date:	1% penalty
Claim paid within 91-120 days of clean claim date:	2% penalty

The penalty continues to accrue at a rate of 1% per month or partial month until the claim is paid by AHCCCS.

Outpatient Hospital Services

AHCCCS covers preventive, diagnostic, rehabilitative, and palliative items or services ordinarily provided in hospitals on an outpatient basis for all members within certain limits based on member age and eligibility. Refer to the AHCCCS Medical Policy Manual (AMPM) for additional information on covered services.

If a member is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, then the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

Observation Services

Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have

been met. Covered observation services include the use of a bed; periodic monitoring by a hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize, or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis For AHCCCS policy information regarding observation services refer to AMPM 310-S, Observation Services.

In general, observation status should not exceed 24 hours. This time limit may be exceeded, if medically necessary, to evaluate the medical condition and/or treatment of a member. Observation services that exceed 23 hours are subject to review and documentation must be submitted with the claim.

Observation Services – Billing Information

Extended stays after outpatient surgery shall be billed as recovery room extensions.

Observation services *without labor*, billed on the UB-04 claim form must be billed with a 0762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code G0378. Each hour or portion of an hour that a member is in observation status must be billed as one unit of service.

Observation services *with labor,* billed on a UB-04 claim form must be billed with 0721 revenue code (Labor Room Delivery – Labor) and the appropriate observation HCPCS procedure code G0378. Each hour or portion of an hour that a member is in observation status must be billed as one unit of service.

Example: Billing observation services

A member is placed in observation status at 2:25 p.m. and sent home at 7:45 p.m. The hospital would submit a UB-04 claim to AHCCCS as follows:

Revenue Code	0762
CPT Code	G0378
Units	6

Each unit of observation services equals one hour or portion of an hour. The member was in observation status for five hours and 20 minutes, which equals six units.

Observation services that directly precede an inpatient admission to the same hospital *must not* be billed separately. These charges must be billed on the inpatient claim. Reimbursement for the observation services provided before the hospital admission is included in the inpatient payment methodology.

All observation services are subject to medical review of records to determine if:

- Observation status was reasonable, cost-effective, medically necessary to evaluate an outpatient condition or determine the need for inpatient status
- Length/type/amount of observation status was medically necessary for the member's condition
- Reimbursement is warranted

AHCCCS will review the immediate and continuing observation status by assessing the severity of illness and intensity of services. Medical review for continued observation status will consider each case on an individual basis and include, at a minimum, the following documentation:

- Emergency room record, if applicable
- Progress notes
- Operative report, if applicable
- Diagnostic test results, if applicable
- Nursing notes, if applicable
- Labor and delivery records, if applicable
- Physician orders

The following are required for documenting medical records:

- Orders for observation status must be written on the physician's order sheet, not the emergency room record, and must specify "admit to observation."

  Orders must be signed and dated by a physician within 24 hours if ordered by non-physician staff.

  Rubber stamped orders are not acceptable.
- Follow-up orders must be written at least every 24 hours.
- Changes from "observation status to inpatient" or "inpatient to observation status" must be made by a physician or authorized individual prior to the member's discharge from the facility.
- Inpatient to observation status must be made by a physician or authorized individual and occur within 12 hours after admission as an inpatient.

- Inpatient/outpatient status change must be supported by medical documentation.

Billing Outpatient Hospital Services

When billing outpatient services, the following information must be included on the UB-04 outpatient claim:

- Bill Type must be 13X, 14X or 85X for Critical Access Hospitals (appropriate third digit as listed in UB-04 manual).
- Revenue code(s), CPT/HCPCs, Modifiers and units must be appropriate and reflect all services provided.
- Revenue codes which are valid only for inpatient services cannot be used for services reimbursed on an outpatient basis.
- If the service is an emergency, the Admit Type (field 19) must be a "1."

Reimbursement of Outpatient Hospital Claims

AHCCCS reimburses in-state, non-IHS/638 hospitals for outpatient services billed on a UB-04 claim form using the AHCCCS Outpatient Hospital Fee Schedule Methodology. The Outpatient Hospital Fee Schedule Methodology will provide rates at the HCPCS/CPT procedure code level, and Surgery/Emergency Department (ED) services will be bundled similar to Medicare for payment purposes.

The listing of revenue codes that are bundled with Surgery and ED can be referenced via the AHCCCS website/Outpatient Fee Schedule as Extract RF796.

Multiple surgeries will pay the higher rate surgery at 100% of the fee schedule and secondary surgeries at 50% of the fee schedule (exceptions will be noted for those procedures that are intended to be paid at 100%) and do not require indication of a 51 modifier.

Quick pay discounts and slow pay penalties are applied to in-state, non-IHS general acute hospital outpatient UB claims according to AHCCCS policy.

Late charge bills are not accepted. When billing changes to the claim (including late charges), hospitals ***must*** rebill the entire corrected claim. (Refer to Chapter 4 General Billing Rules).

If one line of the claim is billed incorrectly, that line will be disallowed/denied as a payment of $0.00.

Out-of-state outpatient hospital claims are reimbursed using the AHCCCS Outpatient Hospital Fee Schedule Methodology or a negotiated rate.

Note: The Medicare Outpatient Prospective Payment System (OPPS) reimburses outpatient hospital services using Ambulatory Payment Classification (APC) rates and requires hospitals to provide more detailed billing on outpatient UB-04 claims. AHCCCS recognizes that hospitals are billing in accordance with the OPPS regulations.

However, AHCCCS does not cover the identical services or pay under the same methodology as Medicare. Irrespective of the change in Medicare billing practices, AHCCCS will continue to calculate reimbursement using only those billed charges that represent medically necessary, reasonable, and customary items of expense of AHCCCS-covered services that meet the medical review criteria of the AHCCCS Administration or the contractor.

Billing CPT/HCPCS Codes with Revenue Codes

AHCCCS requires that outpatient services be billed with an appropriate CPT or HCPCS code and appropriate modifier(s) that further define the services described by the revenue code listed on the UB-04 claim form.

For example, hospitals must indicate the appropriate revenue code and the CPT/HCPCS code for the covered therapy, surgery, Emergency Department, clinic, etc.

Units must be consistent with CPT/HCPCS code definitions. For example, if a hospital bills revenue codes 0421 (PT-visit) with CPT code 97116 (Therapeutic procedure, one or more areas, each 15 minutes; gait training), each 15-minute increment represents one unit. If services were provided for 30 minutes, the hospital would bill two units, and so on.

Billing Other Services

Hospital outpatient pharmacy

All fee-for-service pharmacy providers, including hospital pharmacies, are required to submit claims through the AHCCCS Pharmacy Benefits Manager (PBM).

Outpatient hospital pharmacies must enter into a contract with the AHCCCS PBM to become part of their network. Refer to Chapter 12, Pharmacy Services, of the Fee-For-Service Provider Billing Manual and the Pharmacy web page on the AHCCCS website for additional information, including reimbursement of specialty drugs.

Durable medical equipment

DME revenue codes are not reimbursable to hospitals on the UB-04 claim form.

Items must be correctly coded as medical/surgical supplies, or if DME, billed on the CMS 1500 claim form. Refer to Chapter 13, DME, Orthotics, Prosthetics, and Medical Supplies of the Fee-For-Service Provider Billing Manual for additional information.

Transportation

Transportation services provided by hospitals must be billed on a CMS 1500 claim form using HCPCS codes. Refer to Chapter 5, Billing on the CMS 1500 Claim Form, of the Fee-For-Service Provider Billing Manual for additional information.

Transportation revenue codes are not covered on a hospital UB-04 claim form.

Transportation services provided by hospitals are reimbursed based on the current AHCCCS policy for transportation providers. Refer to Chapter 14, Transportation Services. of the Fee-For-Service Provider Billing Manual and AMPM 310-BB, Transportation Services, for additional information.

Professional services

AHCCCS requires that physician and professional services provided in a hospital setting be billed on a CMS 1500 claim form.

Claims are reimbursed using the AHCCCS capped fee schedule.

Revenue codes for professional services are not covered on a UB-04 claim form.

Physician and mid-level practitioner services must be billed under the individual service provider's AHCCCS provider ID number.

AHCCCS does not allow hospitals and/or clinics to bill AHCCCS or any AHCCCS-contracted plans for physician/mid-level practitioner services using the hospital and/or clinic AHCCCS ID number.

Hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners. In these cases, the claim will carry both the physician/mid-level practitioner ID as the service provider and the hospital group biller ID.

For information on billing for professional services provided by residents, interns and teaching physicians, refer to Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual.

The following Per Diem Tier Table is *NO LONGER* valid:

Effective discharge date = 10/1/2014 for DRG facilities

OR

Effective admit date 10/1/2014 for facilities excluded from DRG reimbursement

Tier	Identification Criteria	Allowed Splits
MATERNITY	A primary diagnosis defined as maternity **640.xx – 643.x, 644.2x -676.xx, V22.22 – V24.xx or V27.xx.**	**None**
NICU	Revenue Code = 174 **AND** the provider has a certified Level II or III NICU. NICU revenue codes should only be billed for the period immediately following the infant's birth. Infants that are discharged home but return to the hospital and require ICU care should be billed using ICU revenue codes.	**Nursery**
ICU	Revenue codes **200 – 204, 207 – 212, or 219**.	**Surgery Psychiatric Routine**
SURGERY	Surgery is identified by a revenue code of **36X**. To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list. The Surgery tier can only split with the ICU tier. All claim accommodation days that do not qualify at the ICU tier will be classified at the Surgery tier.	**ICU**
PSYCHIATRIC	Psychiatric Revenue Codes – **114, 124, 134, 144, or 154 AND Psychiatric Diagnosis = 290.xx – 316.xx**. If a routine revenue code is present and all diagnoses codes on the claim are equal to **290.xx – 316.xx**, classify as a psychiatric claim.	**ICU**
NURSERY	Revenue Code of **17x,** but **not** equal to 174 or 175..	**NICU**
ROUTINE	Revenue Codes of **100 – 101, 110 – 113, 116 – 123, 126 – 133, 136 – 143, 146 – 153, 156 – 159, 16x, 206, 213, or 214**.	**ICU**

Revision History

Date	Description of changes *All page numbers correspond to the individual chapter and not the master PDF document chapter.	Page(s)

3/25/2019	Updated observation services verbiage to read as: "Observation services that exceed 23 hours are subject to review and documentation must be submitted with the claim. "	17
2/28/2019	The section on "DRG payment will be applied to all inpatient claims from acute care hospitals except the following:" to include the following: • Claims for administrative days only • Claims for transplant services • Claims for which admit and discharge are on the same day and the discharge status does not indicate member expired • Claim is an interim bill DRG policy link added. Exclusions and Limitations section updated Clarification added to the Health Care-Acquired Condition (HCAC) section DRG policy website updated Medical Review of Inpatient Hospital Claims section had the following added for clarification: • Physician orders; • Diagnostic test results; • Progress notes; and/or • Documentation listed in Exhibit 11-4, Outlier Records Request, for claims qualifying for outlier payments. Observation clarification added: "Observation services beyond 24 hours will be reviewed for medical necessity and documentation must be submitted with the claim." Recovery room extension clarification added. References to appropriate chapters within the FFS provider billing manual added.	1 3 3 3-4 4 14-15 17 18 Throughout
1/23/2018	Formatting	All
03/01/2017	Added Freestanding Emergency Departments (FrEDs) language	18-19
10/01/2015	"ICD-9" replaced with "ICD" New PBM contractor OptumRx replaces MedImpact effective 10/1/2015	multiple 25
03/03/2015	Correction: same day admit/discharge services	6

09/17/2014	APR-DRG language, effective 10/01/2014	multiple

Exhibit 11-4 ~ Outlier Records Request

FACILITY NAME
ADDRESS
CRN
MEMBER ID
MEMBER NAME

After review of the documentation previously submitted it has been determined that additional information is needed to complete an Outlier review.
Please submit the following documentation:

- ☐ Medication Administration Record (MAR)
- ☐ Operating room and anesthesia times. (Need the operative report and anesthesia records as they contain some of the charges/supplies/implants/medications that might not be listed elsewhere)
- ☐ All other minor procedures (bronchoscopy, laceration repair, lumbar puncture, PICC insertion, etc.)
- ☐ High dollar radiology (CT's, MRI's, MRA's, Nuclear Med scans, IR (Interventional Radiology).
- ☐ High dollar medical supplies
- ☐ Echocardiogram
- ☐ Cardiac Cath records
- ☐ Ventilator days
- ☐ Nitric Oxide days
- ☐ Dialysis records and CRRT
- ☐ Blood administration (copy of the blood administration tag that has the date, start/stop times, and signature of administrator)
- ☐ PACU in/out times
- ☐ Perfusion
- ☐ Cardiac Arrest reports
- ☐ If Observation Days are billed then physicians' orders must be verified per policy
- ☐ Emergency Room records (procedures performed and meds given in ER may not be listed anywhere else).
- ☐ Other

_____
_____
_____
_____
_____

Completed By: Initials
Date:

CHAPTER 11 ~ HOSPITAL ADDENDUM APR-DRG

Chapter 11 ~ Hospital Addendum APR-DRG

- Updated Arizona DRG Payment Policies can be found at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html

AHCCCS
APR-DRG Payment System Design
Payment Policies
January 1, 2018

Table of Contents

1. DRG Pricing Information Summary 242
2. DRG Pricing Formulas 243
3. Admit versus Discharge Date 248
4. Recipient Enrolled in Federal Emergency Services Program (FES) 248
5. Enrollment Change during Hospital Stay 249
6. Medicare Dual Eligibles 250
7. Administrative Days 250
8. Interim Claims 251
9. Transfer Policy 252
10. Recipient Gains Medicaid Eligibility after Admission 253
11. Recipient Loses Medicaid Eligibility Prior to Discharge 254
12. Same Day Admit and Discharge 254
13. Specialty Hospitals 254
14. Rehabilitation and LTAC Hospitals 255
15. Psychiatric Hospitals 255
16. Inpatient Claims for Recipients with Medicare Part B Only 255
17. Carved-out Services Within Claims Paid Under DRG Methodology 255
18. Non-covered Charges 256
19. Transplants 256
20. Negotiated Settlements 256
21. Detox / Behavioral Health versus Physical Health Diagnosis 256
22. HCAC and POA 257
23. Same Day Admit and Date of Death 258
24. Out-of-State Hospitals 258
25. Slow Pay Penalties and Quick Pay Discounts 258
26. Readmission Policy 259

27. Reinsurance 259
28. Non-covered Services 260
29. Newborn Birth Weight Reporting 260
30. Hemophilia HCPCS / NDC Reporting 260
31. Inpatient Services Preceding Transplant 260
32. Hospital Presumptive Eligibility 261
33. Long Acting Reversible Contraceptives (LARC) 261

1. DRG Pricing Information Summary

Effective October 1, 2014, AHCCCS determines Medicaid reimbursement for most acute care hospital inpatient services for the majority of Arizona hospitals and out-of-state hospitals using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems is used to categorize each inpatient stay. Each inpatient hospital claim is assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category. The DRG relative weight is a key factor in determining payment to the hospital. Exceptions to APR-DRG payments are described below and elsewhere in this document. Modifications to components of the APR-DRG pricing for certain in-state and most out-of-state hospitals are also defined later in this document.

DRG payment is applied to all inpatient claims from hospitals except the following:

- Claims from a free-standing rehabilitation facility
- Claims from a free-standing long term acute care facility
- Claims from a free-standing psychiatric facility
- Claims from an Indian Health Service facility or tribally operated 638 facility
- Claims paid by Tribal/Regional Behavioral Health Authorities (T/RBHAs) for behavioral health services
- Claims for administrative days only
- Claims for transplant services
- Claims for which admit and discharge are on the same day and the discharge status does not indicate member expired
- Claim is an interim bill

AHCCCS Contractors are not mandated to utilize AHCCCS' methodology or rates except in the absence of a contract. Contractors may enter into contracts with hospitals which specify alternative methodologies and/or rates. In the absence of a contract as noted above, unless otherwise specified in these policies, the use of the term AHCCCS refers to both the AHCCCS program and its Contractors.

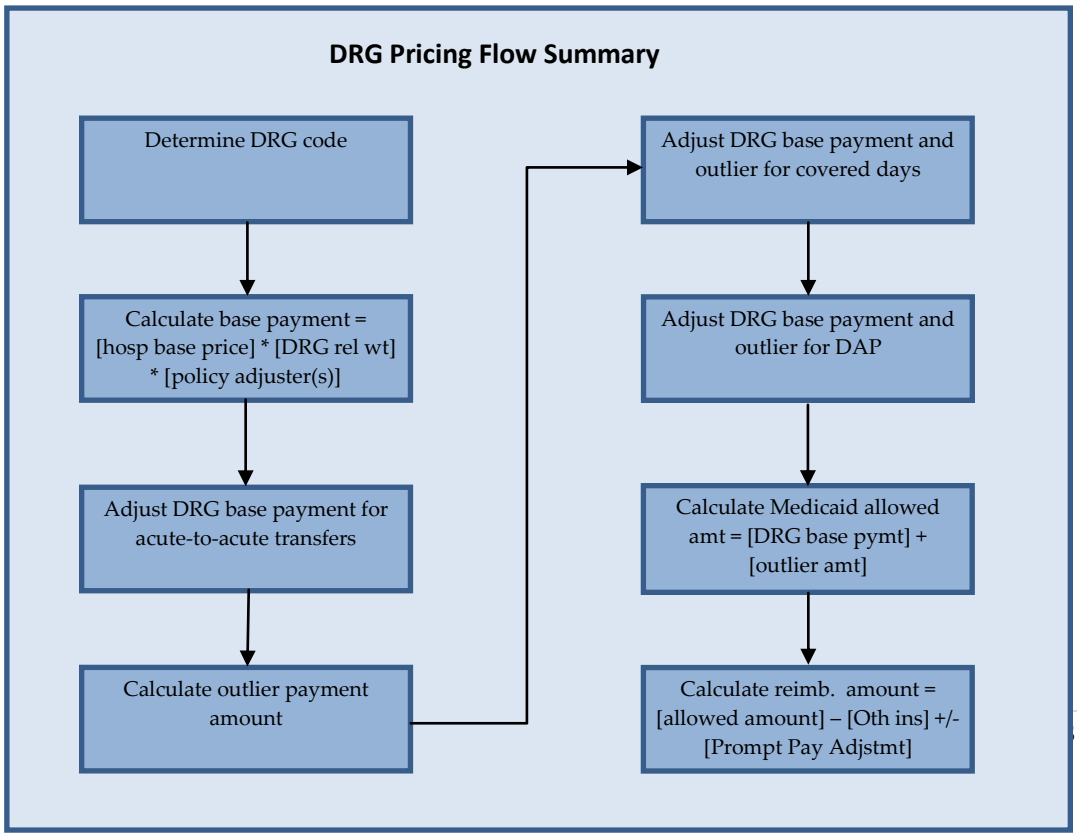
Payment under DRG pricing will comprise a DRG base payment and a DRG outlier add-on payment. Total payment will equal the sum of these two. DRG base payment is generally set to a hospital DRG base price times the DRG relative weight. In addition, a few payment factors referred to as "policy adjustors" will be applied under specific scenarios to affect the DRG base payment. The DRG outlier add-on payment will be cost-based and calculated based on a fixed-loss threshold.

The following are examples of the payment policy adjustors applied to the DRG base payment under specific scenarios,

- Provider specific policy adjustor
- Service specific policy adjustor – applied based on DRG assigned to the claim

2. DRG Pricing Formulas

With DRG pricing, claim payment is made up of a DRG base payment and, when applicable, an outlier add-on payment. The final allowed amount is the sum of the DRG base payment and the outlier add-on payment. In the pricing calculation, an unadjusted DRG base payment and an unadjusted outlier add-on payment are calculated. These values may then be adjusted based on covered days and/or, effective with dates of discharge on and after October 1, 2016, a Differential Adjusted Payment (DAP) Multiplier. A DRG pricing flow chart is given below and details of the pricing calculation are shown in the following pages.



DRG Base Payment

Initial DRG Base Payment will be calculated as:

Initial DRG Base Payment = [Wage Adjusted Provider DRG Base Rate]
** [Post-Health Care Acquired Condition DRG Relative Weight]*
** [Provider Policy Adjustor]*
** [DRG Service Policy Adjustor]*

The DRG Service Policy Adjustor will be determined based on the category of the DRG code found on the claim. Listed below are the DRG code categories along with the applicable DRG Service Policy Adjustor.

1. Normal newborn DRG codes: 1.550
2. Neonates DRG codes: 1.100
3. Obstetrics DRG codes: 1.550
4. Psychiatric DRG codes: 1.650
5. Rehabilitation DRG codes: 1.650
6. Burn DRG codes: 2.700

The applicable DRG Service Policy Adjustors for claims for members under the age of 19 for which the assigned DRG codes fall outside of the categories listed above are:

1. Severity of Illness 1 or 2: 1.250
2. Severity of Illness 3 or 4: 2.300

Where none of the DRG Service Policy Adjustors above apply to the claim, a DRG Service Policy Adjustor of 1.025 is applied the claim.

If the patient discharge status code is in the following list of codes for which the DRG transfer policy applies,

02: Discharged/transferred to a short-term general hospital for inpatient care
05: Discharged/transferred to a designated cancer center or children's hospital
66: Discharged/transferred to a critical access hospital

then the Transfer DRG Base Payment will be calculated as:

Transfer DRG Base Payment = [Initial DRG Base Payment]
/ [DRG National Average Length of Stay]
** [Length of Stay + 1]*

Note: The "DRG National Average Length of Stay" means the national arithmetic mean length of stay published in version 34 of the All Patient Refined Diagnosis Related Group (APR-DRG) classification established by 3M Health Information Systems.

Note: The "Length of Stay" means the total number of days of an inpatient stay beginning with the date of admission through the date of transfer, but not including the date of transfer.

If the patient discharge status code is in the list of codes for which the DRG transfer policy applies, then:

Unadjusted DRG Base Payment = lesser of [Initial DRG Base Payment] and [Transfer DRG Base Payment]

Otherwise,

Unadjusted DRG Base Payment = [Initial DRG Base Payment]

DRG Outlier Add-On Payment

Not all claims will qualify for a DRG outlier add-on payment. For those that do, the DRG outlier add-on payment will be added to the DRG Base Payment to determine the final payment for the claim. The outlier add-on payment is equal to the Claim Cost minus the Outlier Threshold, multiplied by the DRG Marginal Cost Percentage.

To determine if a claim will qualify for an outlier add-on payment, first the Claim Cost must be calculated. The Claim Cost will be calculated as:

*Claim Cost = {[Claim Total Submitted Charges] – [Claim Non-Covered Charges]} * Hospital Cost-to-Charge Ratio*

The Claim Cost must then be compared to the Outlier Threshold. The Outlier Threshold is calculated as:

Outlier Threshold = Unadjusted DRG Base Payment + Fixed Loss Amount

The Fixed Loss Amount is $5,000 for Critical Access Hospitals (CAH) and $65,000 for all other providers.

If the Claim Cost exceeds the Outlier Threshold, then the claim qualifies for a DRG outlier add-on payment; if the Claim Cost does not exceed the Outlier Threshold, the claim receives $0 DRG outlier add-on payment.

For claims that qualify for a DRG outlier add-on payment, the Unadjusted DRG Outlier Add-on Payment will be calculated as:

*Unadjusted DRG Outlier Add-on Payment = [Claim Cost – Outlier Threshold] * DRG Marginal Cost Percentage*

The DRG Marginal Cost Percentage is 90% for burn DRGs and 80% for all other DRGs. The base DRG codes for burn DRGs are 841, 842, 843, and 844.

Covered Day Adjustment

In some cases, not all days of the inpatient stay are payable by AHCCCS. Some examples are:

- Recipient is enrolled in the Federal Emergency Services Program (FES)
- Recipient gains Medicaid eligibility after admission into the hospital
- Recipient loses Medicaid eligibility after admission and before discharge

For each of these scenarios, a payment adjustment factor will be calculated in order to prorate the payment based on covered days. If the factor is greater than 1, it will be reduced to 1 so that the covered day adjustment never has the effect of increasing payment beyond the full DRG payment. The factor will be applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment.

The formulas for calculating the Covered Day Adjustment Factor are:

If recipient enrolled in the FES program:

Covered Day Adjustment Factor Unadjusted = {[AHCCCS Covered Days] + 1}
/ [DRG National Average Length of Stay]

Else if recipient gains Medicaid eligibility after admission then:

Covered Day Adjustment Factor Unadjusted = [AHCCCS Covered Days]
/ [DRG National Average Length of Stay]

Else if recipient loses Medicaid eligibility prior to discharge then:

Covered Day Adjustment Factor Unadjusted = {[AHCCCS Covered Days] + 1}
/ [DRG National Length of Stay]

The final covered day adjustment factor is calculated as:

If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then
Covered Day Adjustment Factor Final = 1.0
Else
Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]

The Covered Day Adjustment Factor Final gets applied to both the Unadjusted DRG Base Payment and the Unadjusted DRG Outlier Add-on Payment using the following formulas:

Covered Day Adjusted DRG Base Payment = [Unadjusted DRG Base Payment]
** [Covered Day Adjustment Factor Final]*

Covered Day Adjusted DRG Outlier Add-on Payment = [Unadjusted DRG Outlier Add-on Payment]
** [Covered Day Adjustment Factor Final]*

Note: The adjustment factors are applied separately to the DRG base payment and the outlier payment so that the percentage of total payment coming from outliers can be monitored.

Final Payment Adjustment

The DRG payment methodology was transitioned over two years (FFY 2015 through FFY 2016). For FFY 2015 and 2016 of DRG pricing, a provider-specific payment adjustment was applied to every claim paid via the DRG pricing method. The Provider DRG Transition Multiplier was a combination of two payment adjustments – one for the DRG transition policy and the second for anticipated improvement in documentation and coding (DCI). The transition to APR-DRG is now complete, and the Transition Multiplier is no longer applicable.

In its place, a Differential Adjusted Payment (DAP) Multiplier is applied as the last step in the DRG pricing logic. Where a hospital qualifies for DAP, the multiplier will increase the total DRG payment.

By applying this adjustment as the last step in the DRG pricing logic, final payment will be calculated as:

Final DRG Base Payment = [Covered Day Adjusted DRG Base Payment]
** [DAP Multiplier]*

Final DRG Outlier Add-on Payment = [Covered Day Adjusted DRG Outlier Add-on Payment]
** [DAP Multiplier]*

Final Allowed Amount = Final DRG Base Payment + Final DRG Outlier Add-on Payment

Final Reimbursement Amount = Final Allowed Amount – Other Insurance Payment
+/- Prompt Pay Adjustment

Note 1: The current prompt pay policy (slow pay penalties and quick pay discounts) will continue to apply. Refer to section 25 of this document for more information.

Note 2: A non-contracted urban hospital shall be reimbursed for inpatient services by an urban contractor at 95% of the final payment, unless otherwise negotiated by both parties.

3. Admit versus Discharge Date

DRG pricing and the DRG pricing logic are based on date of discharge. All hospital stays with a date of discharge ~~on or after~~ 10/1/2014 thru 12/31/2017 are priced using V31 of the DRG methodology and all dates of discharge on or after 1/1/2018 are priced using V34 of the DRG methodology. The Medicaid payer in effect on the date of discharge will always have responsibility for the full DRG for the entire AHCCCS stay. The day of discharge is never paid unless the member expires on the date of discharge.

4. Recipient Enrolled in Federal Emergency Services Program (FES)

Inpatient hospital services provided to recipients enrolled in the Federal Emergency Services Program (FES) are paid by the Administration under the fee-for-service program. Payment is limited to those services that meet the Federal definition of an emergency service, as determined through the Administration's Medical Review process.

The emergency portion of an inpatient hospital service is determined on a claim-by-claim basis by determining the number of days of service for each inpatient hospital claim that meet the Federal definition of an emergency. Any portion of a day during which the FES member receives treatment for an emergency medical condition is counted as an AHCCCS covered day. It is possible that an entire stay will meet the definition of emergency and no covered day adjustment factor will be applied.

DRG payment is designed to be payment for a complete hospital stay. For claims paid via DRG pricing in which only emergency services are reimbursed, payment will be prorated based on the number of AHCCCS covered days, if not all days of the stay meet the emergency definition. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as,

Covered Day Adjustment Factor Unadjusted = {[AHCCCS Covered Days] + 1} / [DRG National Average Length of Stay]

If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then
Covered Day Adjustment Factor Final = 1.0
Else
Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]

5. Enrollment Change during Hospital Stay

A recipient may change AHCCCS payers during a single hospital stay, while maintaining Medicaid eligibility throughout the entire stay. This may occur under a variety of scenarios including:

- A recipient changing enrollment from fee-for-service into a managed care plan
- A recipient changing enrollment from a managed care plan into fee-for-service
- A recipient changing enrollment between managed care plans within the same program
- A recipient changing enrollment between managed care plans in different programs, for example, moving from an Acute MCO to the Arizona Long Term Care System (ALTCS)

In these scenarios, services paid via the DRG method will be paid by the payer with which the recipient is enrolled on date of discharge, except as noted below. This payer will be responsible for reimbursement for the entire hospital stay, including any applicable outlier payment. If the member is eligible but not enrolled with a contractor on the date of discharge, the AHCCCS administration shall be responsible for reimbursing the hospital for the entire length of stay.

Unique to these scenarios, providers are expected to submit a claim to the appropriate payer with the “From” date of service (form locator 6 on the UB-04 paper claim form) equal to the first day in which the recipient was enrolled with that payer. This will avoid denial based on eligibility/enrollment edits. Under these scenarios, the “From” date of service for the payer responsible on the Date of Discharge will be later than the Date of Admission. The “Through” date of service is the date of discharge. The claim may include all surgical procedures (form locator 74 on the UB-04 claim form) applicable for the hospital stay (admit through discharge), even if these procedures were performed prior to the recipient’s enrollment with the payer responsible for reimbursement. However, except as described below for outliers, each payer’s claim should only include revenue codes, service units, and charges applicable to services performed during the covered days included on the claim (e.g. days between the “From” and the discharge date).

In the event the claim is expected to qualify as an outlier, the claim must include condition code 61 (Cost Outlier) indicating the provider’s desire for special outlier consideration. A claim that includes condition code 61 may include all revenue codes, service units, charges, and surgical procedures applicable for the full AHCCCS enrolled eligible hospital stay (admit through discharge), even if performed prior to the recipient’s enrollment with the payer responsible for reimbursement.

Interim claims submitted to a payer other than the one with which the recipient is enrolled on date of discharge shall be handled in the same manner as all other interim claims. See Issue Number 8.

Note: When the recipient changes enrollment from payer 1 to payer 2 during the inpatient stay such that the change to payer 2 is effective on the date of discharge, the AHCCCS administration will make a manual adjustment, upon request, to the system to reflect a change of enrollment effective the day after discharge to ensure that a single AHCCCS payer retains responsibility for paying the claim.

6. Medicare Dual Eligibles

Throughout the duration of a single hospital stay, a recipient dually eligible for Medicare and Medicaid may exhaust the allowable Medicare Part A benefit.

In the event a recipient exhausts Medicare Part A benefits during a hospital stay, a separate 0111 or 0851 bill type claim should be filed for services performed after the date the maximum Medicare Part A benefit is exceeded. On the UB-04 paper claim form or the 837 institutional submission, providers shall report the "From" date of service as the first day Medicaid is the primary payer (i.e. the day after Medicare benefits have been exhausted). The "Through" date of service reported on the claim should be the date of the discharge. The provider will include on the claim only the charges associated with the Medicaid portion of the stay (i.e. the "From" date of service through the "Through" date of service reported on the claim). All diagnosis codes describing the patient's medical condition may be included on the claim. However, the claim(s) should only include those revenue codes, surgical procedures, service units, and charges for services performed between the "From" and "Through" dates of service to ensure that Medicaid does not make a duplicate payment for services already covered for by Medicare. Since a separate claim is filed there is no proration of the claim; a full DRG payment will be paid for the Medicaid claim.

7. Administrative Days

For hospitals reimbursed under the DRG method for acute care services, AHCCCS may also offer reimbursement for Medicaid recipients occupying a bed while not in need of acute care. For example, this may occur prior to an acute care episode when an expecting mother stays in a hospital awaiting birth of a baby. This may also occur at the end of an acute care episode in which a recipient is awaiting placement in a nursing home or other sub-acute or post-acute setting.

Those days in which a member does not meet the criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available or the member cannot be safely discharged or transferred are referred to as administrative days. Administrative days also include discharges/transfers from one acute care facility to another when the receiving hospital provides sub-acute services to the member (see Issue Number 9). Administrative days do not include days when the member is awaiting appropriate placement or services that are currently available but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays. When prior authorized, administrative days will be reimbursed by

AHCCCS using a negotiated per diem rate. Reimbursement for administrative days will be separate from DRG reimbursement for acute care services.

To enable separate payment, administrative days must be billed on a different claim from acute care services. Administrative days are identified by the presence of a prior authorization for the member, the provider, and the dates of service that reflect an administrative rate. Further, administrative days for the provision of sub-acute services shall be billed with revenue code 016X (Room & Board).

When an acute care stay is followed by an administrative day stay, hospitals shall use patient discharge status 70 (Discharged/transferred to another type of health care institution not defined elsewhere in this code list) on the acute care claim. Likewise, when the opposite occurs – an administrative day stay is followed by an acute care stay –hospitals shall use patient discharge status 70 on the administrative day claim.

8. Interim Claims

A recipient may be in the hospital for an extended period of time. If a patient stay exceeds a 29 day period, hospitals may submit interim claims related to the patient stay in increments of 30 days. Interim claims will be reimbursed at a per diem rate of $500 per day.

Hospitals must submit a final claim associated with the patient stay upon the patient's discharge. The final claim should reflect all procedures performed and all charges incurred during the entire patient stay – admit through discharge unless dates of service on the claim must be limited due to changes in Medicaid eligibility or changes in payer enrollment during the stay. The final claim will be paid under the DRG payment methodology.

Single Medicaid Payer for Entire Stay
Hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided.

Multiple Medicaid Payers for Entire Stay
The initial Medicaid payer will recoup all interim payments at the time Medicaid enrollment changes to another Medicaid payer. To the extent that interim bills are submitted to and paid by the Medicaid payer in effect on the date of discharge, hospitals will be required to void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions in Issue Number 5, and paid by the Medicaid payer in effect on the date of discharge.

Medicaid Eligibility Changes During the Stay
A member may lose or gain Medicaid eligibility during an inpatient stay. To the extent there are interim bills submitted to and paid by the Medicaid payer, hospitals will be required to

void all interim bills prior to submitting the final claim for reimbursement. The final claim will not be reimbursed until all interim claims associated with the patient stay are voided. The final claim should be submitted in accordance with the instructions in Issues Number 10 and 11, and paid by the Medicaid payer in effect on the date of discharge or the date that eligibility changes.

See Issue Number 28 for information on reinsurance related to interim claims.

9. Transfer Policy

In the event a recipient is transferred from one acute care facility to another, payment to the "transferring" hospital will be subject to reduction (see clarification below regarding sub-acute services). The "transferring" and "receiving" hospitals will file separate claims and may result in different DRG assignments. Payment to the receiving acute care facility will follow standard DRG pricing rules and is not subject to transfer payment reduction unless the recipient is transferred again out of the receiving hospital.

The transfer payment methodology is applicable when a patient is transferred from one acute care facility to another, as identified by the following discharge status codes:

02: Discharged/transferred to a short-term general hospital for inpatient care
05: Discharged/transferred to a designated cancer center or children's hospital
66: Discharged/transferred to a critical access hospital

Under this transfer payment policy, DRG base payment for the transferring hospital will be calculated as follows:

Lesser of:

$$\text{Transfer DRG Base Payment} = \left[\left(\frac{\text{Initial DRG Base Payment}}{\text{DRG National Average Length of Stay}} \right) * (\text{Length of Stay} + 1 \text{ Day}) \right]$$

Or:

Initial DRG Base Payment

The base DRG payment reimbursed to the "transferring" hospital will be the lesser of the Transfer DRG Base Payment, as calculated above, or the calculated Initial DRG Base Payment for the full hospital stay. The base payment is a prorated per diem amount for each day the recipient is in the hospital prior to the transfer. One additional day is added to the length of stay to account for the disproportionate amount of costs related to the stabilization of the recipient prior to the transfer since the costs of stabilization are generally higher than the remaining days of the patient stay. In calculating the length of stay, the date of the discharge will not be included. The date of discharge is only payable by AHCCCS when the recipient expires in the hospital, which is not a scenario in which the transfer payment policy applies.

AHCCCS will allow outlier payments for the "transferring" hospital if the claim meets the outlier criteria. The outlier payment will be added to the base payment (i.e. the Transfer DRG Base Payment or the Initial DRG Base Payment as appropriate) to determine the final DRG payment.

Clarification Regarding Transfers for Sub-Acute Services: A recipient who no longer meets medical inpatient criteria may be discharged/transferred to another acute care facility without triggering a reduction to the transferring hospital via the 70 Discharge Status Code (Discharged/transferred to another type of health care institution not defined elsewhere in code list) for the provision of sub-acute services. Dates of service for sub-acute services shall be considered administrative days. See Issue Number 7 for information on payment of administrative days.

10. Recipient Gains Medicaid Eligibility after Admission

A recipient may be ineligible for Medicaid upon admission, however, may become eligible for Medicaid during his/her stay in the hospital. Under this circumstance, the DRG payment which is designed to cover the full hospital stay will be prorated based on the number of AHCCCS covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment is calculated as,

Covered Day Adjustment Factor Unadjusted = [AHCCCS Covered Days] / [DRG National Average Length of Stay]

If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then
Covered Day Adjustment Factor Final = 1.0
Else
Covered Day Adjustment Factor Final = [Covered Day Reduction Factor Unadjusted]

The covered day adjustment factor does not include one additional day to account for the first part of the stay when a disproportionate amount of costs are incurred since the recipient is not Medicaid eligible upon the admission of the stay. Rather the recipient gains eligibility at some point after admission.

When submitting a claim under this scenario, providers are expected to report the "From" date of service as the first date the recipient is eligible for reimbursement. Assuming the recipient is enrolled with Medicaid through discharge, the "Through" date of service will be set to the date of discharge. The number of AHCCCS covered days will be calculated as the "Through" date of service on claim less the "From" date of service. If the recipient expires in the hospital, the day of discharge is reimbursable and one day will be added to the number of AHCCCS covered days to account for date of discharge.

Only claims with dates of service where the recipient is enrolled with that payer will be accepted.

11. Recipient Loses Medicaid Eligibility Prior to Discharge

A recipient may be an eligible member upon admission, however, may lose eligibility during the duration of a single hospital stay. In this scenario, the DRG payment attributable to the entire stay will be prorated based on the number of AHCCCS covered days. The proration factor, which is referred to as the Covered Day Adjustment Factor, is maximized at 1.0 so that the prorated payment does not exceed full DRG payment. The Covered Day Adjustment Factor is calculated as,

Covered Day Adjustment Factor Unadjusted = [AHCCCS Covered Days + 1 Day]
/ [DRG National Average Length of Stay]

If [Covered Day Adjustment Factor Unadjusted] > 1.0 Then
Covered Day Adjustment Factor Final = 1.0
Else
Covered Day Adjustment Factor Final = [Covered Day Adjustment Factor Unadjusted]

One additional day is added to the length of stay to account for the disproportionate amount of costs related to the stabilization of the recipient since the costs of stabilization are generally higher than the remaining days of the patient stay.

When submitting a claim in this scenario, the date of admission and the first date of service should be the same. The “Through” date of service on the claim should be reported as the last date the recipient is enrolled with the Medicaid payer. The number of AHCCCS covered days will be calculated as the “Through” date of service less the date of admission.

Only claims with dates of service where the recipient is an enrolled member will be accepted.

12. Same Day Admit and Discharge

Inpatient claims with an admission date equal to the date of the discharge will be paid using the AHCCCS outpatient fee schedule methodology, including same day admission and discharge claims for maternity and nursery. Claims with a same date of admission and date of death will be reimbursed a full DRG payment. (See Issue Number 23)

13. Specialty Hospitals

Hospitals designated as type: hospital, subtype: short-term that have a license number beginning "SH" in the Provider & Facility Database for Arizona Medical Facilities posted by ADHS will be reimbursed under the DRG methodology, under a separate DRG base rate. Hospitals located in a city with a population greater than one million, which on average have at least 15 percent inpatient days for patients who reside outside of Arizona, and at least 50 percent of discharges as reported on the 2016 Medicare Cost Report are reimbursed by Medicare will also be reimbursed under a separate DRG base rate that will also be reimbursed under the DRG methodology. The DRG base rate for these providers will be reflected in the rate tables as with all other DRG providers.

14. Rehabilitation and LTAC Hospitals

Hospitals designated as rehabilitation and long term acute care (LTAC) hospitals will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate, including provisions for outlier payments, with provider designation of condition code 61 for consideration, where rates and outlier thresholds will be included in the capped fee schedule published by the Administration. If the covered costs per day on a claim exceed the published threshold for a day, the claim is considered an outlier. Outliers will be paid by multiplying the covered charges by the outlier CCR. The resulting amount will be the total reimbursement for the claim.

A new provider type (C4) is established to identify these providers and includes freestanding rehabilitation and LTAC providers.

15. Psychiatric Hospitals

Hospitals designated as freestanding psychiatric facilities will not be reimbursed under the DRG methodology. These facilities will be reimbursed under a separate per diem rate consistent with AHCCCS reimbursement policy for this provider type (71). There is no outlier provision.

16. Inpatient Claims for Recipients with Medicare Part B Only

The treatment of Medicare Part B payments on inpatient claims has not changed with the implementation of DRG pricing. On inpatient claims in which the Medicaid recipient has Medicare Part B coverage, has no Medicare Part A coverage, or the Medicare Part A coverage has been exhausted, final Medicaid reimbursement is calculated by subtracting the Medicare Part B payment amount from the Final Allowed Amount.

17. Carved-out Services Within Claims Paid Under DRG Methodology

With the exception of claims described under Issue Number 33, DRG payment when applied to an inpatient hospital claim will cover all inpatient services related to that stay. No services or supplies will be carved out or separately reimbursed.

18. Non-covered Charges

The current billing policy regarding the recording of non-covered charges remains unchanged. Hospitals shall report non-covered charges and AHCCCS shall consider them where appropriate.

19. Transplants

Transplant cases are exempted from DRG payment, and will continue to be reimbursed under the current methodology of contracted rates. The current methodology for identifying claims as transplants will remain the same. The evaluation component, when performed during an inpatient stay, will be paid under the DRG methodology (see Issue Number 31 for more information). Days in the hospital beyond the days covered by the transplant contract will be reimbursed via a per diem when primary payment for the hospital stay is covered under the transplant contract.

20. Negotiated Settlements

AHCCCS will continue to support the current claim dispute and settlement process. The grievance settlement process will be conducted after initial adjudication of the claim and providers will be expected to follow the current claim dispute process independent of whether claim payment is calculated using a per diem, DRG, or other payment methodology.

21. Detox / Behavioral Health versus Physical Health Diagnosis

A recipient admitted to a hospital may require both physical health treatment as well as psychiatric/behavioral health treatment. Only one claim will be submitted and reimbursed for a single hospital stay in which both physical and behavioral health treatment are necessary.

The principal diagnosis for the recipient for the hospital stay will determine if the claim will be submitted to the MCO under which the member is eligible or to the Tribal/Regional Behavioral Health Authority (T/RBHA) assigned to the member. An exception to this rule applies to members who are enrolled with integrated payers. Integrated payers are described more fully below. If the principal diagnosis on the claim is a physical health diagnosis, the claim should be submitted to the associated MCO and will be reimbursed under DRG methodology, if DRG pricing applies. If the principal diagnosis on the claim is a behavioral diagnosis, the claim should be submitted to the appropriate T/RBHA and will be reimbursed under a per diem rate consistent with AHCCCS reimbursement policy for behavioral health services.

When a member is enrolled with the following integrated payers, DRG pricing will apply regardless of principal diagnosis (if DRG pricing applies to the hospital):

- ALTCS Elderly & Physically Disabled (EPD) MCO
- CRS Fully Integrated
- CRS Partially Integrated – Behavioral Health (if the physical health diagnosis is NOT related to the CRS condition, the CMDP or DDD plan of enrollment is the payer)

When the member with Serious Mental Illness is enrolled with the integrated RBHA, pricing will apply as follows:

- If the principal diagnosis is a physical health diagnosis, DRG pricing will apply (if DRG pricing applies to the hospital)
- If the principal diagnosis is a behavioral health diagnosis, AHCCCS per diem pricing will apply

22. HCAC and POA

Health care acquired conditions (HCACs) are identified using the standard rules put forth by the Centers for Medicare and Medicaid Services (CMS). These rules include a finite list of diagnosis codes and surgical procedure codes. In some cases, the surgical procedure codes are considered to be a HCAC only if billed in conjunction with a specific diagnosis code, and only in the absence of a present on admission (POA) indicator.

For claims paid via the DRG methodology, AHCCCS will utilize DRG assignment to determine payment reductions in cases of health care acquired conditions. If a Medicaid recipient acquires a medical condition while in the hospital, that condition will be ignored when assigning a DRG code and calculating DRG payment.

To implement this policy, POA indicators will continue to be required on all inpatient claims. This is because the HCAC payment reduction policy only applies if the HCAC condition(s) were acquired in the hospital (after admission). POA indicators associated with each diagnosis code on the claim (except the admit diagnosis code) will be edited to ensure they are valid. Claims with invalid POA indicators will be denied. Diagnosis codes defined as exempt from POA reporting will not require a POA code. CMS publishes a list of diagnoses exempt from POA reporting annually.

The following values are valid for the POA indicator:

Y	Diagnosis was present at time of inpatient admission
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at the time of inpatient admission
W	Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
Blank	Diagnosis is exempt from POA reporting

Under the DRG pricing methodology, values of “N,” “U,” and “W” will all be interpreted as indicating the diagnosis was not present at the time of admission. This is consistent with

current AHCCCS policy applied to claims paid via per diem. Blank is a valid value only for diagnoses included on CMS' list of codes exempt from POA reporting.
Under the DRG payment methodology, two DRGs will be assigned to every claim, one referred to as a "pre-HCAC" DRG and a second referred to as a "post-HCAC" DRG. The "pre-HCAC" DRG is assigned using all diagnosis codes on the claim whether or not they were present on admission. The "post-HCAC" DRG is assigned after removing any diagnosis and/or procedure codes identified as HCACs.

On the rare cases where the pre-HCAC and post-HCAC DRGs are different, the DRG with the lower relative weight will be used to price the claim. This will almost always be the post-HCAC DRG, but logic will be implemented to compare both relative weights and select the DRG with the lower relative weight to price the claim.

23. Same Day Admit and Date of Death

Claims with a same date of admission and date of death will be reimbursed a full DRG payment. Providers must report the discharge status code of 20 on the claim indicating death.

24. Out-of-State Hospitals

Acute care services provided by out-of-state providers will be reimbursed under the DRG methodology. Out-of-state hospitals determined by the Administration to be high volume out-of-state hospitals will be reimbursed using hospital-specific Wage Adjusted Provider DRG Rates and hospital-specific Cost-to-Charge Ratios. All other out-of-state hospitals will be reimbursed using a uniform Wage Adjusted Provider DRG Rate and a uniform Cost-to-Charge Ratio. Out-of-state hospitals are not eligible for the Provider Policy Adjustor or the Differential Adjusted Payment Multiplier.

25. Slow Pay Penalties and Quick Pay Discounts

The Administration will continue to support the current slow pay penalty and quick pay discount policies. The Administration will calculate the quick pay discounts and slow pay penalties on the Final Allowed Amount for providers classified as types 02 and C4, excluding IHS and 638 providers, billed on the UB-04 claim form.

A quick pay discount of 1 percent will continue to be applied to claims paid within 30 days. The slow pay penalty will continue to be based on a 30 calendar day month, as illustrated below:

Claim paid within 31-60 days of clean claim date:	0% discount/penalty
Claim paid within 61-90 days of clean claim date:	1% penalty
Claim paid within 91-120 days of clean claim date:	2% penalty

The slow pay penalty will continue to accrue at a rate of 1 percent per month or partial month until the claim is paid by AHCCCS.

26. Readmission Policy

A recipient may be readmitted to a hospital after receiving a service or treatment. For claims paid via the DRG methodology, the Administration will identify certain readmission cases and conduct a medical review prior to finalizing payment associated with the readmission claim.

The following criteria will prompt a medical review:

1. Recipient must be readmitted to the same hospital within 72 hours, and
2. The base DRG assignment on the readmission claim must match the base DRG assignment on the initial claim (the base DRG assignment is identified by the first three digits of the DRG code), and
3. In the event that the claim has been prior authorized, the readmission claim may be considered to have already gone through medical review.

If the claim associated with the readmission meets the criteria above, the claim will be pended for medical review. The payment associated with the readmission claim will be held until the completion of the medical review process. Upon the medical review, if the readmission is determined to have been preventable by the hospital, the payment associated with the readmission claim will be disallowed. Alternatively, if upon the medical review it is determined the hospital would not have been able to prevent the readmission, the claim will be paid under DRG methodology.

Specific criteria for identifying preventable readmissions by a hospital during the medical review process will be developed. The criteria will be the same for FFS as well as MCO claims.

The Administration may consider monitoring readmission rates across providers and may consider future rate adjustments for providers with potentially preventable rates in excess of their peers or some established standard.

27. Reinsurance

Any final claims which cross over contract years will not be eligible for reinsurance.

The Administration will not pay reinsurance on interim claims. The final claim submitted by a hospital associated with the full length of the patient stay will be eligible for reinsurance consideration as long as the days of the hospital stay do not cross contract years.

As of 10/1/2018 the following statement will no longer apply:

AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.

28. Non-covered Services

Charges associated with use of robotic technology will be disallowed when claims are reviewed for outlier consideration.

29. Newborn Birth Weight Reporting

For claims submitted related to newborns, providers should include the birth weight of the newborn on all claims in which the age of the newborn is fourteen (14) days or less. Birth weight should be communicated in a value amount field with an associated value code equal to 54. Birth weight should be billed as a number of grams.

For claims submitted related to newborns under the following additional circumstances, the provider should include the birth weight of the newborn:

- Age at admission = 15-28 days and principal diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures.
- Age at admission = 15-28 days with a secondary diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures.

Refer to the relevant list of principal and secondary diagnoses contained in the 3M APR-DRG documentation.

30. Hemophilia HCPCS / NDC Reporting

For claims which include Hemophilia drugs, providers should include the appropriate HCPCS, NDC code and units, on the corresponding Pharmacy revenue code.

31. Inpatient Services Preceding Transplant

During a hospitalization in which transplant services are performed (where those services are governed under specialty transplant contracts between AHCCCS and the hospital, and paid under component pricing) a recipient may first receive inpatient hospital services that are not related to the any transplant components. These services are paid under the APR-DRG methodology.

In the event a recipient receives services during an inpatient stay prior to the “Prep and Transplant” component, services should be billed separately on an admit through discharge claim with a bill type of 0111 or 0851 and a Discharge Status code of 70. The begin date of service reported should be equal to the original admission date of the member. The date of discharge will be the initial date of the prep and transplant and will correspondingly be billed as part of the transplant component. Accommodation days must be equal to the number of

days in the UB04 claim less day of discharge. All diagnosis codes describing the patient's medical condition may be included on the claim and should reflect only the services that are not related to any component of the transplant. Since the claim is filed separately, there is no proration of the claim and a full DRG payment will be paid.

32. Hospital Presumptive Eligibility

DRG claims will be submitted to the recipient's health plan on the date of discharge. AHCCCS and its contractors will not accept split billing of these claim types.

33. Long Acting Reversible Contraceptives (LARC)

Effective for dates of discharge on and after 10/01/2016, Long Acting Reversible Contraceptive (LARC) devices are permitted to be separately reimbursed outside of the DRG payment when billed by the hospital on a professional form 1500 or on and after 10/01/2017 on an Outpatient form UB04 with the appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code. AHCCCS-identified LARC procedure codes are as follows:

- J7297 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg, 3 Year Duration
- J7298 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg, 5 Year Duration
- J7300 Intrauterine Copper Contraceptive
- J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg
- J7307 Etonogestrel (Contraceptive) Implant System, Including Implant And Supplies

Revision History

Date	Description of changes	Page(s)
6/21/18	Due to an update in PPC, the following statement will no longer apply as of 10/1/18: AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted. To correct this, we have changed it to the following: <u>As of 10/1/2018 the following statement will no longer apply:</u> AHCCCS will not pay reinsurance on claims containing any Prior Period Coverage (PPC) for regular and catastrophic reinsurance types. Splitting claims for the purpose of separating PPC from prospective enrollment is not permitted.	20

Chapter posted 6/8/18 Update to the AHCCCS transition to DRG web page completed on 1/1/2018	The entire DRG policy was updated on 1/1/2018, on the AHCCCS web page. The information contained in this chapter matched, however the billing manual chapter and the formal DRG policy will now be one and the same.	All

CHAPTER 12 ~ PHARMACY SERVICES

Chapter 12 ~ Pharmacy Services

REVISION DATES: 10/1/2018; 3/22/2018; 2/16/2018; 12/29/2017; 10/08/2015;10/01/2015; 12/31/2012; 12/06/2012

Covered Services

Medically necessary, cost-effective, and CMS Covered Outpatient Drugs prescribed by a physician, physician's assistant, nurse practitioner, dentist, or other AHCCCS registered practitioner and dispensed by an AHCCCS registered licensed pharmacy are covered for members consistent with 9 A.A.C. 22 Article 2, 9 A.A.C. 28 Article 2, and 9 A.A.C. 31 Article 2 and for persons who have a diagnosis of Serious Mental Illness (SMI), pursuant to A.R.S. §36-550.

The AHCCCS Fee-For-Service (FFS) Acute/LTC Drug List and the AHCCCS FFS TRBHA Drug List contain CMS Covered Outpatient Drugs and medications that are preferred in specific therapeutic drug classes. These drug lists are also known as the AHCCCS FFS Drug Lists. The AHCCCS FFS Drug Lists contain medications that are listed in accordance with the AHCCCS Medical Policy Manual Policy 310-V Prescription Medications / Pharmacy Services.

The AHCCCS FFS Drug Lists are not all-inclusive lists of medications for AHCCCS members. Drug coverage includes all medically necessary, clinically appropriate, and cost-effective medications that are CMS Covered Outpatient Drugs, regardless of whether or not these medications are included on these lists.

Questions regarding pharmacy benefits and services may be directed to the AHCCCS Director of Pharmacy Services Program Administrator at (602) 417-4726 or to the Pharmacy Department's email at AHCCCSPharmacyDept@azahcccs.gov

Specific Parameters of the AHCCCS FFS Pharmacy Benefit

The AHCCCS Pharmacy Program and its Pharmacy Benefit Manager (PBM):

1. Shall utilize a mandatory generic drug substitution policy unless AHCCCS has required the use of a brand name medication. The substitution of a generic drug in place of a brand name drug is required if the generic drug is available and contains the same active ingredient(s) and both products, the brand name and generic, are chemically identical in strength, dosage form and route of administration. Generic substitutions shall adhere to Arizona State Board of Pharmacy rules and regulations.

   Exceptions to this policy include:

a. Members intolerant to a generic medication. The prescribing clinician shall submit a prior authorization request, providing clinical justification for the brand name medication, to the contracted PBM; and

b. AHCCCS has determined that the brand name medication is less costly to the program.

2. May utilize step therapy to ensure that the most clinically appropriate cost-effective drug is prescribed and tried by the member prior to prescribing a more costly clinically appropriate medication.

   Exceptions to this requirement include members enrolled in an AHCCCS Complete Care (ACC) health plan, who have been stabilized on a medication and are transitioning from a T/RBHA to a PCP for their behavioral health needs. The medication, prescribed by the behavioral health practitioner must be clinically appropriate and continued at the point of transition.

3. May utilize prior authorization to ensure clinically appropriate medication use. Requests submitted for prior authorization of a medication must be evaluated for clinical appropriateness based on the strength of the scientific evidence and standards of practice that include, but are not limited to, the following:

   a. Food and Drug Administration (FDA) approved indications and limits;
   b. Published practice guidelines and treatment protocols;
   c. Comparative data evaluating the efficacy, type and frequency of side effects, and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes;
   d. Member adherence impact;
   e. Drug Facts and Comparisons;
   f. American Hospital Formulary Service Drug Information;
   g. United States Pharmacopieia;
   h. DRUGDEX Information System;
   i. UpToDate;
   j. MicroMedex;
   k. Peer reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies; and
   l. Other reference sources.

   All CMS Covered Outpatient drugs that are not listed on the AHCCCS FFS Drug Lists may be eligible for coverage through the prior authorization process.

   Prescribers may submit a prior authorization request to the AHCCCS FFS PBM, OptumRx, for review and coverage determination. The Prior Authorization Form can be found in:

- The FFS Provider Billing Manual as Exhibit 12-1 under the Pharmacy Services chapter.
- The IHS/Tribal Provider Billing Manual as Exhibit 10-1 under the Pharmacy Services chapter.

The PA form is also available on the AHCCCS website at www.azahcccs.gov under the Resources section. Under the this section click on Pharmacy and then go to Pharmacy Member Information-American Indian Health Program and the Drug Prior Authorization Form is listed under this section.

4. May cover an over-the-counter medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication.

5. Allows CMS Covered Outpatient Drugs dispensed by an IHS/638 facility pharmacy and submitted to the AHCCCS Administration for reimbursement at the All Inclusive Rate (AIR) to not be subject to prior authorization.

AHCCCS FFS Pharmacy Exclusions

The following are excluded from coverage under the outpatient FFS pharmacy benefit:

1. DESI Drugs that are determined to be “less than fully effective” by the Food and Drug Administration;

2. Experimental/Research Drugs;
3. Cosmetic Drugs;
4. Cosmetic Drugs for Hair Growth;
5. Nutritional/Diet Supplements;
6. Blood and Blood Plasma Products;
7. Drugs and Products to Promote Fertility;
8. Drugs used for Erectile Dysfunction Drugs;
9. Drugs from manufacturers that do not participate in the FFS Medicaid Drug Rebate Program;
10. Diagnostic /Medical Supplies except:
    a. Syringes
    b. Needles
    c. Lancets
    d. Alcohol Swabs
    e. Blood Glucose Meters and Test Strips
    f. Inhaler Sprays
12. Intrauterine Devices

Prescription Drug Coverage Limitations

1. A new prescription or refill prescription in excess of a 30-day supply or a 100-unit dose is not covered unless:
   a. The medication is prescribed for chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater;

   b. The member will be out of the provider's service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater; or

   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.

2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies as outlined in AMPM 310-DD.

3. AHCCCS covers the following for AHCCCS members who are eligible to receive Medicare:

   a. Over the counter medications that are not covered as part of the Medicare Part D prescription drug program when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication; and

   b. A drug that is excluded from coverage under Medicare Part D by CMS and the drug is medically necessary, and federally and state reimbursable.

4. Drugs personally dispensed by a physician or dentist, or other authorized prescriber are not covered. Exceptions may be granted upon application and approval by AHCCCS for registration as a pharmacy provider in geographically remote areas where there is no participating pharmacy.

AHCCCS Pharmacy Benefit Manager (PBM)

All Fee-For-Service prescription claims must be submitted electronically at the point-of-sale to the AHCCCS contracted PBM, Optum Rx.

The OptumRx Help Desk is available 24 hours per day and 365 days per year. For information or assistance with prescription claims, prior authorization, contracted network pharmacies, or the AHCCCS FFS Drug List, please contact the OptumRx Customer Service Help Desk at (855) 577-6310.

The OptumRx Prior Authorization Department's hours of operation are:

Monday through Friday: 7:00 AM – 6:00 PM Central Standard Time
Saturday: 8:00 AM – 4:30 PM Central Standard Time

For assistance with online claim submissions, contact the OptumRx Customer Service Help Desk at 855-577-6310.

Some medications on the AHCCCS Drug List require prior authorization approval from OptumRx. If a prescription claim rejects at the point-of-sale for "NDC Not Covered" or "Prior Authorization Required," the pharmacist should contact the prescribing clinician to request an alternative on the AHCCCS FFS Drug List. If there is not an available alternative medication, the pharmacist should inform the prescriber that a prior authorization request for the medication must be submitted to the PBM for review.

- All prior authorization requests must be submitted by the prescribing clinician to OptumRx.
- The OptumRx PA Request Form (See Exhibit 12-1) is to be faxed to **866-463-4838**.
- Prior Authorizations may be faxed 24 hours per day, 7 days per week, and 365 days per year.

After Hours Instructions

After 5:00 p.m. on weekdays, on weekends, and holidays, please contact the OptumRx Customer Service Desk, at (855) 577-6310 for an override if the medication is for:

- A hospital discharge;
- Members transitioning from one level of care to another;
- Urgent care or emergency room prescriptions; and
- Other emergent situations.

Return of and Credit for Unused Medications

The AHCCCS FFS Program and its Contractors shall require the return of unused medications to the outpatient pharmacy from nursing facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge or death of a Medicaid member. A payment credit shall be issued for unused prescription medications by the outpatient pharmacy to the AHCCCS FFS PBM or the appropriate Contractor. The pharmacy may charge a reasonable restocking fee as agreed upon with the AHCCCS FFS Program or its PBM.

The return of unused prescription medication shall be in accordance with Federal and State laws. Arizona Administrative Code (A.A.C. R4-23-409) allows for this type of return and the redistribution of medications under certain circumstances.

Documentation must be maintained and must include the quantity of medication dispensed and utilized by the member. A credit must be issued to AHCCCS when the unused medication is returned to the pharmacy for redistribution.

Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications shall not be billed to AHCCCS. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician-administered drug is not covered because it's not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

Prior Authorization Protocol for Smoking Cessation Aids

AHCCCS has established a prior authorization protocol for smoking cessation aids. Refer to the AHCCCS Medical Policy Manual (AMPM) Policy 320-K, Tobacco Cessation Product Policy for further information.

Vaccines and Emergency Medications Administered by Pharmacists

AHCCCS covers vaccines and emergency medication for adults without a prescription order when administered by a pharmacist, who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law A.R.S §32-1974.

IHS and 638 Pharmacies may bill the outpatient AIR one time which includes the vaccine and the administration of the vaccine.

For purposes of this section "Emergency Medication" means emergency epinephrine and diphenhydramine. "Vaccines" are limited to AHCCCS covered vaccines for adults as noted in the AHCCCS Medical Policy Manual (AMPM) Policy 310-M, Immunizations.

In addition to the requirements specified in A.R.S. § 32-1974, AHCCCS requires the following:

1. The pharmacy providing the vaccine must be an AHCCCS registered provider;
2. IHS and 638 Pharmacies must be registered with AHCCCS; and
3. The AHCCCS member receiving the vaccine must be age 19 years or older.

Prior Authorization Criteria for Direct Acting Antiviral Treatment for Hepatitis C

AHCCCS has established a prior authorization protocol for direct acting antiviral treatment for Hepatitis C. Please refer to the AHCCCS Medical Policy Manual (AMPM) Policy 320-N, Hepatitis C (HCV) Prior Authorization Requirements for Direct Acting Antiviral Medication Treatment for further information.

Billing for Pharmacy Services

Prescription medications may be reimbursed by the AHCCCS Administration or the Fee-For-Service (FFS) Pharmacy Benefit Manager (PBM), OptumRx, depending upon the member's enrollment and filling pharmacy, which are detailed in the table below:

Program/Member Type	Enrollment in AIHP, AHCCCS Complete Care (ACC), Kidscare or TRBHA	Pharmacy Dispensing Medication	Claims Shall Be Submitted To:
Title XIX Members	AIHP, ACC, and TRBHA	IHS/638 Pharmacies	AHCCCS Administration
Title XIX & XXI Members	AIHP and TRBHA	Non-IHS/638 PBM Network Pharmacies	FFS PBM – OptumRx
Title XIX & XXI Members	ACC	Non-IHS/638 PBM Network Pharmacies	The ACC Plan's PBM
Title XXI Members	Kidscare members enrolled in AIHP & TRBHA	All IHS/638 and non-IHS/638 PBM Network Pharmacies	FFS PBM – Optum Rx

The AIR may be billed for adults 19 years of age and older, when a prescription is filled at an IHS/638 facility pharmacy. The AIR for prescription services may be billed once daily, per member, per facility pharmacy. Up to five AIRs may be billed daily, per member, per facility and they must be qualifying non-duplicative visits.

In a case where more than one prescription is prescribed and filled on the same day, at the same facility, for the same member, the NDC codes for all of the filled prescriptions must be included on that day's claim submission for the AIR, however, only one AIR shall be reimbursed.

Example: A member is seen at an IHS 638 facility and has a dental visit, a PCP visit, and is prescribed 1 medication during the dental visit for pain and 2 medications during the PCP visit. All visits occur at the same IHS 638 facility. The member has all 3 prescriptions filled on the same day.

In this scenario three AIRs may be billed for reimbursement. One AIR may be billed for each of the following:

- The dental visit;
- The PCP visit; and
- All 3 prescriptions.

The claim submitted for the three prescriptions must include all 3 NDC codes.

340B Reimbursement

A.R.S. §36-2930.03. requires:
1. 340B covered entities to submit AHCCCS Member point-of-sale prescription and physician-administered drug claims, that are identified on the 340B pricing file, whether or not the drugs are purchased under the 340B drug pricing program at the lesser of:
a. The actual acquisition cost, or
b. The 340B ceiling price.

2. Drugs dispensed to AHCCCS members by a 340B covered entity pharmacy shall be reimbursed a professional fee.

3. Drugs administered to AHCCCS members by a 340B covered entity provider shall not be reimbursed a professional fee.

4. The administration and its contractors shall not reimburse 340B Contracted Pharmacies for drugs that are purchased, dispensed or administered as part of or subject to the 340B drug pricing program.

Licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital are excluded from this statute.
For additional details on claim submission and reimbursement refer to A.R.S. §36-2930.03

A.A.C. R-9-22-710(C) describes the reimbursement methodology to be used by AHCCCS and its Contractors for Federally Qualified Health Center (FQHC) and FQHC Look-Alike Pharmacies for 340B drugs as well as reimbursement for Contract Pharmacies that have entered into a 340B drug purchasing arrangement with any 340B entity. The Rule also specifies reimbursement for FQHC and FQHC Look-Alike Pharmacies for drugs, which are not part of the 340B Drug Pricing program. The rule is located on the A.A.C. R9-22-709.

Behavioral Health Medication Coverage

For information about prescription medication coverage for behavioral health please see AMPM 310-V, Prescription Medications-Pharmacy Services, Section C.

Medication Assisted Treatment (MAT) for Opioid Use Disorder

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A

combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

The AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a Primary Care Provider (PCP) when used to treat Opioid Use Disorder (OUD). For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

For further information regarding MAT please refer to AMPM 510, Primary Care Providers.

REFERENCES

- The AHCCCS Medical Policy Manual (AMPM) can be found at https://www.azahcccs.gov/shared/MedicalPolicyManual/.
- Refer to AMPM 310-V Prescription Medications/Pharmacy Services for further information about pharmacy coverage.
- Refer to AMPM-510 Primary Care Providers for further information about Opioid Use Disorders and Medication Assisted Treatments.
- Refer to AMPM Policy 320-K, Tobacco Cessation Product Policy for further information about smoking cessation aids.
- Refer to AMPM 320-N, Hepatitis C (HCV) Prior Authorization Requirements for Direct Acting Antiviral Medication Treatment for further information about Direct Acting Antiviral Medication Treatments for Hepatitis C.
- Refer to AMPM Policy 320-M, Medical Marijuana for further information on medical marijuana.
- Section 1903(i)(10) of the Social Security Act as amended by Section 6033 of the Deficit Reduction Act of 2005
- Center for Medicare and Medicaid Services (CMS) State Medicaid Director Letter dated March 22, 2006
- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) section 1860D-2(e)(2)(A) as amended by Section 175.
- Arizona Revised Statute § 32-1974

- Arizona Administrative Code R-9-22-710

REVISION HISTORY

Date	Description of changes	Page(s)
10/1/18	Clarification added to the Covered Services section. • "Federally and state reimbursable medications" changed to "CMS Covered Outpatient Drugs." 1 • Added: "The AHCCCS Fee-For-Service (FFS) Acute/LTC Drug List and the AHCCCS FFS TRBHA Drug List contain CMS Covered Outpatient Drugs and medications that are preferred in specific therapeutic drug classes." The Specific Parameters of the AHCCCS Pharmacy Benefit section was updated. • "Managed care" changed to "AHCCCS Complete Care health plan." • "…and members who are being treated for anxiety, depression, ADHD and/or OUD" was removed. Clarification added to the Vaccines and Emergency Medications Administered by Pharmacists section. The Billing for Pharmacy Services grid has been updated to include information about where claims should be submitted for Title XIX and XXI members.	1 2 6 7
3/22/18	The FFS Pharmacy Exclusions section has been updated	3
2/16/18	Billing for Pharmacy Services grid added AIR Claims Billing Specifications for Title XIX Members section added AIR Claims Billing for Title XIX Dual Eligible Members section updated AIR Claims Billing Specifications for Title XXI Members section added Pharmacy department updates General formatting	7 8 8-9 9 All All
12/29/17	Prior Authorization Criteria for Direct Acting Antiviral Treatment for Hepatitis C Section/Reference Added Behavioral Health Medication Coverage Section/Reference Added Medication Assisted Treatment (MAT) for the Treatment of OUD Section Added References Updated General formatting	7 9 9 9-10 All

	Updating of phone numbers and links	All
10/8/2015	New formatting; New PBM vendor effective 10/01/2015 - OptumRX	All & Exh 12-1
12/31/2012	Section title alpha corrections	All
10/01/2012	New PBM vendor – MedImpact effective 10/01/2012	All

Exhibit 12-1 ~ OptumRx Prior Authorization Request

- **Please see the exhibit attachment underneath the individual chapters for the PDF file of the OptumRx Prior Authorization Request Form.**

Arizona Health Care Cost Containment System (AHCCCS)
Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Prescriber:
Pharmacy:
Patient:

Effective 10/01/2015
Optum Rx Prior Authorization Department
P.O. Box 5252
Lisle, IL 60532- 5252

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This Medication Request Form is only for use by prescribing clinicians for AHCCCS FFS members and must be signed by the prescribing clinician. In addition to member identifying data, the prescribing clinician must provide the medication requested, the dosage and the clinical justification/rationale for the request. If the request is for a drug not listed on the AHCCCS Drug List, the documentation must demonstrate why the member cannot use the medication(s) listed on the drug list. The Medication Request Form is also used to request overrides for step therapy, quantity limits and other edits. If you have any questions regarding this process, please contact Optum Rx's Customer Service at (855) 577-6310. **Please complete this form and fax to Optum Rx at (866) 463-4838.**

Retail & Long Term Care Pharmacy Instructions for After Hours Emergencies, Hospital Discharges & Care Transitions
The participating network pharmacy staffs are to contact the Optum Rx's Customer Service Unit at (855) 577-6310 to request medication overrides for after-hours emergencies, hospital discharges or patients transitioning from the hospital to a lower level of care; this also includes antibiotics infusion requests.

☐ CHECK HERE IF THE PATIENT IS A DIRECT TRANSFER FROM A HOSPITAL TO A LONG TERM CARE FACILITY.

☐ CHECK HERE TO REQUEST AN EXPEDITED (URGENT) REVIEW: BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION.

Medication Request Information (please complete each section of this form prior to submission): *Denotes Required Fields

PATIENT INFORMATION		PRESCRIBING CLINICIAN INFORMATION	
*Name:		*Name:	
*ID#:		*Specialty:	
*Date of Birth:		ID# / DEA#:	
*Health Plan:		*Phone: ( ) -	*Fax: ( ) -
*Diagnosis (ICD-10 Code, if known):			
REQUESTED DRUG INFORMATION		**PHARMACY INFORMATION**	
*Requested Drug:		Name:	
*Dose:	*Strength:	Phone: ( ) -	Fax: ( ) -
*Quantity: (per month)	Dosage Form: (Oral, Injection, etc.)	*Length of Treatment: (Please be specific.)	
*Clinical Justification for the Requested Medication:			
*Other Medications Tried and/or Failed (Please be specific, give detail.):			
Additional Information / Other Pertinent History:			
*Prescriber Signature Required:			*Date:

CHAPTER 13 ~ DME, ORTHOTICS, PROSTHETICS, & MEDICAL SUPPLIES

Chapter 13 ~ DME, Orthotics, Prosthetics, & Medical Supplies

REVISION DATES: 10/1/2018; 1/23/2018; 10/01/2017; 08/03/2015; 12/15/2014; 09/11/2013; 05/31/2012

GENERAL INFORMATION

NOTE: The covered services, limitations, and exclusions described in this chapter provide general guidance to providers. For a more comprehensive, updated summary of AHCCCS coverage and requirements, please review Arizona Administrative Code (A.A.C.) R9-22-201 et seq. and the AHCCCS Medical Policy Manual (AMPM). The AMPM is located at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/

More detailed information regarding medical equipment, appliances, and supplies may be found in AMPM 310-P, Medical Equipment, Medical Appliances, and Medical Supplies. Additional information on orthotics and prosthetics may be found in AMPM 310-JJ, Orthotic and Prosthetic Devices.

Effective date of service 10/1/17, in accordance with CFR § 440.70, the initiation of Medical Equipment, Appliances and Supplies (hereafter referred to as medical equipment and supplies) will be subject to face-to-face encounter requirements for the Fee-For-Service (FFS) population.

OVERVIEW

AHCCCS covers reasonable and medically necessary medical equipment, appliances and supplies; orthotic devices and prosthetic devices when ordered by an AHCCCS registered primary care provider, a physician, or a dentist within certain limits based on member age and eligibility. Per 42 CFR 455.410 a provider must be registered with AHCCCS in order to be reimbursed. For additional information on compliance with 42 CF 455.410 refer to Chapter 3, Provider Records and Regulations.

> Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice.

Definitions

For purposes of this policy:

- **Medical equipment and appliances** are any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic; and

1. Is customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness, disability, or injury;
2. Can withstand repeated use; and
3. Can be reusable by others or removable.

Medical equipment and appliances are often referred to as Durable Medical Equipment (DME).

- **Medical supplies** are health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].

- **Prosthetics** are devices that are prescribed by a physician or other licensed practitioner to artificially replace a missing, deformed or malfunctioning portion of the body, such as artificial upper and lower limbs (R9-22-212).

- **Orthotics** are devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, or prevent or correct physical deformity or malfunction, (42 CFR 440.120, AAC R9-22-212).

Medical equipment and appliances are used to assist members in optimizing their independence and maintaining placement in the most integrated setting. This may include an institutional setting as appropriate. An example for the institutional setting is the authorization of customized medical devices such as wheelchairs. Criteria for the authorization of a customized wheelchair must be the same regardless of setting as each setting is considered the member's home.

Incontinence Supplies

AHCCCS covers incontinence briefs for members over age 3 and under age 21 as described in AMPM 430, EPSDT Services.

AHCCCS covers incontinence briefs for acute members 21 years of age and older, when they are necessary to treat a medical condition, as described in AMPM 310-P, Medical Equipment, Medical Appliances and Medical Supplies.

AHCCCS covers incontinence briefs for ALTCS members over age 21 in order to prevent skin breakdown, when the conditions described in AMPM 310-P, Medical Equipment, Medical Appliances and Medical Supplies, are met.

Medical Equipment and Appliances Supplied as a Part of a Hospital Inpatient Admission or Outpatient Treatment

For all AHCCCS members, no separate payment is made for medical equipment and appliances supplied as part of a hospital inpatient admission or outpatient treatment.

When medical equipment and/or appliances are supplied by the hospital during an inpatient stay or outpatient treatment *and are a part of the treatment the member is receiving*, then those supplies are not reimbursed separately, even if the member takes that medical equipment and/or appliance home for further use upon discharge. Emergency room visits and observation stays, not resulting in a member admission, are considered an outpatient treatment visit.

> Note: In the above circumstances, no separate payment for the medical equipment and/or appliance(s) may be made to the hospital by AHCCCS.

Medical equipment and appliance suppliers may submit separate claims for medical equipment and appliances provided to an AHCCCS member while inpatient in a hospital facility if that medical equipment and/or appliance was provided to facilitate discharge of the member from the hospital and was neither necessary for nor used as part of the treatment the member received while an inpatient.

When medical equipment and appliances are provided to an inpatient member more than two days prior to their discharge, the medical equipment and appliances are presumed to have been used as part of the member's treatment and recovery during their hospital stay, so may not be claimed separately.

Medical equipment and appliances and supplies are an ALTCS-covered service for members receiving Home and Community Based Services (HCBS). Medical equipment and appliances and supplies are also covered for members residing in nursing facilities if they are not included under the facility's per diem rate and if ordered by a physician or primary care practitioner and approved by the case manager.

Outliers

Non-covered prosthetic/orthotic devices are not included when determining whether an inpatient stay qualifies as an outlier.

If an inpatient stay does qualify as an outlier without considering charges for non-covered devices, the charges for those devices are not included in the outlier payment calculations.

FACE-TO-FACE ENCOUNTER REQUIREMENTS

Effective date of service 10/1/17, in accordance with CFR § 440.70, the initiation of medical equipment and supplies will be subject to face-to-face encounter requirements for the FFS population. The face-to-face encounter must meet the following criteria:

1. It must relate to the primary reason the member requires the medical equipment and/or supplies.

2. It must occur no more than six months prior to the start of services.

3. The-face-to-face encounter must be conducted by one of the following:
   a. The ordering physician,
   b. A nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law,
   c. A physician assistant under the supervision of the ordering physician, or
   d. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The non-physician practitioner specified above, who performs the face-to-face encounter, must communicate the clinical findings of the face-to-face encounter to the ordering physician.

5. The clinical findings must be incorporated into a written or electronic document in the member's record. Regardless of which practitioner performs the face-to-face encounter, the physician responsible for ordering the medical equipment and/or supplies must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes within the medical record.

6. The ordering physician must also document on the prescription order the face-to-face encounter details, including date of encounter, the diagnosis, and the practitioner who conducted the encounter.

The face-to-face encounter may occur through telehealth.

Face-to-face encounter requirements apply for the initiation of services only. An additional face-to-face encounter is only required if a new medical equipment, supply, or appliance is needed. Renewals, repairs, and the need for ancillary equipment do not require a face-to-face encounter.

The ordering of orthotics and prosthetics are excluded from the face-to-face encounter requirements.

Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice.

BILLING REQUIREMENTS

Medical equipment and appliance revenue codes are not reimbursable to hospitals on the UB-04 claim form. Items must be correctly coded as medical/surgical supplies, or if medical equipment and appliances, billed on the CMS 1500 claim form.

Procedures related to medical equipment and appliances cannot be interpreted without modifiers that describe the type of service and payment arrangement made. Without an appropriate modifier the claim will be denied.

The appropriate modifiers are:

LL lease/rental
NR new when rented
NU new equipment
RA replacement of medical equipment and appliance item
RB replacement of part of a medical equipment and appliance

Apnea Monitors

Providers who bill for apnea management, training, and the use of the apnea monitor must use procedure codes E0618 (apnea monitor, without recording feature) or E0619 (apnea monitor, with recording feature) and the RR modifier. The RR modifier is to be used when DME is rented.

The total charge billed to AHCCCS must include the management, training, and use of the apnea monitor.

Apnea management and training services may not be billed using procedure code 94799 (Unlisted pulmonary service or procedure).

Ventilators

Ventilators are rented on a month-to-month basis. AHCCCS does not cover the purchase of ventilators. Section 1834(a)(3) of the Social Security Act classifies ventilators as items requiring frequent and substantial servicing in order to avoid risk to the patient's health. To ensure that members have equipment that is functioning and serviced frequently, these devices may only be rented.

Devices that produce positive airway pressure (PAP), including continuous positive airway pressure (CPAP) and bi-level respiratory assist (Bi PAP) devices, are excluded from this rental requirement and purchase may be covered, if medically necessary.

PRIOR AUTHORIZATION (PA) REQUIREMENTS

For a comprehensive list of prior authorization requirements refer to AMPM 820, Prior Authorizations, to Chapter 8, Prior Authorizations of the Fee-For-Service Provider Billing Manual, and to the Fee-For-Service Prior Authorization Requirements web page at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

The division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU) is DFSM's prior authorization unit, and will be referred to as DFSM in this chapter.

Prior authorization from DFSM is required for:

- All medical equipment and appliance **rentals**;
- All medical equipment and appliance **repairs**;
- All consumable medical supplies (supplies that have limited potential for re-use) in excess of $100.00;
- All medical equipment and appliances, and prosthetic devices when the purchase price exceeds $300.00 for acute members and $500.00 for ALTCS members; and
- All orthotics when the purchase price exceeds $300.00 for members age 21 years and older.

Unless otherwise noted, the Prior Authorization requirements above apply to acute, EPSDT, and Tribal ALTCS members.

ALTCS members require PA from their Case Manager for all medical equipment and appliances (rentals and purchases), and prosthetics and orthotic devices.

References:

For additional information on medical equipment, appliance and supplies please refer to AMPM 310-P, Medical Equipment, Medical Appliances and Medical Supplies.

For additional information on orthotics and prosthetics, please refer to AMPM 310-JJ, Orthotics and Prosthetics.

For additional information on medical equipment, appliances, supplies, orthotics, prosthetics and EPSDT services for members under the age of 21, please refer to AMPM 430, EPSDT Services.

For additional information on EPSDT services please refer to Section 42 USC 1396d (r), 1396a(a)(43), and 42 CFR 441.50 et. seq.

For additional information on prior authorization, please refer to AMPM 820, Prior Authorization and to the Fee-For-Service website available at:
https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

For additional information on the ALTCS program and Home and Community Based Services (HCBS) please refer to Chapter 1200 of the AMPM.

Revisions/Update History

Date	Description of Change(s)	Page(s)
10/1/2018	The General Information section was updated. A section on Incontinence Supplies was added. The Medical Equipment and Appliances Supplies as a Part of a Hospital inpatient Admission or outpatient treatment section was clarified and updated. A section on outliers was added. The following clarification was added under the Face-to-Face Encounter Requirements section: "Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice. " A section on Apnea Monitors and billing was added. A section on Ventilators and billing was added. Prior Authorization requirements section updated. PA Requirements updated Duplicative information that is in the AMPM was removed and references to the appropriate AMPM policies was added.	1 2 2-3 3 4 5 5 5-6 6 Throughout
1/23/2018	Phone number removed	1
10/1/2017	Face-To-Face Requirements Formatting and verbiage change of "DME" to "Medical Equipment and Appliances"	8 All
8/3/2015	Chapter renamed;	7

	Orthotics benefit changes effective 08/01/2015 for adults	
4/22/2015	New formatting; Incontinence briefs benefit changes retro-effective 12/15/2014	All 2

CHAPTER 14 ~ TRANSPORTATION SERVICES

Chapter 14 ~ Transportation Services

REVISION DATES: 10/1/2018; 7/1/2018; 05/04/2018; 01/09/2017; 09/28/2015; 01/28/2015; 08/28/2014; 04/17/2014; 03/18/2014; 12/11/2013.

GENERAL INFORMATION

This chapter details transportation guidelines and reimbursement for all Fee-For-Service programs, including limitations.

EMERGENCY TRANSPORTATION SERVICES

AHCCCS covers emergency ground and air ambulance transportation services, within certain limitations, for most members.

This includes emergency ground and air ambulance services that are required to manage an emergency medical condition, both at an emergency scene and in transport to the nearest appropriate facility.

Prior authorization is not required for emergency transportation services.

Determination of whether a transport is an emergency is not based on the call to the provider, but upon the member's medical condition at the time of transport.

Emergency transportation may be initiated by an emergency response system call to “9-1-1,” fire, police, or other locally established system for emergency medical calls. Once emergency teams arrive on scene, the services required at that time (based on the field evaluation by the emergency team) may be determined to be:

- Emergent;
- Non-emergent, but medically necessary; or
- Not medically necessary.

Emergency transportation is determined to be needed due to the sudden onset of a medical condition or a behavioral health emergency manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could be reasonably expected to result in:

- Placing the member's health in serious jeopardy; and/or
- Serious impairment of bodily functions; and/ or
- Serious dysfunction of any bodily organ or part; and/or
- Serious physical harm to self or another person.

Emergency transportation includes transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility and may include, but is not limited to, the Maternal Transport Program (MTP), Newborn

Intensive Care Program (NICP), Basic Life Support (BLS), Advanced Life Support (ALS), and air ambulance services depending upon the member's medical needs.

The following coverage limitations and exclusions apply to emergency transportation services:

1. Coverage of ambulance transportation is limited to those emergencies in which specially equipped transportation is required to safely manage the member's medical condition.
2. Emergency transportation is covered only to the nearest appropriate facility medically equipped to provide definitive medical care.
3. Emergency transportation to an out-of-state facility is covered only if it is to the nearest appropriate facility. Mileage reimbursement is limited to loaded mileage. Loaded mileage is the distance traveled, measured in statute miles, while a member is on board the ambulance and being transported to receive emergency services.
4. A Fee-For-Service ground ambulance provider, who responds to an emergency call and provides medically necessary treatment at the scene, but does not transport the member, is eligible for reimbursement. This service is billed with HCPCS code A0998 (Response No Transport), and reimbursement can vary based on a provider's designation as follows:

   For ground ambulance providers operating under an ADHS Certificate of Necessity (CON):

   - For providers operating under a CON, ADHS does not set a rate specifically for A0998 Ambulance Response No Transport. The rate that applies for the CON provider is their ADHS-established ALS or BLS base rate.
   - Where ADHS has established a base rate for the CON provider that <u>does not include</u> supplies, the provider may bill the supplies separately and be reimbursed separately for them; this is true for any ambulance trip whether or not a transport resulted.
   - Where ADHS has established a base rate for the CON provider that <u>includes</u> supplies, the provider may not bill supplies separately. Reimbursement for the supplies is included in the reimbursement for the ambulance trip; this is true whether the trip was a response with transport or A0998 Response No Transport.
   - Therefore, for some CON providers, A0998 includes reimbursement for supplies and they are not permitted to bill supplies separately; for other CON providers A0998 does not include supplies and they may bill and be reimbursed separately for the supplies. This is determined by ADHS, not AHCCCS.

   For non-CON ambulance providers:

- Distinct from the above, AHCCCS has established a FFS rate for A0998 for non-CON ambulance providers, and that rate is deemed to include reimbursement for any supplies used during the service. The provider may not bill supplies separately.

5. A provider who responds to an emergency call, but does not treat or transport a member as a result of the call, is not eligible for reimbursement.
6. When two or more members are transported in the same ambulance, each shall be charged an equal percentage of the base rate and mileage charges.
7. Air ambulance services are covered under the following conditions:
    - If initiated at the request of:
        - An emergency response unit,
        - A law enforcement official,
        - A clinic or hospital medical staff member, or
        - A physician or practitioner.
    - The point of pick-up is inaccessible by ground ambulance,
    - Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities, or
    - The medical condition of the member requires air ambulance services and ground ambulance services will not suffice.

Note: Emergency ambulance providers that are regulated by the Department of Health Services (ADHS) and operated under an ADHS-granted Certificate of Necessity (CON) are reimbursed according to A.R.S. R22-39(H).

If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:

- For physical health use ICD-10 code R68.89, or
- For behavioral health use ICD-10 F99.

AIR AMBULANCE SERVICES

The current emergency air transportation procedure codes covered by AHCCCS are published annually, effective from October 1st to September 30th of the following calendar year. Refer to:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transportationairambulance.html

Code A0888 may only be billed for AHCCCS members who also are covered by Medicare. Services must be medically necessary.

All covered services (oxygen, disposable supplies, etc.) are included in payment for the listed codes.

All air ambulance providers receive the same reimbursement for non-specialty care transports.

Effective 1/1/2014, the appropriate diagnosis code(s) must be billed. ICD-9 code 799.9 is no longer a valid or acceptable diagnosis code. Claims billed with this diagnosis code will be denied.

If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:

- For physical health use ICD-10 code R68.89, or
- For behavioral health use ICD-10 F99.

SPECIALTY CARE TRANSPORTS

Specialty care transports are services for high-risk members through the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by the Arizona Department of Health Services (ADHS). ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center.

The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport. A provider may bill for specialty care transport when the following conditions are met:

1. The provider must have a current MTP/NICP contract with ADHS, and AHCCCS must have a copy of that contract.
2. The provider must use a high-risk transport team and equipment for the transport.
3. The provider must send supporting documentation, including either:
   a. A completed Request for Participation Form with approval from an ADHS-contracted perinatologist or neonatologist, with privileges at an Arizona tertiary perinatal center; or
   b. A completed Request for Maternal Transport Form with approval from an ADHS-contracted perinatologist, with privileges at an Arizona tertiary perinatal center.

Specialty care transport providers must bill the "TH" modifier with one of the following: A0430, A0431, A0435, A0436 and A0888. If the “TH” modifier is used by a non-specialty care provider the claim will be denied.

In addition, code A0225 (Ambulance service, neonatal transport, base rate, emergency transport, one way) may be used for the maternal/neonate transport team to accompany the ground ambulance. This code may only be used by specialty care providers, but it does not require the “TH” modifier.

GROUND AMBULANCE SERVICES

The current emergency ground transportation procedure codes covered by AHCCCS are published annually, effective from October 1st to September 30th of the following calendar year. Refer to:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transportationground.html

Code A0888 may only be billed for AHCCCS members who also are covered by Medicare. Services must be medically necessary.

BILLING FOR AIR AND GROUND AMBULANCE SERVICE

Claims for ground and air ambulance service must be billed on the CMS 1500 claim form. Emergency transportation does not require prior authorization. However, providers must mark the emergency field (Field 24C) to indicate emergency services on each applicable line.

Emergency air and ground ambulance claims are subject to Medical Review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:

1. Medical condition, signs and symptoms, procedures, and treatment;
2. Transportation origin, destination, and mileage (statute miles);
3. Supplies; and
4. Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

MULTIPLE AMBULANCE TRANSPORTS

When multiple ground or air ambulance transports occur in the same day, only one base rate may be charged unless the additional transport is a separately identifiable service.

In addition, supplies (either BLS routine disposable supplies with code A0382 *or* ALS routine disposable supplies with code A0398) and oxygen supplies (for either BLS or ALS in a life sustaining situation with code A0422) may be charged for only one ground ambulance trip, unless the additional transport is a separately identifiable service.

EXAMPLE 1:
A member is transported by ground ambulance from an accident scene to a hospital. The ambulance remains at the hospital while the member is stabilized. The same ambulance then transports the member to another hospital or airport for transfer to a higher level of care or for services not available at the current facility. In this example, one base rate, waiting time and total mileage should be

billed. The provider also may bill the appropriate codes for supplies and oxygen, and the corresponding charges.
EXAMPLE 2:
A member is transported by air ambulance from an accident scene to a hospital. The air ambulance remains at the airstrip while the member is stabilized. The same air ambulance then transports the member to another hospital for services not available at the current facility. In this example, one base rate and total mileage should be billed.
EXAMPLE 3:
A member is transported by ground ambulance from an accident scene to a hospital. The ambulance leaves the hospital and returns to base or takes another call. At the hospital's request, the same ambulance returns to the hospital to transport the member to another hospital or airport for transfer to a higher level of care or for services not available at the current facility.

In example 3, the provider may bill two base rates, mileage, supplies, and oxygen using one of the following methods:

1. If the *same* HCPCS code is used to bill the base rate for separately identifiable trips:
   a. Two units of the base rate should be billed on Line 1 of the CMS 1500 claim form.
   b. The total mileage for both trips should be billed on Line 2.
   c. Supply charges for both trips should be billed on Line 3.
   d. Oxygen charges for both trips should be billed on Line 4.
   e. Waiting time should *not* be billed.

2. If a *different* HCPCS code is used to bill the base rate for each separately identifiable trip:
   a. One unit of the first base rate should be billed on Line 1 of the claim form.
   b. Mileage for the first trip should be billed on Line 2.
   c. One unit of the second base rate should be billed on Line 3.
   d. Mileage for the second trip should be billed on Line 4.
   e. Supply charges for both trips should be billed on Line 5.
   f. Oxygen charges for both trips should be billed on Line 6.
   g. Waiting time should *not* be billed.

AHCCCS covers medically necessary, non-emergency ground ambulance and air transportation to and from a required, covered medical service for most members.

Non-emergency transportation is not covered for Federal Emergency Services Program members.

Round-trip air or ground ambulance transportation services may be covered when a hospitalized member is transported to another facility for necessary specialized diagnostic and/or therapeutic services if all of the following requirements are met:

1. The member's condition is such that the use of any other method of transportation is not appropriate;
2. Services are not available in the hospital, in which the member is an inpatient;
3. The hospital furnishing the services is the nearest one with such facilities; and
4. The member returns to the point of origin.

Non-ambulance transportation providers may not provide emergency transportation because providers cannot assure adequate life support systems.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

When free transportation services are unavailable and an eligible person is unable to arrange or pay for transportation, AHCCCS covers medically necessary non-emergency medical transportation (NEMT) to and from an AHCCCS covered medical or behavioral health service for most members. Non-emergency medical transportation is not covered for Emergency Services Program members.

Transportation is limited to the cost of transporting the member to and from either of the following active AHCCCS registered provider locations capable of meeting the member's needs:

- The nearest appropriate IHS/Tribal 638 medical or behavioral health facility, *or*
- The nearest appropriate medical or behavioral health provider.

In addition to the above, as of 7/1/18, non-emergency transportation services are covered under the following circumstances:

- To transport a member to obtain Medicare Part D covered prescriptions; and
- To transport a member to participate in one of the local community based support programs, as identified in the member's service plan. Transportation coverage to these programs is limited to transporting the member to the nearest program capable of meeting the member's need as identified on the member's service plan. Covered local community-based support programs are limited to the programs identified in AMPM 310 BB, Transportation, Attachment A, Community Based Support Programs.

As of 4/1/2014, all NEMT providers MUST have a sign or logo with the transport company's name on the vehicle when transporting AHCCCS members.

Special Considerations for Non-Emergency Medical Transportation

Attendant Care Non-Emergency Medical Transportation

NEMT services may be provided, with limitations, by providers registered as provider type 40 (Attendant Care). If the provider has been an AHCCCS registered provider for 12 months, then the provider may bill for NEMT services if that category of service has been approved by provider registration. However, the NEMT services cannot exceed 30% of their overall services billed.

Family Members

Transportation of a member by a family member will not be reimbursable unless the transportation provider is an AHCCCS registered provider *prior* to the transportation *and* prior to seeking PA *if* PA is required.

If the family member, who is an AHCCCS registered provider, could reasonably be expected to provide transportation services to the member, such as a mother providing transportation to their child, then transportation would not be reimbursable. Transportation is only reimbursable if transportation services would otherwise be unavailable and an eligible person is unable to arrange or pay for transportation.

NEMT on Reservations

Effective 10/1/2014, all non-emergency medical transportation providers that transport AHCCCS members (pick up and/or drop off) on reservation will be required to obtain a Tribal business license from the Tribe. A copy of the Tribal business license must be submitted to AHCCCS Provider Registration for documentation. When auditing claims AHCCCS will ensure that this documentation is on file. Failure to obtain and submit your Tribal business license will result in claims recoupment.

Prior authorization will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration. Please refer to exhibit 14-3 for tribal contact information.

Pick-Up and Drop-Off Locations

The pick-up and drop-off locations do not always have to be at/to the member's home address. However, additional information may be requested by the AHCCCS Administration if it looks like the difference in mileage between the pick-up/drop-off locations

and the member's home address could result in AHCCCS reimbursing a higher mileage to the provider.

If using a location other than the member's home address would result in a higher mileage for the NEMT, then the provider will need to provide a justification to AHCCCS. The provider will have to provide justification as to why it was necessary to pick-up/drop-off the member at a location other than the member's home. AHCCCS may also request details regarding the necessity if enough details are not provided in the initial request.

Prescription Pick-Up

A NEMT provider may not submit any claim for unloaded mileage. This includes prescription pick-up. A NEMT provider may not bill for picking up a member's prescription on the member's behalf.

Self-Driving

No member may drive themselves and subsequently bill AHCCCS for it, even if they are driving themselves to an AHCCCS approved service. To qualify for NEMT, free transportation services must be unavailable and an eligible person must be unable to arrange or pay for transportation. If an eligible person drives themselves, they were able to arrange for their own transportation. This is **not** reimbursable.

Special Considerations Involving Minors

In order for a member to sign for their own transportation, they must be either 18 years of age or older *or* an emancipated minor in accordance with A.R.S. §12- 2451 and §44-131. Emancipated minors must prove that they are emancipated, and then they may sign for their own transportation.

Minors that are not emancipated must have their legal guardian sign for their transportation. If a member is a minor and has a minor child, only the legal guardian of the minor child may sign for their transportation.

NEMT Authorization Requirements

Prior authorization is required for NEMT trips in excess of 100 miles (one-way, round trip, or multiple trips in the same day) for both medical and behavioral health services for FFS members.

Exception: PA is not required for IHS/Tribal 638 transportation providers.

For NEMT trips less than 100 miles (one-way, round trip, or multiple trips in the same day) for both medical and behavioral health services, prior authorization is not required for FFS members.

When prior authorization (PA) is required for transportation, PA will not be issued unless the transportation provider is an AHCCCS registered provider *prior* to seeking the PA.

Transports over 100 miles require authorization from the AHCCCS Prior Authorization (PA) Department for Acute FFS Members or from the Tribal ALTCS Case Manager for Tribal ALTCS Members. Only codes for base and mileage will be authorized.

- In order to obtain prior authorization for NEMT services the provider must provide AHCCCS with enough information to demonstrate that the member is being transported to an AHCCCS covered service. Prior authorization requests with insufficient or vague information regarding the reason for the NEMT will result in a request for additional information. This can include a request for supporting documentation from the referring provider. The supporting documentation must provide the information necessary to allow AHCCCS to determine the medical necessity.
    - The referring medical or behavioral health provider can fax this information directly to the Prior Authorization Department using the Medical Documentation form located at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

Note: It is not a violation of HIPAA for a NEMT provider to request sufficient information to determine whether the transport is to an AHCCCS covered service.

When audits are conducted additional information may be requested to verify that the NEMT was to an AHCCCS covered service. Verifying that transportation is to an AHCCCS covered service is the provider's responsibility, regardless of whether or not the service was prior authorized.

Special Considerations:

For American Indian members enrolled with AIHP, and /or who are enrolled with a TRBHA, or who receive medical or behavioral health services at an IHS/Tribal 638 facility, transportation services are covered on a FFS basis.

For American Indian members enrolled with a RBHA, who receive behavioral health services at an IHS/Tribal 638 facility, transportation services are covered through the RBHA.

For American Indian members enrolled with an ACC plan, who receive services at an IHS/Tribal 638 facility, transportation services are covered through the ACC plan.

For American Indian members, who are TRBHA enrolled and who are also enrolled with an ACC plan for physical health services, transportation to physical health services are covered through the ACC plan.

For an ACC/TRBHA enrolled member receiving behavioral health services, transportation services are covered on a FFS basis.

Refer to AMPM Policy 310-BB for a complete description and discussion of covered transportation services.

For information on submission of prior authorization requests please refer to AMPM 820, Prior Authorization.

A prior authorization request for NEMT must contain a valid diagnosis code for physical or behavioral health services, if known.

If the diagnosis is unknown at the time of the authorization request, use the following diagnosis codes:

- For physical health use ICD-10 code R68.89, or
- For behavioral health use ICD-10 F99.

Note: The diagnosis codes R68.89 and F99 are also valid diagnosis codes for claims submitted for NEMT.

Effective for service dates prior to 1/1/2017:

For AHCCCS American Indian members who reside either on-reservation or off-reservation and are enrolled with AIHP (Contract ID number 999998) transportation services are covered on a FFS basis under the following conditions:

1. The request for transportation service is prior authorized through the AHCCCS DFSM UM/CM department, when mileage is greater than 100 miles per trip, whether one-way or round trip. PA is not required for IHS/638 providers.
2. The member is not able to provide, secure or pay for their own transportation and free transportation is not available; and
3. The transportation is provided to and from either of the following locations:
   a. The nearest appropriate IHS/Tribal 638 medical facility located either on-reservation or off-reservation, or
   b. The nearest appropriate AHCCCS registered provider located off-reservation.

Effective 10/1/2014 prior authorization will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration.

For American Indian members enrolled in either an AHCCCS Complete Care Health Plan or ALTCS managed care organization, please check with the managed care organization for prior authorization requirements.

Members who are enrolled with AIHP and live either on-reservation or off-reservation, and are receiving behavioral health services as specified in Chapter 12, Behavioral Health Services, may receive non-emergency medically necessary on-reservation transportation services as follows:

1. Non-emergency medical transportation may be provided as outlined above on a FFS basis for the following members:

    a. An AIHP enrolled member, residing either on-reservation or off-reservation, who is receiving behavioral health services, but is not enrolled with an ADHS designated Regional Behavioral Health Authority (RBHA); or

    b. An AIHP enrolled member, who lives on-reservation, but is a member of a tribe that is not designated as a Tribal Behavioral Health Authority (TRBHA) through an agreement with the ADHS, and who receives services at an IHS/Tribal 638 facility or through an off-reservation provider; or

2. If the AIHP member is enrolled with and receiving behavioral health services through a RBHA or TRBHA, non-emergency medically necessary on-reservation transportation is coordinated, authorized and provided by the RHBA or TRBHA.

PA for non-emergency medical transport provided to an AHCCCS FFS member or American Indian Health Plan (AIHP) enrolled member through the use of a private vehicle must be requested by the member's medical service provider. PA for transportation will not be issued unless the transportation provider is an AHCCCS registered provider prior to seeking PA.

Effective 4/1/2012, members enrolled in a Tribal Regional Behavioral Health Authority (TRBHA) and the American Indian Health Plan (AIHP) must obtain Prior Authorization for non-emergency transportation service that is:

- In excess of 100 miles, whether one way or round trip; and
- Billed with ICD-9 diagnosis code 799.9 (prior to date of service 10/1/2015) or billed with ICD-10 diagnosis code R68.89 (effective date of service 10/1/2015).

Members enrolled in a TRBHA and a health plan, other than AIHP, non-emergency medical transportation claims that are billed with a behavioral health diagnosis code should continue to follow the Department of Behavioral Health Services guidelines.

Transports over 100 miles will continue to require authorization from the AHCCCS Prior Authorization Department for Acute Care members or from the ALTCS case manager for ALTCS members. Only codes for base and mileage will be authorized.

BILLING FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The AHCCCS Daily Trip Report **must** be submitted with the claim.

Providers may bill without obtaining Prior Authorization if the total mileage for one member, on one date of service, is under 100 miles.

All trips for the same member, for the same date of service should be submitted on one claim form.

NEMT providers submitting claims can bill in the following ways:

- By using the Professional Claim, if using the provider web portal;
- By using the 837P for electronic claims submissions; or
- By using the CMS 1500 Claim Form.

All services occurring on the same date of service for a member's transport *must* be billed on a single claim. If multiple transports occurred on the same date of service, then the provider must bill the total number of trips (base rate) on the first line and the total loaded mileage on the second line of the claim.

- All trips taking place on the same day, for the same member, must be billed on one claim. The base rate must be billed on the first line, the loaded mileage on the second line, and the wait time (in the event that wait time is billed for) on the third line. Any additional lines will deny.

A claim submitted with only the base code and a second claim submitted with only the mileage *will be denied*, as split-billing transport services is not permitted. Multiple claims submitted for the same date of service will be denied as duplicates.

Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a member on board the vehicle and being transported to receive medically necessary AHCCCS covered medical or behavioral health services.

Example case scenarios:

1. If a member travels from his/her home to an AHCCCS provider's office in town and the total trip is 95 miles then the trip does **NOT** require Prior Authorization**.**

2. If a member is transported from a car accident scene in a BLS or ALS ambulance to an emergency room then the trip is considered to be emergency transportation and

does **NOT** require Prior Authorization. The return trip, however, could be non-emergency and could possibly require Prior Authorization IF the return trip is **more** than 100 miles**.**

3. Dialysis, non-emergency transports that had previously been billed monthly and exceeded 100 miles in total must be billed individually (per trip). Date span or "bulk" billing is no longer acceptable. Each service date must be identifiable on the claim and must be billed with actual loaded miles, as supported by odometer readings.

4. If a member is transported via non-emergency AIR ambulance for medically necessary discharge to a lower level facility and that transport is **less than 100 miles** then the trip **DOES** require Prior Authorization.

Effective 9/1/2014, all services for the member's transport *must* be billed on one claim using multiple lines for that date of service. A claim submitted with base code only and a second claim submitted with mileage only *will be denied*, as split-billing the transport service is inappropriate.

Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a member on board the vehicle and being transported to receive medically necessary AHCCCS covered services.

If **multiple transports on the same day** are authorized for a member, providers must bill the second trip (and any subsequent trips) as follows:

- Two units of the authorized base rate should be billed on Line 1 of the claim form. (If there are two trips on the same day for the member.)

- The total mileage for both trips should be billed on Line 2.

If a member's transport involves multiple destinations then the daily trip report must document each segment of the transport, including the full address of each location as well as the times and odometer readings.

Special Consideration for Multiple Transports on the Same Day

All FFS transports occurring on the same day for the same member must be billed on the same claim, including multiple stops.

Non-FFS transports (e.g. transports for a RBHA enrolled member to a behavioral health provider) shall be billed to the RBHA.

> Note: This means that when multiple stops occur that it is possible, depending on the type of service, that you may need to submit one claim to FFS and one to the RBHA.

Wait time shall only be billed for the amount of time the driver *actually waited* at the member's medical service destination *if* the distance traveled was such that it was not feasible for the driver to return to the provider's base of operations or the origination site.

Wait time is billed with code T2007 where each unit is 30 minutes. If transporting multiple members at one time, the wait time shall be reimbursed for no more than one member.

In addition, billing for wait time is not appropriate:

- If the odometer reading changes from the drop-off at the medical service to the pick-up at the medical service;
- For a one way trip;
- When two different vehicles and/or drivers are used for the round trip;
- If wait time is less than 30 minutes; or
- If the distance to the medical service location is 10 miles or less.

Special Considerations for the Transportation of Multiple Members

If multiple AHCCCS members are transported in the same vehicle a separate AHCCCS daily trip report must be submitted for each member.

Each AHCCCS Daily Trip Report must list the location where the member was picked up and dropped off. The reported miles from the odometer shall reflect the number of miles of the most direct route between **that member's pick up and drop off location.**

Billing with the "TN" Modifier

AHCCCS has established separate urban and rural rates and procedure codes for certain non-ambulance transportation services. Urban transports are those that originate within the Phoenix and Tucson metropolitan areas. All other transports, outside of the Phoenix and Tucson metropolitan areas, are defined as rural and must be billed with the "TN" modifier. A rural designation is meant to accommodate atypical conditions, such as the use of unmaintained and/or dirt roads, long distances required to reach the member, and a lack of providers in the area.

Transportation Codes

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all local codes be replaced with the appropriate HCPCS, CPT-4, and revenue codes and modifiers for dates of

service on and after December 1, 2003. This applies to non-emergency transportation providers who submit claims electronically and on paper.

The AHCCCS website provides a table that summarizes available non-emergency transportation procedure (HCPCS, CPT) codes and provides the AHCCCS Capped Fee-For-Service Fee Schedule for transportation, for each code. NEMT reimbursement is dependent upon the code billed for reimbursement, not the FFS member type. There is no difference in reimbursement between FFS and ALTCS members. For further information refer to:

https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

Mileage Discrepancies

If there is a mileage discrepancy between the total loaded mileage on the 1st trip (from the pick-up location to the drop-off destination) and the total loaded mileage on the 2nd trip (from the service location to the original pick-up destination), justification for the discrepancy must be provided. If no justification is provided than the mileage difference may be reduced by AHCCCS.

The justification can be provided on the AHCCCS Daily Trip Report. There is a section for additional information to be entered in at.

DOCUMENTATION REQUIREMENTS

All non-emergency medical transport providers will be required to use the AHCCCS Daily Trip Report, which is Exhibit 14-1. Detailed instructions for completing the Daily Trip Report can be found in Exhibit 14-2.

Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Report found in Exhibit 14-1 will be denied.

- Please note that different versions of the Daily Trip Report may ***not*** be used or submitted. The attachment in Exhibit 14-1 is the ***only version*** that may be submitted.
- Providers are ***not*** permitted to create their own versions of the Daily Trip Report for submission. **Only the AHCCCS approved Daily Trip Report can be used.**

The AHCCCS Daily Trip Report may be filled out in either blue or black ink.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, so long as all federal and state requirements for the protection of member information are taken, including but not limited to HIPAA compliance and adherence to the AHCCCS Security Rule Compliance Summary Checklist (found in ACOM Policy 108, Attachment A).

If the AHCCCS Daily Trip Report is filled out electronically it may be submitted by printing it out and mailing it in, or electronically submitting it through the 275 provider portal as a PDF file.

- AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.
- AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was included at provider request.
- AHCCCS **will** accept PDF files of the AHCCCS Daily Trip Report.
    - Note: If the AHCCCS Daily Trip Report is submitted as a PDF file through the 275 Provider Portal, it is necessary that the PDF file allow AHCCCS to extract the document, otherwise AHCCCS will not be able to view the submitted PDF file.

AHCCCS will conduct retrospective audits of non-emergency ground transportation providers to verify that the mileage, wait time, diagnosis, and medical necessity are correct and that all charges are supported and justifiable. The transportation provider will submit all requested documentation, including the justification of the transport, upon request by AHCCCS anytime after the date of service. Each service must be supported with the following documentation on the Daily Trip Report:

- **Provider Information:** NEMT provider name, ID, address, and phone number. Using a stamp is acceptable.
- **Driver's name:** Printed first and last name of the driver who provided the service.
- **Date:** Indicate the date of service (mm/dd/ccyy).
- **Vehicle Identification:** This must include the state the vehicle is licensed in, the fleet or license plate number, and the make and color of the vehicle.
    - NOTE: If the driver uses more than one vehicle for the same date of service, they must use a new Daily Trip Report for each separate vehicle and they must indicate (at the bottom right) the page number. All pages become the *complete* Daily Trip Report for the transport services for that member, on that service date.
- **Vehicle Type:** Indicate the type of vehicle (car, van, wheel chair van, stretcher van, etc.)
- **Member Information:** Member's full name, AHCCCS ID, date of birth (mm/dd/ccyy), and mailing address.
- **Pick-up address:** Complete address (including street address, city, state and zip code) of pick-up destination.
    - If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the pick-up location can be used.
- **Pick-up time:** Clock time including the a.m./p.m. indicator (example: 7:12 AM). Please circle the appropriate time of day (a.m./p.m.) provided.
- **Pick-up Odometer:** Document the actual odometer reading at the pick-up location.
- **Drop-off address:** Complete address (including street address, city, state and zip code) of drop-off address.

  - If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the drop-off location can be used.
- **Drop-off time:** Clock time including the a.m./p.m. indicator (example: 4:46 PM). Please circle the appropriate time of day (a.m./p.m.) provided.
- **Drop-off Odometer:** Document the actual odometer reading at the drop-off location.
- **Trip miles:** Subtract the pick-up odometer reading from the drop-off odometer reading. This will be the number of trip miles. (Drop-off odometer reading – pick-up odometer reading = trip miles)
- **Type of Trip:** Round Trip, One Way, or Multiple Stops
- **Reason for Visit:** Only include as much information as the member is willing to share.
  - **Note:** When transportation services are initially arranged, the transportation provider must obtain sufficient information to determine whether the transportation is occurring to an AHCCCS covered service.
- **Diagnosis (if known):** Only include as much information as the member is willing to share.
- **Name of Escort:** If member is traveling with an escort, include their first and last name.
- **Relationship:** Indicate the escort's relationship to the member.
- **Member Signature:** Member must sign, if able. If member is unable to sign, please check the appropriate box and identify the person* signing for the member ***or*** include the member's fingerprint.
  - If a tablet or other electronic device is being used, a method for the member or authorized representative of the member to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name). A fingerprint may also be used if they are unable to sign.
  - Typing the member's name in cannot serve as a substitute for an actual signature or fingerprint.
- **Driver's Signature:** The driver must sign each page.
  - If a tablet or other electronic device is being used, a method for the driver to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name).
  - Typing the driver's name in cannot serve as a substitute for an actual signature or fingerprint.
- **Date:** The driver must date each page.
- **Page ___ of ___:** Indicate each page number and the total number of pages used to document all transports for the member, for the same date of service.
- **Did multiple members get transported in the same vehicle on this trip?** Choose yes if multiple AHCCCS members are being transported in the same vehicle.
  - **Were the pick-up and drop-off locations different for the members?** Choose yes if even one member in the vehicle had a different pick-up or drop-off location, as this can affect the odometer readings.

- **Additional Information:** Any additional information that the provider thinks is needed for the processing of the claim can be entered here.

Clarification of member's "signature" requirement
If a member is physically unable to sign (or fingerprint) the non-emergency medical transport trip report then a parent or guardian, caretaker, escort, or family member can sign for the member and indicate their relationship to the member. If the member is transporting alone, then the trip report may be signed by the provider at the medical service appointment.

When someone else signs the trip report for the member, the trip report should show the member's name and a notation such as "by J Smith, daughter" to identify the person signing for the member.

Under no circumstances is the transport driver to sign for a member.

- Even if the transport driver is a physical or behavioral health care provider for the member, they still cannot sign for the member. If the member cannot sign for themselves then a parent, guardian, caretaker, escort, or other family member would have to sign for them. **The driver cannot sign, even if the driver overlaps one of the categories that normally could.**

For further instructions on how to fill out the Daily Trip Report, please see the Non-Emergency Medical Transportation Daily Trip Report Instructions, Exhibit 14-2.

It is the provider's responsibility to maintain documentation that supports each transport service claimed. The AHCCCS Daily Trip Report must be completed by the driver in pen with all information clear and legible.

Erasures and white-out are not acceptable. If an error is made, draw a single line through the error and enter the correct information.

Trip records with missing information will be subject to audit error and recoupment.

Effective for dates of service 7/1/2013 and forward, all non-emergency medical transport providers will be required to use the AHCCCS standard Daily Trip Report, Exhibit 14-1, with instructions for completing the standard Daily Trip Report found at Exhibit 14-2.

Effective for dates of service 8/1/2013 and forward, any non-emergency transport claim submitted without the AHCCCS standard Daily Trip Report will be denied.

ILLEGAL INCENTIVES/REMUNERATIONS

Providers offering gift cards, free lunches or other cash in kind inducements to have the member select their transportation services are prohibited by Federal Criminal Penalties Statute 42 USC 1320a-7b(b)(2).

Among other activities not permitted, this law 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.

The provision from 42 USC 1320a-7b (b)(2) reads:

(b) Illegal remunerations

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-

(A) To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) To purchase, lease, order or arrange for, or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

For further information regarding provider regulations when it comes to incentives, please refer to Chapter 3, Provider Records and Registration, of the Fee-For-Service Provider Billing Manual.

References

Refer to AMPM Chapter 310-BB for additional information regarding transportation services.

Refer to AMPM Chapter 1200 for additional information regarding Arizona Long Term Care System (ALTCS) authorization requirements.

Refer to AMPM Chapter 800 for additional information regarding prior authorization for non-ALTCS FFS members.

Refer to Exhibit 14-1 for the AHCCCS Daily Trip Report for NEMT.

Refer to Exhibit 14-2 for instructions on how to fill out the AHCCCS Daily Trip Report for NEMT.

Refer to Exhibit 14-3 for Tribal Contact Information.

Revision History

Date	Description of changes	Page(s)
10/1/2018	Information regarding procedure code A0998, ambulance providers operating under an ADHS Certificate of Necessity (CON), and providers not operating under an ADHS CON was added under bullet point number 4.	2
	Bullet point number 8 was updated, due to a change in rule. It now reads as: *Air ambulance services are covered under the following conditions:* • *If initiated at the request of:* ▪ *An emergency response unit,* ▪ *A law enforcement official,* ▪ *A clinic or hospital medical staff member, or* ▪ *A physician or practitioner.*	3 3
	The following information was added under the emergency transportation section: *If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:* • *For physical health use ICD-10 code R68.89, or* • *For behavioral health use ICD-10 F99*	4
	The following information was added under the air ambulance transportation section: *If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:* • *For physical health use ICD-10 code R68.89, or* • *For behavioral health use ICD-10 F99.*	

	Information regarding PA requests and claims for NEMT services and appropriate diagnosis codes, when the diagnosis code is not known at the time of PA or claim submission was added. NEMT Prior Authorizations and Special Considerations sections were updated for integration	11 11--13
7/1/2018	Clarification added regarding the initiation of emergency transportation. An update regarding what NEMT services are covered as of 7/1/18 was added, including transports to: • Take a member to obtain Medicare Part D covered prescriptions; and • Take a member to participate in one of the local community based support programs, as identified in the member's service plan. Transportation coverage to these programs is limited to transporting the member to the nearest program capable of meeting the member's need as identified on the member's service plan. Covered local community-based support programs are limited to the programs identified in AMPM 310 BB, Transportation, Attachment A, Community Based Support Programs. The PA requirements section was updated, including the special considerations section. A section on Special Consideration for Multiple Transports on the Same Day was added. A section on Special Considerations for the Transportation of Multiple Members was added.	1 6 8-11 13-14 14
05/04/2018	Clarification added to A0998, regarding supplies. Note added regarding emergency ambulance providers regulated by the Department of Health Services (ADHS) and operating under an ADHS-granted Certificate of Necessity. NEMT information clarified Attendant Care NEMT Section Added Family Members Section Added Pick-Up and Drop-Off Locations Section Added Prescription Pick-Up Section Added Self Driving Section Added Minors (Special Considerations) Billing section updated Wait Time Billing Section Added TN Modifier Section Added	2 2 6 6 7 7 7-8 8 8 11-12 13 13

	Mileage Discrepancies Section Added Documentation Requirements Updated Trip Report Information Updated References Updated The word 'recipient' was changed to 'member' throughout. Formatting Updated version of the Trip Report added as Exhibit 14-1 Updated version of the Trip Report Instructions added as Exhibit 14-2	13-14 14 14-16 18-19 All All Exhibit 14-1 Exhibit 14-2
01/09/2017	Revision Date added Updated links Insert policy language effective on or after 01/01/2017 Add identifier for policy language effective prior to 01/01/2017 Update Revision History table	1 2, 3, 7, 10 6-7 14
09/28/2015	Effective date of service 10/01/2015: ICD-9 code 799.9 replaced with ICD-10 code R68.89	2, 7
01/28/2015	Clarification language added for member's signature requirements on NEMT trip report	10, 11
08/28/2014	Effective 09/01/2014 split billing services on multiple claims will be denied Effective 10/01/2014 PA denied if no tribal business license on file for NEMT provider	8 6

Exhibit 14-1 Daily Trip Report

The AHCCCS Daily Trip Report is available as both PDF and Excel files at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

Please note the following:

- AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.
- AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was included at provider request.
- AHCCCS **will** accept PDF files of the AHCCCS Daily Trip Report.
  - Note: If the AHCCCS Daily Trip Report is submitted as a PDF file through the 275 Provider Portal, it is necessary that the PDF file allow AHCCCS to extract the document, otherwise AHCCCS will not be able to view the submitted PDF file.

NEMT AHCCCS Provider ID, Name, Address, and Phone Number

* One Daily Trip Report Per Member, Per Day

AHCCCS DAILY TRIP REPORT

Driver's Name: _____
Date: _____
Vehicle License/Fleet ID: _____
Vehicle Make & Color: _____
Vehicle Type: ☐ Wheelchair Van ☐ Taxi ☐ Bus ☐ Stretcher Car ☐ Other (List type) _____

AHCCCS #: _____ Date of Birth: _____
Member Name: _____ Mailing Address: _____

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: One Way _____ Multiple Stops _____

* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.

Reason for Visit: _____
Name of Escort: _____ Relationship: _____

2nd Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
2nd Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____

Reason for Visit: _____
Name of Escort: _____ Relationship: _____

3rd Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
3rd Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____

Reason for Visit: _____
Name of Escort: _____ Relationship: _____

page ____of_____

AHCCCS #: _____ Date of Birth: _____
Member Name: _____

4th Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
4th Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
Reason for Visit: _____
Name of Escort: _____ Relationship: _____

5th Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
5th Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
Reason for Visit: _____
Name of Escort: _____ Relationship: _____

6th Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
6th Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Drop-Off Time	Drop-Off Odometer	Trip Miles
	a.m./p.m.		

Type of Trip: Round Trip _____ One Way _____ Multiple Stops _____
Reason for Visit: _____
Name of Escort: _____ Relationship: _____

Did multiple members get transported in the same vehicle on this trip? ☐ Yes ☐ No
If the above answer is yes, were the pick-up and drop-off locations different for the members? ☐ Yes ☐ No
Additional Information: _____

Member Signature: _____

☐ Member is unable to sign. Identify the person signing for the member ***or*** include member's fingerprint.

_____
(Attendant / Escort / Guardian / Parent / Provider)

Member Fingerprint

This is to certify that the information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Driver Signature: _____ Date: _____

page ____of_____

Exhibit 14-2 ~ Non-Emergency Medical Transportation Daily Trip Report Instructions

Updated: May 2018

AHCCCS requires the use of the AHCCCS standard Daily Trip Report, which is Exhibit 14-1 in the Fee-For-Service Provider Billing Manual.

- Please note that different versions of the Daily Trip Report may ***not*** be used or submitted. The attachment in Exhibit 14-1 is the ***only version*** that may be submitted.
- Providers are ***not*** permitted to create their own versions of the AHCCCS Daily Trip Report for submission. **Only the AHCCCS approved Daily Trip Report can be used.**
- It is available as a PDF and Excel file (to allow providers to expand the additional information area if needed).

The upper left area of the form is where the provider will write the NEMT provider's name, provider ID, address, and phone number.

The driver must print clearly. Illegible Daily Trip Reports can result in audit error and recoupment.

The AHCCCS Daily Trip Report must be completed in pen. It may be filled out in either blue or black pen. If an error is made, draw a single line through the error and print the correct information.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, as long as all federal and state requirements are taken to protect member information. If this is done it may be submitted in one of two ways:

1. Printing it out and mailing it in, or
2. Electronic submission through the provider portal as a PDF file.
    - AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.
    - AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was included at provider request.
    - AHCCCS **will accept** PDF files of the AHCCCS Daily Trip Report.
        - Note: If the AHCCCS Daily Trip Report is submitted as a PDF file through the 275 Provider Portal, it is necessary that the PDF file allow AHCCCS to extract the document, otherwise AHCCCS will not be able to view the submitted PDF file.

If a member's transport has more than one "stop" or destination, then each trip must be fully documented on the Daily Trip Report.

For example:

- A member is picked up at home and transported to the doctor's office. (1st trip)
  The doctor gives the member a prescription for medication.
  The member is transported from the doctor's office to a pharmacy that is at a different location than the doctor's office. (2nd trip)
  The member picks up their prescription.
  The member is then returned home. (3rd trip)

In the above example, the Daily Trip Report would have 3 trips documented as indicated.

Only one trip report should be filled out per member, per day. If there are more than three stops for one member, in one day, please use multiple pages. If more than one vehicle is used and/or if more than one driver transports the member on the same day, please use multiple pages (one for each vehicle) and document that more than one vehicle and/or driver was used in the additional information section. If multiple pages are used, the page number must be indicated at the bottom right of the Daily Trip Report. All pages become the *complete* Daily Trip Report for the transport services for that member, on that service date.

How to Fill Out the Trip Report

Upper Left Hand Corner

- **Provider Information:**
  - Provider Name
  - Provider ID
  - Provider Address
  - Provider Phone Number
  - NOTE: Using a stamp is acceptable.

Upper Right Hand Corner

- **Driver's Name:** Printed first and last name of the driver who provided the service.
- **Date:** Indicate the date of service (mm/dd/ccyy) or (mm/dd/ccyy).
- **Vehicle Identification:**
  - List the state the vehicle is licensed in.
  - License Plate Number/Fleet Number

  - Make and Color of Vehicle
  - NOTE: If the driver uses more than one vehicle for the same date of service, they must use a new Daily Trip Report for each separate vehicle and they must indicate (at the bottom right) the page number. All pages become **the** *complete* Daily Trip Report for the transport services for that member, on that service date.
- **Vehicle Type:** Check the box next to the type of vehicle used (car, van, wheelchair van, stretcher van, etc.)
  - NOTE: Check 'Other' and write in the vehicle type if the description does not match the available options.

Upper Middle Section

- **Member Information:**
  - Member's AHCCCS ID
  - Member's Name
  - Member's Date of Birth (mm/dd/ccyy)
  - Member's Mailing Address.

Main Section for Transportation Information

There will be 3 trip sections per Daily Trip Report page. The 1st Pick-Up and Drop-Off area, the 2nd Pick-Up and Drop-Off area, and the 3rd Pick-Up and Drop-Off area. This is to accommodate multiple trips on the same day. If more than 3 stops occur on the same day please use additional Daily Trip Reports as pages and indicate that they are the 4th, 5th, etc. stops.

- **Pick-Up Address:** Complete address (including street address, city, state and zip code) of pick-up destination.
  - If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the pick-up location can be used.
- **Pick-Up time:** Clock time including the a.m./p.m. indicator (example: 7:12 AM). Please circle the appropriate time of day (a.m./p.m.) provided.
- **Pick-Up Odometer:** Document the actual odometer reading at the pick-up location.
- **Drop-Off address:** Complete address (including street address, city, state and zip code) of drop-off address.
  - If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be

found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the drop-off location can be used.

- **Drop-Off time:** Clock time including the a.m./p.m. indicator (example: 7:12 PM). Please circle the appropriate time of day (a.m./p.m.) provided.
- **Drop-Off Odometer:** Document the actual odometer reading at the drop-off location.
- **Trip miles:** Subtract the pick-up odometer reading from the drop-off odometer reading, and that will equal the total number of trip miles. (Drop-Off Odometer Reading – Pick-Up Odometer Reading = Total Trip Miles)
- **Type of Trip:** Round Trip, One Way, or Multiple Stops (Check the appropriate one.)
- **Reason for Visit:** Only include as much information as the member is willing to share.
    - **Note:** When transportation services are initially arranged, the transportation provider must obtain sufficient information to determine whether the transportation is occurring to an AHCCCS covered service. This should be done prior to the transportation taking place.
- **Diagnosis (if known):** Only include as much information as the member is willing to share.
- **Name of Escort:** If member is traveling with an escort, include their first and last name.
- **Relationship:** Indicate the escort's relationship to the member.

Lower Section

- **Member Signature:** Member must sign, if able. If member is unable to sign, please check the appropriate box and identify the person* signing for the member ***or*** include the member's fingerprint.
    - If a tablet or other electronic device is being used, a method for the member or authorized representative of the member to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name). A fingerprint may also be used if they are unable to sign.
    - Typing the member's name in cannot serve as a substitute for an actual signature or fingerprint.
- **Driver's Signature:** The driver must sign each page.
    - If a tablet or other electronic device is being used, a method for the driver to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name).
    - Typing the driver's name in cannot serve as a substitute for an actual signature or fingerprint.
- **Date:** The driver must date each page.
- **Page ___ of ___:** Indicate each page number and the total number of pages used to document all transports for the member, for the same date of service.
- **Did multiple members get transported in the same vehicle on this trip?** Choose yes if multiple AHCCCS members are being transported in the same vehicle.

- **Were the pick-up and drop-off locations different for the members?** Choose yes if even one member in the vehicle had a different pick-up or drop-off location, as this can affect the odometer readings.

- **Additional Information:** Any additional information that the provider thinks is needed for the processing of the claim can be entered here.

Clarification of member's "signature" requirement

* If a member is physically unable to sign (or fingerprint) the non-emergency medical transport Daily Trip Report then a parent or guardian, caretaker, escort, or family member can sign for the member and indicate their relationship to the member. If the member is transporting alone, then the trip report may be signed by the provider at the medical service appointment.

When someone else signs the trip report for the member, the trip report should show the member's name and a notation such as "by J Smith, daughter" to identify the person signing for the member.

Under no circumstances is the transport driver to sign for a member.

- Even if the transport driver is a physical or behavioral health care provider for the member, they still cannot sign for the member. If the member cannot sign for themselves then a parent, guardian, caretaker, escort, or other family member would have to sign for them. **The driver cannot sign, even if the driver overlaps one of the categories that normally could.**

Exhibit 14-3 ~ Tribal Contact List

FFS Chapter 14 Transportation Services Exhibit 14-3
Effective April 1, 2014, non-emergency transportation provider type 28 will be required to obtain a Tribal business license from the Tribe prior to performing any transport service on the reservation. A copy of the Tribal business license must be submitted to AHCCCS Provider Registration for documentation. When auditing claims AHCCCS will verify that this documentation is on file, if not the claims will be subject to recoupment.

Below are the **Tribal Business License Contacts:**

: **Ak-Chin Indian Community** 42507 West Peters & Nall Rd. Maricopa, AZ 85138 (520) 568-1063	**Pascua Yaqui Tribe** 7474 S. Camino de Oeste Tucson, AZ 85757 (520) 883-5000
Cocopah Indian Tribe 14515 S. Veterans Drive Somerton, AZ 85350 (928) 627-2061	**Pueblo of Zuni** 1203B State Highway 53 P.O. Box 339 Zuni, NM 87327-0339 (505) 782-7000 or (505) 782-7092
Colorado River Indian Tribes 2660 Mojave Road Parker, AZ 85344 (928) 669-9211	**Quechan Tribe** P.O. Box 1899 Yuma, AZ 85366-1899 (760) 572-5270
Fort McDowell Yavapai Nation P.O. Box 17779 Fountain Hills, AZ 85269 (480) 789-7000 or 480-789-7744	**Salt River Pima-Maricopa Indian Community** 10005 East Osborn Rd. Scottsdale, AZ 85256 (480) 362-7600
Fort Mojave Indian Tribe 500 Merriman Ave. Needles, CA 92363 (760) 629-4591	**Sal Carlos Apache Tribe** P.O. Box 0 San Carlos, AZ 85550 (928) 475-1600
Gila River Indian Community P.O. Box 97 Sacaton, AZ 85247 (520) 562-9621	**Tohono O'odham Nation** P.O. Box 837 Sells, AZ 85634 (520) 383-1800
Havasupai Tribe P.O. Box 10 Supai, AZ 86435 (928) 448-2731	**Tonto Apache Tribe** #30 Tonto Apache Reservation Payson, AZ 85541 (928) 474-5000
Hopi Tribe P.O. Box 123 Kykotsmovi, AZ 86039 (928) 734-2441 or 928-734-3172	**White Mountain Apache Tribe** P.O. Box 700 Whiteriver, AZ 85941 (928) 338-4346 or 928-338-1012 or 928-338-1258
Hualapai Tribe P.O. Box 179 Peach Springs, AZ 86434-0179 (928) 769-2216	**Yavapai-Apache Tribe** 2400 W. Datsi Street Camp Verde, AZ 86322 (928) 567-3649 or 928-

	649-7127
Navajo Nation P.O. Box 9000 Window Rock, AZ 86515 (928) 871-6352	**Yavapai Prescott Tribe** 530 E. Merritt Prescott, AZ 86301 (928) 445.8790

CHAPTER 15 ~ DIALYSIS SERVICES

Chapter 15 ~ Dialysis Services

Revision Dates: 4/5/2018; 1/23/2018

GENERAL INFORMATION

The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to providers. Specific questions regarding covered services, limitations, and exclusions can be found in the Arizona Administrative Codes (A.A.C.) R9-22-201 et. seq. and in the AHCCCS Medical Policy Manual (AMPM), which is available on the AHCCCS website at https://www.azahcccs.gov/shared/MedicalPolicyManual/.

COVERED SERVICES

AHCCCS covers dialysis services provided by Medicare-certified hospitals and Medicare-certified End Stage Renal Disease (ESRD) providers registered with AHCCCS.

For non-Federal Emergency Services Program (FESP) members, no prior authorization is required for dialysis supervision or services.

Covered services include:

1. All supplies, diagnostic testing (including routine, medically necessary laboratory tests), and drugs medically necessary for the dialysis treatment;
2. Medically necessary outpatient dialysis treatments;
3. Self-dialysis training provided by free-standing dialysis facilities; and/or
4. Inpatient dialysis treatments only when the hospitalization is for:
    a. An acute medical condition requiring hemodialysis treatments; or
    b. An AHCCCS-covered medical condition experienced by a member routinely maintained on an outpatient chronic dialysis program; or
    c. Placement, replacement, or repair of the dialysis access route (shunt, cannula, fistula, or graft).

The following services are *not* covered:

1. Hospital admissions solely for chronic dialysis;
2. Blood, including its storage and processing, independent of the dialysis service; and
3. Method II services.

FEDERAL EMERGENCY SERVICES (FES) MEMBERS

Arizona Revised Statutes §36-2903.03 and 8 USC 1611 provide that certain non-citizens, who otherwise meet the requirements for Title XIX eligibility, are entitled to receive only emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act, 42 CFR 440.255, and in AMPM 1100, Federal Emergency Services Program

Overview. AHCCCS will reimburse providers for emergency outpatient dialysis services provided to Federal Emergency Services Program (FESP) members with End Stage Renal Disease (ESRD).

Outpatient dialysis services are covered as an emergency service when the member's physician, nurse practitioner or physician assistant signs a monthly certification stating that the member requires dialysis services at least three times a week. The monthly certification, which will be audited by the Division of Fee-for-Service Management (DFSM), must be maintained by the provider in the patient's medical records. This required form is called a "Monthly Certification of Emergency Medical Condition" and can be found in AMPM 1120, Exhibit 1120-2.

When dialysis services are needed for the first time, the provider must submit an "Initial Dialysis Case Creation" form to DFSM. This form can be found in AMPM 1120, Exhibit 1120-1.

Both forms are also available online at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

Inpatient dialysis services for FESP members are subject to the same criteria of a current "emergency medical or behavior health condition" as defined in AMPM 1100, Federal Emergency Services Program Overview. The monthly certification form retained in the member's records must include the treating physician's opinion that a failure to receive dialysis at least three times per week would reasonably be expected to result in:

1. Placing the member's health in serious jeopardy, or
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

Reimbursement

AHCCCS reimburses free-standing dialysis facilities under an **all inclusive composite rate, which covers non-physician services, supplies, diagnostic testing and drugs.**

Rates include separate composite rates for metropolitan Phoenix, metropolitan Tucson, and all other areas.

Composite rates have been established for the following revenue codes for services provided by free-standing dialysis facilities:

821	Hemodialysis (HD) per treatment
841	Continuous Ambulatory Peritoneal Dialysis (CAPD) per day
851	Continuous Cycling Peritoneal Dialysis (CCPD) per day

All other separately billable dialysis services will be reimbursed at the FFS rate for covered services.

For hospital-based dialysis facility reimbursement, refer to Chapter 11, Hospital Services, of the Fee-For-Service Provider Billing Manual.

Providers who bill for self-dialysis training services are reimbursed at the training composite rate, when claims are billed with revenue codes 841 or 851 and condition code 73.

BILLING FOR DIALYSIS SERVICES

Physicians who bill for ESRD services must specify the units of service, as defined by the procedure code, in order to be reimbursed correctly.

- For example, if the procedure code billed by the physician states that the services are for one month, then only one unit should be billed. If the physician bills 30 units for the procedure code for dates of service September 1st through September 30th, then the claim could be denied.

Physician charges for EKG or radiology services must be billed by the physician. Hospital-based or free standing renal dialysis centers must bill on the UB-04 claim form, using bill type 72X along with the appropriate condition codes.

Hospitals with Medicare-certified outpatient dialysis facilities must split claims between dialysis services and other outpatient services.

Free standing renal dialysis facilities must bill all of the charges for one month on one UB-04 claim form. Split billing these dates of service is not allowed and the claims will be denied.

Free-standing dialysis facilities are reimbursed a composite rate, and services included in the composite rate may not be billed separately unless they are provided more frequently than specified by this policy.

The following is the list of drugs that are included in the composite rate and may *not* be billed separately:

1. Heparin and Heparin Antidotes,
2. Mannitol,
3. Glucose,
4. Antiarrhythmics,
5. Saline,
6. Antihypertensives,
7. Protamine,
8. Pressor Drugs,
9. Antihistamines,
10. Local Anesthetics,

11. Dextrose,
12. Antibiotics (if used to treat peritonitis associated with peritoneal dialysis), and
13. Albumin (if used as a volume expander).

Separately billable drugs and vaccines require medical documentation. Separately billable drugs dispensed outside the dialysis facility must be billed by the dispensing pharmacy. For additional information on pharmacy services please refer to Chapter 12, Pharmacy Services, of the Fee-For-Service Provider Billing Manual.

A free-standing ESRD facility must have appropriate CLIA certification to bill for clinical laboratory services. Laboratory services included in the composite rate, which are performed by a separate laboratory, are the responsibility of the dialysis facility.

Laboratory services that may *not* be billed separately, because they are included in the composite rate for hemodialysis and CCPD patients, include:

1. All routine clinical chemistry tests, including the below listed items.

- The following if performed *per treatment or less frequently*:
  - Hematocrit or hemoglobin and clotting time tests furnished incident to dialysis treatments.

- The following if performed *once a week or less frequently*:
  - Prothrombin time for patients on anticoagulant therapy,
  - Creatinine, and
  - BUN.

- The following if performed *once a month or less frequently*:
  - Calcium,
  - Chloride,
  - Total protein,
  - CBC,
  - Bicarbonate,
  - Phosphorous,
  - Total potassium,
  - Albumin,
  - Alkaline phosphatase,
  - SGOT, and
  - LDH.

CAPD tests that may *not* be billed separately because they are included in the composite rate for CAPD patients if performed *once a month or less frequently* include:

- BUN,
- Creatinine,

- Sodium,
- Potassium,
- Carbon Dioxide,
- Calcium,
- Magnesium,
- Inorganic Phosphate,
- Total Protein,
- Albumin,
- Alkaline Phosphatase,
- LDH,
- SGOT,
- Hematocrit (HCT),
- Hemoglobin (HGB), and
- Dialysate Protein (Serum Protein).

If any of these tests are performed more frequently than specified, the additional tests may be billed separately. These tests may be covered by AHCCCS only if medically justified by supporting documentation.

Free-standing and hospital-based dialysis facilities must bill for the Erythropoietin (EPO) on the UB-04 claim form with revenue code 634 (less than 10,000 units administered per dialysis treatment) or 635 (10,000 units or more). If the total units of EPO administered is more than 100,000 then documentation of medical necessity is required. Providers must enter the total units administered in Field 39, 40, or 41 using value code 68 *and* the number of times EPO is administered in Field 46.

For Method I patients self-dialyzing at home, EPO may be ordered for one or two months. Revenue code 635 should be billed. Providers should enter condition code 70 in any condition code field (Fields 24-30). Value code 68 and the total units of EPO ordered should be entered in Field 39, 40, or 41. Because the facility's staff did not administer EPO, the units field (Field 46) is zero. No special documentation for revenue code 635 is required in this case.

Dialysis facilities must enter the appropriate HCPCS code for EPO injections when billing revenue codes 634 and 635. Providers must enter the appropriate HCPCS code in the HCPCS/Rates field (Field 44) on the UB-04 paper claim form. If a HCPCS code is not billed with revenue code 634 or 635, the line will be denied.

Providers must enter hematocrit test results in Field 39, 40, or 41 using value code 49. EPO will not be reimbursed if the hematocrit results are greater than 37.4 percent unless medically justified. If the member resides at an elevation above 6,000 feet, a hematocrit of up to 39.5 percent is allowed. Documentation specifying the elevation is required.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter condition code 73 in any condition code field (Fields 18-28) of the UB-04 claim form. Facilities must bill revenue code 0841 (Continuous ambulatory peritoneal dialysis, per day) or revenue code 0851 (Continuous cycling peritoneal dialysis, per day). If revenue code 0841 or 0851 is billed without condition code 73, claims will be reimbursed the per diem for free-standing dialysis facilities.

Billing for Self-Dialysis Training

Providers must not bill for self-dialysis training on the same claim form used to bill for other dialysis services. Billing for self-dialysis training on a separate claim form ensures that the AHCCCS claims processing system accurately distinguishes between claims for dialysis services and claims for self-dialysis training. The claim for self-dialysis training will be assigned a separate AHCCCS Claim Reference Number (CRN) from the claim for other dialysis services for the same member and date of service span.

Billing CPT/HCPCS Codes with Revenue Codes

AHCCCS requires that certain services provided by ESRD facilities and hospitals be billed with a CPT or HCPCS code that further defines the services described by the revenue code listed on the UB-04 claim form. Units must be consistent with CPT/HCPCS code definitions.

The following table summarizes revenue code – CPT/HCPCS code requirements for ESRD facilities.

UB-04 REVENUE – CPT/HCPCS REQUIREMENTS FOR ESRD FACILITIES	
REVENUE CODE	**HCPCS/CPT CODES**
0270 – Med-Sur Supplies & Drug Admin	Various
0304 – Lab/NR Dialysis	83036, 85041
0320 – Dx X-Ray	78350
0380 – Blood	P9022
0381 – Blood/Pkd Red	P9021
0382 – Blood/Whole	P9010
0383 – Blood/Plasma	P9017
0384 – Blood/Platelets	P9019, P9020
0385 – Blood/Leukocytes	P9016
0387 – Blood/Derivatives	P9012
0390 – Blood/Stor-Processing	86000 – 86999
0634/635 – Drug/EPO	Enter the appropriate HCPCS code
0636 – Drugs/Detail Coding	Enter the appropriate HCPCS/CPT code for injections and vaccines administered.
0730 – EKG/ECG	93000, 93005

0771 – Vaccine Administration	G0008, G0009, G0010, 90471, 90472
0821 – Hemo/Composite	90935, 90937, 90999
0841 – CAPD/Composite	90999
0851 – CCPD Composite	90999
0921 – Perivascular Lab	93990
0922 – EMG	95900, 95904

DIALYSIS CLAIMS WITH MEDICARE COVERAGE

If the member has Medicare coverage, the provider must bill AHCCCS for the actual cost of the treatment. The Medicare EOMB must be attached to the claim.

AHCCCS reimburses the Medicare deductible and coinsurance amounts. To be reimbursed properly, providers must report the Medicare coinsurance and deductible amounts in the Value Code fields on the UB-04 claim form. Claims with zeroes in both the coinsurance and deductible field may be denied. For additional information refer to Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual.

Providers should report the Medicare Part B Deductible, if applicable, by entering Value Code B1 and the amount in Field 39B. Medicare Part B Coinsurance is reported by entering Value Code B2 and the amount in Field 40B.

	39 VALUE CODES			40 VALUE CODES			41 VALUE CODES		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a									
b	B1	100	00	B2	125	00			
c									
d									

Value Code B1 = Medicare Part B Deductible
Value Code B2 = Medicare Part B Coinsurance

MEDICAL REVIEW

Fee-For-Service dialysis claims submitted to the AHCCCS Administration are subject to medical review.

Services that are billed separately from the composite rate, because they were provided more frequently than specified by policy, must be justified by supporting documentation. If no documentation is submitted with the claim, or if the documentation does not support the charges, then payment for those services will be disallowed.

References

For further information on covered dialysis services for members refer to AMPM 310-E, Dialysis.

For further information on covered dialysis services for FESP members refer to AMPM 1120, Federal Emergency Services Program Dialysis.

For further information on prior authorization refer to AMPM 820, Prior Authorization.

Revision History

Date	Description of changes	Page(s)
4/5/2018	Prior authorization information added FESP Member Section updated Billing for Dialysis Services Section updated Medical Review Section updated References Section added	1 1-2 3-7 8 8
1/23/2018	Phone number removed References section added Formatting	1 8-9 All

CHAPTER 16 ~ FREE-STANDING AMBULATORY SURGERY CENTERS

Chapter 16 ~ Free Standing Ambulatory Surgery Centers

REVISION DATES: 10/1/2018; 09/30/2014; 02/04/2012

NOTE: Historically AHCCCS used an ASC Grouper system for pricing which is no longer supported by Medicare. AHCCCS transitioned to the "new" ASC model effective 10/1/2008. This revision as presented below is a replacement of the outdated chapter.

COVERED SERVICES

An Ambulatory Surgical Center (ASC) is a certified, free-standing facility that operates exclusively for the purpose of furnishing outpatient surgical services.

The AHCCCS ASC fee schedule will not group rates, but will assign a rate to each allowable code. This structure is similar to the Medicare ASC structure but rates will be AHCCCS specific. AHCCCS does not bundle procedure codes with implants.

The AHCCCS fee schedule payment covers all services provided in the ASC in conjunction with rendering surgical procedures, including but not limited to, nursing services, medical supplies, equipment, and the use of the facility.

PRIOR AUTHORIZATION

Ambulatory surgical facilities furnishing non-emergency surgical services must obtain a PA number for scheduled ambulatory surgery except voluntary sterilization procedures and dialysis related services including FES on Extended Services.

The facility's PA number is *separate* from the surgeon's PA number.

GENERAL BILLING

The Ambulatory Surgical Center must bill on the CMS1500 form type with the surgical CPT procedure code(s) and appropriate modifier(s). Refer to the ASC FFS Rates & Codes available on the AHCCCS website at:

https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/ASCrates.html
The ASC will also follow the Facility Outpatient Fee Schedule (OPFS) Correct Coding Initiatives (CCI).

REIMBURSEMENT

The AHCCCS ASC fee schedule will assign a rate to each allowable code.
The AHCCCS fee schedule may have fees established as zero for codes that are allowable in the ASC setting, but are included in the fees associated with the surgical procedures. Unlike

other AHCCCS fee schedules, if the fee for the procedure is $0.00 for the claim date of service, the allowed amount should be $0.00 (zero pay).
Appropriate modifier reductions are applied for ASC claims (i.e. multiple surgeries, bilateral surgeries, etc.) ASC claims with more than four secondary surgical procedures will pend for Medical Review.

Revision History

Date	Description of changes	Page(s)
10/1/2018	Updating Link to ASC Rates Formatting	1 All

CHAPTER 17 ~ FREE STANDING BIRTHING CENTERS

Chapter 17 ~ Free Standing Birthing Centers

Revision Dates: 4/2/2018; 12/1/2011

General Information

Free Standing Birthing Centers are out-of-hospital, outpatient obstetrical facilities staffed by registered nurses and equipped to manage uncomplicated low-risk labor and delivery. The facility must be affiliated with and in close proximity to an acute care hospital for management of complications if they arise. Birthing centers must be licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birthing Centers to be registered with AHCCCS.

Labor and delivery services rendered through free standing birthing centers must be provided by licensed physicians (i.e., the member's attending physician or an obstetrician with hospital admitting privileges), or a certified nurse practitioner in midwifery (a.k.a. certified nurse midwife) or a registered nurse who is both accredited/certified by the American College of Nurse-Midwives *and* who has admitting privileges for labor and delivery services.

Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery are anticipated may be scheduled to deliver at a free standing birthing center.

Risk status must be determined by the attending physician or nurse midwife using standardized assessment tools for high-risk pregnancies from the American College of Obstetricians and Gynecologists and the National Association of Childbearing Centers. The age of the member must be a consideration in the risk status evaluation. Generally, members under 18 years of age may be considered high risk.

Billing Requirements

Birthing centers must bill for services on a UB-04 claim form using Revenue Code 724 (Birthing Center) and Bill Type 84X.

AHCCCS reimburses licensed and certified free standing birthing centers a facility fee that covers labor and delivery services provided to eligible AHCCCS members. Claims for birthing center services are reimbursed at 80 percent of covered charges.

Professional providers must bill separately on a CMS 1500 claim form for prenatal care, delivery, postpartum care, and the newborn exam. Claims for OB services must be billed in accordance with AHCCCS policy. For additional information please refer to Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual.

Reimbursement for professional services is the lesser of billed charges or the AHCCCS capped-fee-for-service fee schedule amount.

References

For additional information on labor and delivery services provided in a Free Standing Birthing Facility please refer to AMPM 410, Maternity Care Services.

For additional information on billing for professional services please refer to Chapter 10, Individual Practitioner Services and Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual.

For additional information on what AHCCCS does not consider to be a low-risk delivery, that is not appropriate for a Free Standing Birth Center, please refer to A.A.C R9-16-111 through A.A.C. R9-16-113.

Revision History

Date	Description of changes	Page(s)
4/2/2018	Added a certified nurse practitioner in midwifery as an approved clinician type. Updated the birthing center reimbursement rate to 80% of covered charges. A References Section was added for additional information. Formatting	1 1 2 All

CHAPTER 18 ~ FEDERAL EMERGENCY SERVICES PROGRAM

Chapter 18 ~ Federal Emergency Services Program

Revision Dates: 1/8/2018

GENERAL INFORMATION

AHCCCS provides emergency health care services through the Federal Emergency Services Program (FESP) for qualified and nonqualified aliens, as specified in 8 USC 1611 et seq., who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship.

The covered services, limitations and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM) available on the AHCCCS website at https://www.azahcccs.gov/shared/MedicalPolicyManual/.

COVERED SERVICES AND LIMITATIONS

Any services billed must meet the federal definition of emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement.

"Emergency medical or behavioral health condition" for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including extreme pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Serious physical harm to self or another person (for behavioral health conditions).

Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary, but may not meet this definition for FESP.

For purposes of this chapter, "acute" means symptoms that have arisen quickly and which are short-lived. "Chronic" means a health related state that is not acute.

NOTIFICATION REQUIREMENTS

In accordance with the Balanced Budget Act, prior authorization cannot be required for emergency services. Each time emergency services are delivered to an FESP member, the federal criteria for an emergency medical condition must be met in order for the claim to be considered for payment.

Prior authorization for outpatient dialysis is met when:

- The treating physician has submitted the completed and signed Initial Dialysis Case Creation Form to AHCCCS; and
- When the treating provider has completed and signed a Monthly Certification of Emergency Medical Condition for the month in which outpatient dialysis services are received.

Please refer to AMPM Exhibit 1120-1 (Initial Dialysis Case Creation Form) and Exhibit 1120-2 (Monthly Certification of Emergency Medical Condition) for the initial form and the monthly certification form.

The monthly certification form is retained in the member's records by the treating physician and must include the treating physician's opinion stating that the failure of the FESP member to receive dialysis at least three times per week would reasonably be expected to result in:

4. Placing the member's health in serious jeopardy, or
5. Serious impairment of bodily function, or
6. Serious dysfunction of a bodily organ or part.

Services rendered through the FESP are subject to all exclusions and limitations on services in R9-22-217. This includes, but is not limited to, the limitations on inpatient hospital services as described in R9-22-204 and AMPM Chapter 300, Policy 310-K, Hospital Inpatient Services.

All emergency services under the FESP, in any setting, are subject to retrospective review to determine if an emergency did exist at the time of service. If AHCCCS determines that the service did not meet the definition of an emergency medical or behavioral health condition then the following actions may occur:

1. Denial or recoupment of payments,
2. Feedback and education to the provider, and/or
3. Referral for investigation, if there appears to be a pattern of inappropriate billing.

BILLING AND DOCUMENTATION REQUIREMENTS

FESP members are not enrolled in health plans and they have no primary care physician. Claims for services are reimbursed by the AHCCCS Administration on a Fee-For-Service basis.

CMS 1500 billers must check the emergency box (Field 24I) and UB-04 billers must enter a "1" in the Admit Type (Field 19) to identify the services billed as an emergency.

All claims for services provided to members eligible under the FES program will be reviewed by the AHCCCS Administration on a case-by-case basis. All claims must be submitted to AHCCCS with documentation that supports the emergent nature of the services provided or AHCCCS must have remote access to the medical records.

Examples of documentation include emergency room records, physician progress note(s), operative reports, OB triage records, discharge summary, etc. The documentation must verify the medical emergency as defined in the federal guidelines. Providers should not attach the entire medical record.

Claims submitted without documentation will be denied because AHCCCS will not be able to verify the emergent nature of the services billed on the claim.

Providers should follow all other applicable billing instructions in this manual.

SPECIAL INSTRUCTIONS ON MATERNITY CLAIMS

Routine prenatal services are not covered under the FES Program.

Providers should only bill the following codes for labor and delivery services for FESP members:

59409	Vaginal delivery only
59514	Cesarean delivery only
59612	Vaginal delivery only, after previous Cesarean delivery
59620	Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery

Claims billed using the global delivery codes will be systematically reduced to the delivery only reimbursement rate.

REFERENCES

Detailed information is also available in Chapter 1100 of the *AHCCCS Medical Policy Manual (AMPM)* available at https://www.azahcccs.gov/shared/MedicalPolicyManual/.

Questions about *billing* should be directed to the AHCCCS Claims Customer Service Unit at:

(602) 417-7670 (Phoenix area)

(800) 794-6862 (In state)

(800) 523-0231 (Out of state)

REVISION HISTORY

Date	Description of changes	Page(s)
1/8/18	Documentation Requirements section updated Updated phone numbers Formatting Changes	3 All All

CHAPTER 19 ~ BEHAVIORAL HEALTH SERVICES

Chapter 19 ~ Behavioral Health Services

REVISION DATE: 12/7/2018; 7/31/2018; 2/16/2018; 1/17/2018; 12/29/2017; 10/1/2017; 09/17/2015; 07/15/2014

Important Notice:

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- AMPM 310-B, Behavioral Health Services Benefit
- AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit
  - Non-Title XIX/XXI service information will be transferred to AMPM 320-T.
- The Provider Billing Manuals
  - Billing information for Fee-For-Service providers will be transferred to the Provider Billing Manuals.
    - Chapter 19, Behavioral Heath Services, of the Fee-For-Service Provider Billing Manual
    - Chapter 12, Behavioral Heath Services, of the IHS/Tribal Provider Billing Manual
- Appropriate Policies as necessary.
  - i.e. Service benefit information, including transportation and transportation billing information pertinent to MCOs and FFS providers, will be transferred to AMPM 310-BB.

Behavioral Health Services

The covered services, limitations, and exclusions described are global in nature and are listed in this chapter to offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual (AMPM), AHCCCS Administrative Code A.A.C. R9-28-201 et seq., and R9-22-201 et seq. The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at www.azahcccs.gov.

AHCCCS covered behavioral health services include, but are not limited to:

- Inpatient hospital services
- Behavioral Health Inpatient Facilities (BHIF)
- Behavioral Health Residential Facilities (BHRF)
- Partial care (supervised day program, therapeutic day program, medical day program)

- Individual therapy and counseling
- Group and/or family therapy and counseling
- Emergency/crisis behavioral health services
- Behavior management (behavioral health personal assistance, family support, peer support)
- Evaluation and diagnosis
- Psychotropic medication, including adjustment and monitoring of medication
- Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support)
- Laboratory and Radiology Services for medication regulation and diagnosis
- Screening
- Case Management Services
- Emergency Transportation
- Non-Emergency Transportation
- Respite Care (with limitations)
- Therapeutic foster care services

Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services

On October 1, 2018, AHCCCS integrated acute physical and behavioral health services for most members. This is referred to as AHCCCS Complete Care (ACC).

Title XIX and Title XXI (KidsCare) members are eligible to receive behavioral health services through their integrated health plan. American Indian/Alaskan Native (AI/AN) members may choose the American Indian Health Program (AIHP); or AIHP and a Tribal Regional Behavioral Health Authority (TRBHA), if a TRBHA is available in their area; or an AHCCCS Complete Care (ACC) Health Plan.

AIHP is an integrated Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians, which reimburses for both physical and behavioral health services, including Children's Rehabilitative Services (CRS), provided by and through the Indian Health Services (IHS), tribal health programs operated under 638, or any other AHCCCS registered provider.

AI/AN members who enroll with AIHP for their physical health services also receive their behavioral health services through AIHP, or may choose to receive their behavioral health services through a TRBHA, if a TRBHA is available in their area.

The ACC plan, AIHP or AIHP/TRBHA is responsible for the payment of *both* physical and behavioral health services, including CRS services. (For exceptions, see Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services, below.)

Claims for *both* physical and behavioral health services, including CRS services, should be sent to the member's integrated health plan*. Integrated health plans include:

- ACC health plans,
- AIHP, and
- AIHP/TRBHA.

Claims for AIHP and TRBHA members should be sent to AHCCCS DFSM.

***** Claims for services provided for Title XIX members through IHS or Tribal 638 facilities should be sent to AHCCCS DFSM.

Claims for services provided for Title XXI (Kidscare) members through IHS/638 facilities should be sent to the enrolled ACC plan, or to AHCCCS DFSM for AIHP enrolled members.

<u>ALTCS/Tribal ALTCS EPD</u>

MCO ALTCS and Tribal ALTCS Elderly and Physically Disabled (EPD) plans are integrated long term care services plans that reimburse for both physical and behavioral health services, including CRS services.

Tribal ALTCS Programs provide case management services to American Indians who reside on reservation. Members enrolled with Tribal ALTCS Programs may receive behavioral health services on a Fee-For-Service basis from any AHCCCS registered Fee-For-Service provider, with prior authorization from the tribal case manager.

Claims for Tribal ALTCS members should be sent to AHCCCS DFSM.

Additional information on behavioral health services for Tribal ALTCS members can be found in AMPM 1620-G, Behavioral Health Standards.

Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services

This section assists Fee-for-Service providers in benefit coordination and in determining financial responsibility for AHCCCS covered physical and behavioral health services for members enrolled with **different entities** for their physical and behavioral health services. These members include:

- ALTCS members enrolled with DES/DDD;
- Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and
- Adults with a Serious Mental Illness (SMI) designation.

Behavioral Health services for the above members are provided through the RBHAs or TRBHAs.

For the above members enrolled with different entities for their physical and behavioral health services, payment is determined by the principal diagnosis appearing on the claim, except in limited circumstances as described in ACOM Policy 432, Attachment A - Matrix of Financial Responsibility.

Definitions

For definitions regarding behavioral health services and practitioners, please see AMPM 310-B, Behavioral Health Service Benefit.

Behavioral health diagnoses can be located in the AHCCCS Outpatient Behavioral Health Diagnosis List available on the AHCCCS website.

Behavioral Health Entity
For members enrolled with different entities for their physical and behavioral health services, the Behavioral Health Entity is the entity which provides behavioral health services.

Behavioral Health Entities can be one of the following:

- Regional Behavioral Health Authority (RBHA);
- Tribal Regional Behavioral Health Authority (TRBHA)

Enrolled Health Plan
For members enrolled with different entities for their physical and behavioral health services, the Enrolled Health Plan is the entity which provides physical health services.

- For members who elect AIHP, the enrolled health plan is AIHP. This includes AIHP members with or without a CRS designation.
- For members who elect an ACC plan, the enrolled health plan is the ACC plan.
- For members enrolled in DDD, the enrolled health plan is DDD. This includes DDD members with or without a CRS designation.
- For members enrolled in CMDP, the enrolled health plan is CMDP. This includes CMDP members with or without a CRS designation.
- For members with an SMI designation who elect a TRBHA or non-integrated RBHA for behavioral health services, the enrolled health plan is the elected ACC plan or AIHP.

Medication Assisted Treatment (MAT)
The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

Principal Diagnosis
The condition established to be chiefly responsible for occasioning the admission or care for the member, as indicated by the principal diagnosis on a UB-04 claim form from a facility, or the first-listed diagnosis on a CMS 1500 claim form.

The principal diagnosis should not be confused with the admitting diagnosis or any other diagnosis on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services

Payment for AHCCCS covered services for members enrolled with different entities for their physical and behavioral health services is determined by the principal diagnosis appearing on the claim, except in limited circumstances. Benefit coordination and financial responsibilities for AHCCCS covered behavioral health services can be found in the AHCCCS Contractor Operations Manual (ACOM) Policy 432, Attachment A, Matrix of Financial Responsibility. ACOM is available online at:

https://www.azahcccs.gov/shared/ACOM/

For further information on requirements for providers in determining payment responsibility and a member's eligibility, please refer to AMPM Chapter 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits.

Inpatient Facility Payment Responsibility

Facility Claims

1. If the principal diagnosis on the claim is a behavioral health diagnosis, then payment of the facility claim is the responsibility of the behavioral health entity for both behavioral and physical health services.

2. If the principal diagnosis on the claim is a physical health diagnosis, then payment of the facility claim is the responsibility of the enrolled health plan for both behavioral and physical health services.

3. When the principal diagnosis on an inpatient claim is a behavioral health diagnosis, the assigned behavioral health entity shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the member's enrolled health plan authorized and/or determined medical necessity of the stay, such as when the admitting diagnosis is a physical health diagnosis.

4. The enrolled health plan must coordinate with the assigned behavioral health entity when both physical and behavioral health services are rendered during an inpatient stay. The enrolled health plan must be notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations and determinations of medical necessity.

Professional Claims

1. Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the professional claim.

2. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity.

3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless of the entity that authorized the inpatient stay.

Emergency Department Payment Responsibility

Facility Claims

1. Payment of a facility claim for an emergency department visit, not resulting in an inpatient admission, is the responsibility of the enrolled health plan regardless of the principal diagnosis on the facility claim.

Professional Fees

1. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim.

2. Payment responsibility for the emergency department visit and professional services may not necessarily be the same entity.

3. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the emergency department visit.

Primary Care Provider Payment Responsibility

1. The enrolled health plan is responsible for reimbursement of services associated with a primary care provider visit, when behavioral health services are provided by a PCP within their scope of practice, including professional fees, related prescriptions, laboratory and other diagnostic tests.

   The primary care providers who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory, and other diagnostic tools necessary for diagnosis and treatment. Clinical tool kits for the treatment of anxiety, depression, postpartum depression, and ADHD are available in Appendix F, Adult Behavioral Health Tool Kits of the AMPM.

   The enrolled health plan is responsible for payment of medication management services provided by the primary care provider, while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the assigned behavioral health entity.

   Note: For Tribal ALTCS members with an AHCCCS ID card, the member ID card may state the Tribal ALTCS Program the member is enrolled in, however, claims should still be submitted to AHCCCS DFSM.

Transportation Payment Responsibility

When the enrolled health plan is ACC or AIHP and the member is assigned to a RBHA, the enrolled health plan is responsible for payment of medically necessary transportation services (emergent and non-emergent) when the diagnosis code on the claim is for physical health, regardless of which entity scheduled the appointment.

There are unspecified diagnoses designated for physical health (R68.89) and behavioral health (F99). These unspecified diagnoses, when permitted, will tell the system who is the responsible payer. If a member is enrolled with a RBHA and submits a claim to AHCCCS with the unspecified diagnosis code F99, the claim may deny since the claim would need to be sent to the RBHA.

Additional Information

For further information regarding payment responsibility for transportation, outpatient services, physician services, and therapies associated with behavioral health, or for additional information on inpatient and emergency department payment responsibilities, please see ACOM Policy 432 Attachment A, the Matrix of Financial Responsibility by Responsible Party Matrix.

https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432A.pdf

All AHCCCS services musts be medically necessary, cost effective, and federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712 et seq.

General Billing Information

Place of Service

To determine which place of service codes are available with specific service codes, please reference the B2 matrix at: https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls.

Common Modifiers for the Billing of Behavioral Health Services

For additional information on modifiers please reference the B2 matrix at https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls.

Emergency Services

Emergency behavioral health services may include inpatient services, evaluation, crisis management counseling, psychotropic medication stabilization, and/or other therapeutic activities to reduce or eliminate the emergent/crisis situation.

Emergency behavioral health services are provided in situations where the absence of immediate medical attention could result in:

- Placing the member's health in serious jeopardy,
- Serious impairment of bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Serious physical harm to self or another person.

A behavioral health evaluation provided by a psychiatrist or a psychologist is covered as an emergency service, if required to evaluate or stabilize an acute episode of mental disorder or substance abuse.

Providers of emergency behavioral health services must verify a member's eligibility and enrollment status to determine the need for notification for care coordination (e.g., ALTCS program, ACC plan, RBHA, TRBHA, AIHP), and to determine who is responsible for payment for services rendered (e.g., ACC plan, RBHA, AHCCCS DFSM for AIHP, TRBHA, Tribal ALTCS).

Claims for emergency services do not require prior authorization, but when requested, the provider must submit documentation with the claim which justifies the emergent nature of the service.

In the event of an emergency behavioral health admission for FFS members, the provider is required to coordinate care with the member's enrolled health plan and/or behavioral health entity. Contact information for RBHA/TRBHAs, ACC health plans, AIHP, and Tribal ALTCS Programs is available on the AHCCCS website.

In the case of an emergency admission for a Tribal ALTCS member, the provider should notify a tribal case manager within 24 hours of the emergency admission, and for MCO ALTCS, the provider should notify the ALTCS contractor within 24 hours of the emergency admission.

The provider must notify the AHCCCS Prior Authorization Unit within 72 hours of the emergency behavioral health admission of a Tribal ALTCS, AIHP or TRBHA-Assigned Fee-For-Service (FFS) member. AHCCCS may perform concurrent review to determine whether the hospitalization of a member for emergency behavioral health services is medically necessary.

Crisis Services

A crisis is any situation in which a person's behaviors put them at risk of hurting themselves and/or others, and/or when they are not able to resolve the situation with the skills and resources available to them. Persons in a crisis present with sudden, unanticipated, or potentially dangerous behavioral health conditions, episodes or behaviors.

Crisis services include mobile team services, telephone crisis response, and urgent care inpatient services including those provided at a hospital, sub-acute and/or residential treatment center. Crisis stabilization services will continue to include related transportations and facility charges.

Crisis services for American Indian/Alaskan Native (AI/AN) members enrolled in either an ACC health plan or AIHP are the responsibility of the Regional Behavioral Health Authority (RBHA).

> Note: Integration begins on 10/1/2018, and there will be no change in crisis services for Title XIX and XXI members. RBHAs will continue to serve the same geographic service areas that they served prior to 10/1/2018.

For AIHP members, for the first 24 hours, crisis services should be billed to the RBHA. Services us to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

After the first 24 hours (i.e. the 25th hour forward) crisis services should be billed to AIHP. Services up to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

In situations where the crisis services overlap days, the per diem code can span the two dates. The crisis provider would bill the first per diem as described above the dates of service 1 and 2, and the second per diem for dates of service 2 and 3, if applicable. The crisis provider may also bill hourly as described above, if applicable, in addition to the per diem.

For further information regarding what services are considered a crisis service and when the RBHA and ACC health plan or AIHP are responsible for payment, please see Exhibit 12-1, Matrix of Financial Responsibility for Crisis Services.

Example 1: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 6 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
  - The per diem code should be billed <u>once</u> to the RBHA for the first 24 hour time frame. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 3 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for the first 5 hours of Day 2:
  - An hourly rate for 3 hours (from 3 p.m. to 6 p.m.) should be billed to AIHP. This covers the 3 hours beyond the 24th hour on October 9th (from 3 p.m. to 6 p.m.).

Example 2: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 11 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
  - The per diem code should be billed once to the RBHA for the first 24 hour time period. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 3 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for Day 2:
  - "Day 2" started at 3 p.m. on October 9th. Since crisis services extended beyond the 5th hour of Day 2, the provider should bill the per diem to AIHP.

For mobile services, H2011 should be used and the HT modifier added for the two-person multi-disciplinary team.

For additional information on crisis services please visit the Crisis Services FAQs on the AHCCCS website at:

https://www.azahcccs.gov/AHCCCS/Downloads/ACC/View_Crisis_System_FAQs.pdf

Pre-Petition Screening, Court Ordered Evaluations, and Court Ordered Treatment

At times it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a person's mental disorder when that person is unable or unwilling to participate in treatment. For specific information pertaining to the pre-petition screening that examines the person's mental status please refer to AMPM 320-U.

Financial responsibility for the cost of legal proceedings, the pre-petition screening, and the court-ordered evaluation related to civil commitment proceedings is the responsibility of the county, unless the county has an agreement with AHCCCS to provide those services. For specific information pertaining to such agreements and financial responsibility please see ACOM 437. For specific policy information pertaining to court ordered evaluations and treatments please refer to AMPM 320-U.

Services are no longer the county's responsibility after the earliest of the following events:

- The member decides to seek treatment on a voluntary basis,
- A petition for court ordered treatment is filed with the court, or
- The member is released following the evaluation.

Court ordered treatment or voluntary treatment, following one of the above events, should be billed to the entity responsible for reimbursement of the member's behavioral health services.

During the pre-petition screening and court-ordered evaluation process, the member's enrolled entity is responsible for those medically necessary, covered behavioral health services that are not associated with the pre-petition screening and court-ordered

evaluations. Services that are Medicaid covered for an enrolled member, separate from the pre-petition screening and court-ordered evaluation services, such as case management, may also be paid with Title XIX or Title XXI funding. Physical health services provided during the court-ordered evaluation process remain with the member's enrolled entity, and are not the responsibility of the county.

Preparation of a report on the member's psychiatric status for primary use within the court is not a Title XIX or Title XXI reimbursable service. However, Title XIX or Title XXI funds may be used for a report on the member's psychiatric status if it is to be used by a treatment team or physician. The fact that the report may also be used in court, as long as it is not the primary reason for the report's creation, doesn't disqualify the service for Title XIX or Title XXI reimbursement.

Based on the results of the court-ordered evaluation and hearing, the member may be assigned to court-ordered treatment. Treatment may include a combination of inpatient and outpatient treatment. Fiscal responsibility for the court-ordered treatment will be with the member's enrolled entity.

For further information pertaining to court-ordered evaluation, treatment, and fiscal responsibility please refer to ACOM 437 and AMPM 320-U.

Inpatient Services

Inpatient services include services provided in an acute care hospital or a distinct unit of an acute care hospital, inpatient psychiatric hospital, Level I residential treatment centers, and Level I sub-acute facilities.

Billing for Inpatient and Outpatient Services

For a list of allowable procedure codes by provider type, refer to the Provider Types and Allowable Procedure Codes Matrix at:

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixB2.xls

Inpatient services are billed on the UB-04 claim form and are reimbursed on a per diem basis. Inpatient services include all services provided during the inpatient stay except those provided by behavioral health independent providers. Please refer to the Billing for Professional Services section below.

Outpatient hospital services are billed on a UB-04 and reimbursed at the Outpatient Prospective Fee Schedule (OPFS) rate.

Billing for Professional Services

Provider types that can bill for category of service 47 (mental health) include:

08 MD-physician with psychiatry and/or neurology specialty code 192 or 195

11 Psychologist

18 Physician Assistant

19 Registered Nurse Practitioner

31 DO-Physician Osteopath with psychiatry and/or neurology specialty code 192 or 195

77 Behavioral Health Outpatient Clinic

85 Licensed Independent Social Worker (LISW)

86 Licensed Marriage and Family Therapist (LMFT)

87 Licensed Professional Counselor (LPC)

A4 Licensed Independent Substance Abuse Counselor

BC Board Certified Behavioral Analyst

Not all provider types can bill for all services. For a list of allowable procedure codes by provider type refer to the Allowable Procedure Code Matrix online at:

https://www.azahcccs.gov/resources/Downloads/PerformanceMeasures/AccesstoBHProviderServiceCodes_CYE%2014.pdf

Claims from the above-listed providers must be submitted under the individual provider ID number.

Provider type 77 must use their facility **NPI** as the **billing** and **attending** provider, unless the attending provider is a registered AHCCCS provider, in which case they must use the attending provider NPI.

All other behavioral health professionals, like a behavioral health technician (BHT), must be affiliated with a licensed behavioral health agency/facility, clinic, alternative residential facility or outpatient hospital, and those services must be billed through the affiliated setting.

For BCBA and BHT criteria refer to:

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA1.pdf

Services must be billed on a CMS 1500 claim form with appropriate ICD diagnosis codes and CPT procedure codes. AHCCCS does not accept DSM-IV codes. Claims submitted with DSM-IV codes will be denied.

The attending physician must be listed as the provider's NPI, except when billing for BCBA, BHPP, or BHT professionals. When billing for BCBA, BHPP or BHT professional services, the clinic NPI is billed as the attending.

Services are reimbursed at the AHCCCS capped Fee-For-Service rate.

Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice. This includes the monitoring and adjustments of behavioral health medications. For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

For further information regarding MAT please refer to AMPM 510, Primary Care Providers.

Billing for Methadone Administration

AHCCCS policy allows only five provider types to bill for methadone administration. Provider types 08 (MD-physician), 18 (Physician assistant), 19 (Registered nurse practitioner), 31 (DO-physician osteopath), and 77 (Clinic) may bill the AHCCCS Administration and its contracted health plans and program contractors for methadone administration. These codes are in category of service 01 – Medicine.

Methadone administration must be billed with the following codes:

- H2010 Comprehensive medication services, office, per 15 minutes; and/or
- H0020 Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program).

Both codes must be billed with the HG (Opioid addiction treatment program) modifier.

References

Please refer to the following chapters for additional information:

AMPM Exhibit 300-2A AHCCCS Covered Services Behavioral Health

AMPM Chapter 300, Policy 310-B Behavioral Health Services

AMPM Chapter 310-V Prescription Medications-Pharmacy Services (the section on Behavioral Health Medication Coverage)

AMPM Chapter 510 – Primary Care Providers

AMPM Chapter 320-U Pre-Petition Screening, Court Ordered Evaluation and Court Ordered Treatment

ACOM Chapter 437 Financial Responsibility for Services After the Completion of Court-Ordered Evaluation

ACOM Chapter 432, Attachment A – Matrix of Financial Responsibility by Responsible Party

AMPM Chapter 1200 contains additional information regarding behavioral health services for members eligible for the ALTCS program.

AMPM Chapter 650 – B, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening/Application for Public Health Benefits

Chapter 12, Pharmacy, of the Fee-For-Service Provider Billing Manual

For the Case Manager Billing Guide refer to:
https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA4.pdf

Presentation: Overview of BH Services for IHS and 638 Providers:
https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA3.pdf

For additional crisis service billing examples please view the November 2018 edition of Claims Clues:
https://www.azahcccs.gov/PlansProviders/Downloads/ClaimsClues/2018/ClaimsCluesNov2018.pdf

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the AHCCCS Medical Policy Manual and the FFS and IHS/Tribal Provider Billing Manuals. Please see ‘Important Notice’ on page 1.

Revision History

Date	Description of changes	Page(s)
** Please note that all page numbers correspond to the updated pages in the individual chapters, not the Master PDF document.		
12/7/2018	The entire chapter was restructured and formatting updated.	1-18
	Important Notice regarding the Covered Behavioral Health Service (CBHSG) added.	1-2
	List of covered behavioral health services updated.	2-3
	New section added called 'Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services.'	
	ALTCS/Tribal ALTCS EPD section updated, including an addition regarding where claims should be sent for BH services. (To AHCCCS DFSM).	3
	New section added called 'Benefit Coordination for Members Enrolled with Different Entities for Physical and Behavioral Health Services.' The referenced populations are: • ALTCS members enrolled with DES/DDD; • Foster care children enrolled with the Comprehensive Medical Dental Program (CMDP); and • Adults with a Serious Mental Illness (SMI) designation.	4
	Definitions section updated for integration. The following definitions were removed (and a reference to where they can be found in AMPM has been added): Acute Care Services Acute Care Hospital American Indian Health Program (AIHP) Behavioral Health Diagnosis Court Ordered Evaluation Court Ordered Treatment CRS Fully Integrated CRS Only CRS Partially Integrated – Acute CRS Partially Integrated – Behavioral Health (BH) Primary Care Provider The following definitions were updated: Behavioral Health Entity Enrolled Health Plan	4-5
	Payer responsibility section updated to read as 'Payment Responsibility for Members Enrolled with Different Entities for their	5-8

	Physical and Behavioral Health Services.' The information regarding who the payer is for inpatient facility and professional claims, ER facility and professional claims, transportation claims, and primary care provider payments has been updated. A General Billing Information section was added. A Place of Service section was added. A Common Modifiers for the Billing of Behavioral Health Services section was added. The Emergency Services section was updated for integration billing information. A Crisis Services section was added with billing examples. The Pre-Petition, Court Ordered Evaluations, and Court Ordered Treatment section was updated. A minor update to the Medication Assisted Treatment section was done. It was changed from: "To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat anxiety, depression (including postpartum depression), ADHD, and/or Opioid Use Disorder (OUD)" to "To address the opioid use epidemic, the AHCCCS Administration and its Contractors shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP within their scope of practice." The References section was updated.	 8 8 8 8-9 9-10 10-11 12 15-16
7/31/2018	Link updated on page 8 to link to the AHCCCS Behavioral Health Allowable Procedure Code Matrix	8
2/16/2018	Billing the AIR for BH services conducted by a non-AHCCCS registered behavioral health professional, like a BHT, clarification added.	10
1/17/2018	IHS Tribally Owned or Operated 638 Facilities section corrected to read as "KidsCare members enrolled with a MCO should have claims sent to the TRBHA."	13
12/29/2017	Definitions updated Emergency Services section updated Billing for Professional Services section updated Billing for Methadone Administration section updated Medication Assisted Treatment for Opioid Use Disorder added General Requirements Regarding Payment for Physical and Behavioral Health section updated. Inpatient Facility Payment Responsibility section updated Emergency Department Payment Responsibility section updated	2-7 7-8 11 10-11 11 12-14 12 12

	IHS Tribally Owned or Operated 638 Facilities section updated Specific Circumstances Regarding Payment for Behavioral Health section updated Court Ordered Evaluations & Financial Responsibility section added References updated Format changes	13 13-14 15 15-16 All
10/1/2016	Behavioral Health changes effective service date 07/01/2016 and later BH Billing Matrix	9 – 16
09/17/2015	New format Changed “ICD-9” to “ICD” in preparation for 10/1/2015 ICD-10	All

CHAPTER 20 ~ HOME HEALTH CARE SERVICES

Chapter 20 ~ Home Health Care Services

REVISION DATES: 10/1/2018; 10/1/2017

Effective date of service 10/1/17, in accordance with CFR § 440.70, the initiation of Home Health Services will be subject to face-to-face encounter requirements for the FFS population.

COVERED SERVICES

AHCCCS covers medically necessary home health services provided in the member's place of residence in lieu of hospitalization. AHCCCS also covers home health services for elderly and physically disabled and developmentally disabled ALTCS members under Home and Community Based Services.

Covered services include:

- Home health nursing visits;
- Home health aide services;
- Medical equipment, appliances and supplies; and/or
- Therapy services within certain limits.

Home health nursing and home health aide services must be provided on an intermittent basis and ordered by a physician.

Outpatient speech therapy services are covered for EPSDT and ALTCS members only.

Home health care services are not covered for members eligible for the Emergency Services Program.

Face-To-Face Encounter Requirements

Effective date of service 10/1/17, in accordance with CFR § 440.70, the initiation of Home Health Services will be subject to face-to-face encounter requirements for the FFS population. The face-to-face encounter must meet the following criteria:

7. It must relate to the primary reason the member requires home health services.

8. It must occur no more than 90 days prior to or 30 days following the start of services.

9. The-face-to-face encounter must be conducted by one of the following:

a. The ordering physician,
b. A nurse practitioner, clinical nurse specialist, or certified nurse midwife working in collaboration with the physician in accordance with state law,
c. A physician assistant under the supervision of the ordering physician, or
d. For member's admitted to home health immediately after an acute or post acute stay, the attending acute or post acute physician.

10. The non-physician practitioner specified above, who performs the face-to-face encounter, must communicate the clinical findings of the face-to-face encounter to the ordering physician.

11. The clinical findings must be incorporated into a written or electronic document in the member's record. Regardless of which practitioner performs the face-to-face encounter, the physician responsible for ordering the home health service must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes within the medical record.

12. The ordering physician must also document on the prescription order the face-to-face encounter details, including date of encounter, the diagnosis, and the practitioner who conducted the encounter.

The face-to-face encounter may occur through telehealth.

Face-to-face encounter requirements apply to the initiation of services only.

Face-to-face encounter requirements do apply to rehabilitative therapies done in the home.

Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice.

BILLING FOR SERVICES

All home health services require prior authorization from the AHCCCS Prior Authorization Unit (acute care members) or the member's case manager (ALTCS members). All home health agencies must bill for services on a CMS 1500 claim form.

- For dates of service on or after January 1st, 2016, G0154 has been replaced with the following:

  G0299 (Direct skilled nursing services of a registered nurse – RN – in the home health or hospice setting)

  G0300 (Direct skilled nursing of a licensed practical nurse – LPN – in the home health or hospice setting

Under the Health Insurance Portability and Accountability Act (HIPAA), all local codes have been replaced by standard HCPCS codes and modifiers. AHCCCS local codes included the "W" and "Z" codes formerly used to bill nursing services and respiratory therapy services.

Providers may bill with the new codes for dates of service on and after October 1, 2003. Providers may continue to use the current AHCCCS-specific local codes for dates of service prior to January 1, 2004. For dates of service on and after January 1, providers must use the new codes. Claims billed with the old AHCCCS-specific codes will be denied.

This change in coding requirements applies to providers who submit claims electronically and on paper.

Home health nursing services

- Home health nursing services must be billed with the following codes:

  S9123 Nursing care, in the home; by registered nurse, per hour

  ✓ This code replaces:

  Z3030 RN & LPN (Cert HHA) Intermittent Visit

  Z3031 RN (Non-Cert HHA) Intermittent Visit

  Z3033 RN (HH Nurse/Independent) Intermittent Visit

  S9124 Nursing care, in the home; by licensed practical nurse, per hour

  ✓ This code replaces:

  Z3030 RN & LPN (Cert HHA) Intermittent Visit

  Z3035 LPN (HH nurse/independent) intermittent visit; per hour

Private duty nursing services (RN or LPN)

Private duty nursing services (RN or LPN) for ventilator dependent individuals at home who require more care than is defined as part-time or intermittent must be billed as follows:

- Registered nurse (RN) services must be billed with the following code and modifier:

  S9123 billed with TG modifier – Nursing care, in the home; by registered nurse, per hour (complex/high level of care).

  ✓ This code with modifier replaces:

  Z3032 RN (Non-Cert HHA) Continuous Visit

  Z3034 RN (HH Nurse/Independent) Continuous Visit

  Z3039 RN & LPN (Cert HHA) Continuous Care

- Licensed Practical Nurse (LPN) services must be billed with the following code and modifier:

  S9124 billed with TG modifier – Nursing care, in the home; by licensed practical nurse, per hour (complex/high level of care).

  ✓ This code with modifier replaces:

  Z3036 LPN (HH Nurse/Independent) Continuous Visit

  Z3038 LPN (Non-Cert HHA) Continuous Care

  Z3039 RN & LPN (Cert HHA) Continuous Care

Respiratory therapy services

- Respiratory therapists must bill with the following code:

  S5180 Home health respiratory therapy, initial evaluation

  ✓ This code replaces:

  W2404 Respiratory therapy performed by non-Medicare certified home health agency, limited to one (1) visit per day

  W2405 Respiratory therapy performed by Medicare certified home health agency, limited to one (1) visit per day

  W2406 Visit by respiratory therapist, limited to one visit per day

Respiratory therapists may not use the 94000 codes. Physicians and hospitals will continue to use the 94000 codes.

References

For additional information on Home Health Services please refer to AMPM 310-I, Home Health Services.

For additional information on the Prior Authorization process, please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual and to AMPM 820, Prior Authorizations. Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process, which can be found at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

Revisions/Update History

Date	Description of Change(s)	Page(s)
10/1/2018	Revision Date section added Clarification added to General Information section (changed from “medically necessary supplies” to “Medical equipment, appliances and supplies; and/or”) The following addition was made to the Face-To-Face Encounter Requirements section: “Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice. “ Information on G0299 and G0300 has been added. “Member” changed to “Member” References section added.	1 1 2 2 All 5
10/1/2017	Face-To-Face Requirements Formatting	1-2 All

CHAPTER 21 ~ ALTCS SERVICES

Chapter 21 ~ ALTCS Services

REVISION DATES: 5/04/2018; 1/23/2018; 10/01/2017; 10/01/2016; 10/01/2015; 12/18/2013

GENERAL INFORMATION

The covered services, limitations, and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual and AHCCCS Administrative Code A.A.C. R9-28-201 et seq. and R9-22-201 et seq. The AHCCCS Medical Policy Manual is available on the AHCCCS website at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/

OVERVIEW

The Arizona Long Term Care System (ALTCS) provides care and services for eligible individuals who are elderly and/or those with physical or developmental disabilities. ALTCS provides institutional care and home and community based services to members who have been determined to be at risk of institutionalization.

Covered services include the following when considered medically necessary:

1. Medical services
2. Institutional services, including:
   a. Nursing facilities
   b. Inpatient psychiatric facilities for individuals under age 21 (RTCs)
   c. Intermediate care facilities for person with Intellectual Disabilities (not covered for Fee-for-Service members)
3. Home and community based services (HCBS)
4. Hospice services
5. Speech, physical, and occupational therapies
6. Behavioral health services
7. Durable medical equipment and medical supplies
8. Private duty nursing services
9. Limited Dental Services (effective 10/01/2016 service date)
10. Emergency Dental Services (effective 10/01/2017 service date)

COVERAGE LIMITATIONS

Private rooms in nursing facilities require physician orders and must be medically necessary.

Respite care is limited to 600 hours per benefit year.

Attendant Care, when provided by the member's spouse, is limited to no more than 40 hours per week.

Therapeutic leave days are limited to nine days per contract year.

Bed hold days for members admitted to a hospital for a short stay are limited to 12 days per contract year.

Home based services not provided when member is in the hospital.

ELIGIBILITY

Application for ALTCS may be made at any of the ALTCS offices located throughout Arizona (See Exhibit 21-2). An individual may submit his or her own application or may have a family member or other representative make the application.

Applicants must meet financial and medical eligibility requirements. When it appears that an applicant is financially eligible for ALTCS, medical eligibility is determined by a Preadmission Screening (PAS). The PAS measures functional and medical disability to determine if the applicant is at risk of institutional placement.

Once determined eligible, members who are elderly or have physical disabilities (referred to as EP/D members) are enrolled with a program contractor in their county of residence. American Indian EP/D members who maintain a residence on the reservation are enrolled with a tribal contractor and receive services on a fee-for-service basis. All persons with developmental disabilities (referred to as DD members) are enrolled with the Department of Economic Security, Division of Developmental Disabilities (DES/DDD).

CASE MANAGEMENT

All ALTCS members are assigned a case manager who is responsible for identifying, planning, obtaining, and monitoring appropriate and cost-effective medical and medically related services.

The AHCCCS Administration maintains Intergovernmental Agreements (IGA) with seven tribal governments for the delivery of ALTCS case management services to tribal EP/D members with ties to their respective reservations. The seven tribal governments are the Pascua Yaqui Tribe, Gila River Indian Community, Tohono O'Odham Nation, San Carlos Apache Tribe, White Mountain Apache Tribe, Navajo Nation, and the Hopi Tribe.

EP/D members of other tribes without an IGA are enrolled with Native Health. Native Health and the tribal governments (referred to as Tribal Contractors) employ case managers who are responsible for coordinating ALTCS services to members.

The Tribal Contractors receive a monthly capitation for case management services, based on the number of tribal ALTCS members enrolled. Providers and Tribal Contractors are prohibited from billing for Case Management Services (T1016).

All other services are provided and reimbursed on a fee for service basis.

Case manager authorization of ALTCS services is required unless:

1. The member has Medicare or other insurance coverage *and* the services are covered by Medicare or the other insurance, or
2. Services were provided during a period when the member was retroactively eligible.

ALTCS services that require authorization are:

1. Medically necessary non-emergency transportation (when mileage exceeds 100 miles)
2. Homemaker services, attendant care, and personal care
3. Respite (in home and nursing facility)
4. Home health nurse and home health aide
5. Therapy (occupational, speech, respiratory, and physical)
6. DME, all orthotic and prosthetic devices, and medical supplies
7. Adult day health and home delivered meals
8. Nursing facility services, including bed hold and therapeutic leave days
9. Acute Care services

Acute care services such as in-patient hospitalizations for non-Medicare covered members and outpatient surgery must be authorized by the AHCCCS Care Management Services Unit (CMSU). Tribal case managers are not involved with acute care service authorization.

To arrange services, the case manager first contacts the appropriate provider. Once arrangements are confirmed, the case manager enters the authorized services in the Case Management Service Plan in the AHCCCS system. An authorization letter is automatically sent to the provider (except nursing facilities) verifying the services authorized.

The information entered on the provider's claim form must match what has been authorized and listed on the confirmation letter. The AHCCCS claims system matches the claim information against established authorizations and identifies the appropriate case manager authorization for the services that require authorization. If there are any discrepancies

between the service billed and the authorized service, the system will not find the appropriate authorization, and the claim will be denied. (See Exhibit 21-1 for a sample authorization letter.)

NURSING FACILITY SERVICES

Nursing facilities provide care for members who are chronically ill and/or for those recuperating from illness that need nursing care but not hospitalization. Many facilities offer several levels of care and various specialized services such as therapies. A limited number serve patients with extensive rehabilitation needs, problems due to wandering behavior, or serious respiratory problems. (Refer to AMPM Chapter 1200.)

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and community based services (HCBS) are services for ALTCS members residing in their homes who would otherwise require supervision and assistance through nursing facility services. (Refer to the AMPM Chapter 1200 for detailed description of these services, coverage, requirements and, limitations.)

Covered HCBS services include:

1. Assisted living facility
   ALTCS covers services, except room and board, for EP/D members who are physically or functionally unable to live independently in the community but can have their needs met safely while residing in an assisted living facility.

   - Assisted living homes provide room, board, personal care and supervision for up to 10 adults.
   - Adult foster care homes provide room, board, personal care, and supervision for one to four adults in a family environment.
   - Assisted living centers provide room, board, personal care, and supervision for more than 10 adults.

2. Adult day health services provide supervision, recreation, socialization, personal care, personal living skills training, congregate meals, health monitoring and other health-related services.

3. Attendant care services provide assistance with homemaking, personal care and general supervision for a member in his/her own home as an alternative for those who may otherwise have to go to a nursing facility.

4. Home delivered meal services provide for one meal per day containing at least 1/3 of the Recommended Dietary Allowance to be delivered to a member's residence (Covered only for EP/D members).

5. Homemaker services provide assistance to a member in the performance of activities related to household maintenance.

6. Home health services provide intermittent in-home care for members such as nursing services, home health aides, medical supplies, equipment and appliances, and therapies (See Chapter 20, Home Health Care Services).

7. Hospice services provide supportive care for terminally ill members and their family or caregivers in the home or in an institution (See Chapter 23, Hospice Services).

8. Personal care services provide assistance to members who need help doing essential activities of daily living (i.e., eating, bathing, dressing).

9. Respite services provide short term or intermittent care and supervision in order to provide an interval of rest or relief for family members, up to 600 hours per benefit year. Short-term in-home respite service cannot exceed 12 hours on a specific date. When necessary and authorized, more than 12 hours of respite in a 24 hour period can be authorized as continuous respite.

THERAPY SERVICES

AHCCCS covers physical, occupational, speech and respiratory therapy services that are ordered by a physician, and provided by or under the direct supervision of a licensed therapist.

Occupational Therapy

Occupational Therapists must be licensed by the Arizona Board of Occupational Therapy Examiners, or governing Board of the State where the therapist practices or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of Occupational Therapy Examiners.

AHCCCS covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient occupational therapy services are covered for ALTCS members when medically necessary.

Occupational Therapy services may include, but are not limited to:

1. Cognitive training
2. Exercise modalities

3. Hand dexterity
4. Hydrotherapy
5. Joint protection
6. Manual exercise
7. Measuring, fabrication or training in use of prosthesis, arthrosis, assistive
1. device or splint
8. Perceptual motor testing and training
9. Reality orientation
10. Restoration of activities of daily living
11. Sensory reeducation, and
12. Work simplification and/or energy conservation.

Physical Therapy

Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices. A Physical Therapy Assistant (under the supervision of the PT according to A.A.C. 24, Article 3) must be certified by the Arizona Physical Therapy Board of Examiners. Out of state physical therapists providing services to AHCCCS members outside the State of Arizona must meet applicable State and/or Federal requirements.

Physical Therapy (PT) is an AHCCCS covered treatment service to restore or improve muscle tone, joint mobility or physical function. Physical therapy prescribed only as a maintenance regimen is excluded.

AHCCCS covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's attending physician.

Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility).

For Outpatient PT services please refer to AMPM 310-X.

Service limits will be applied to physical therapy CPT codes 97001-97546.

A physical therapy visit is defined as:

1. An occurrence of CPT codes 97001-97546
2. Billed on form types 1500 and UB-04 outpatient
3. Any provider type *except:*

13	Occupational Therapist
22	Nursing Home

4. Any place of service excluding:

31	Nursing Home

32	Nursing Facility
33	Custodial Facility

Physical Therapy Definitions:

Visit - a visit equals PT services received in one day per provider. The PT service limit applies regardless whether the member has the same AHCCCS health plan or changes plans during the contract year.

Setting - the location of service i.e. outpatient, inpatient, institutional (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).

Service limits prior to 01/01/2014
In accordance with A.A.C. R9-22-215, outpatient PT services are covered for adult members, 21 years of age and older (ACUTE and ALTCS), as follows:

A. AHCCCS members who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the member changes Contractors. (Contract year is defined as October 1-September 30.)

B. For AHCCCS members who are also Medicare members, refer to AMPM Chapter 300, Exhibit 300-3A regarding Medicare cost sharing and the outpatient physical therapy limit.

Dual Eligible refers to a member with income above 100% FPL who is Medicare and AHCCCS eligible (also known as Medicare Primary, non-QMB dual). The member does not qualify for the Federal QMB program. The health plan is responsible for the Medicare cost sharing amount (Medicare's deductible, copay and coinsurance) up to 15 PT visits.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will pay the Medicare cost sharing up to the 15 visit limit per contract year.
As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; however the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the member's responsibility.

Should the member exhaust their Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the health plan.

QMB Dual refers to a member with income not exceeding 100% FPL who qualifies for Medicare under the Federal QMB program and is enrolled in Medicaid. The health plan is responsible for the Medicare cost sharing amount (Medicare deductible and coinsurance) up to the Medicare maximum dollar amount.

If the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the health plan will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

Should the member exhaust their Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the health plan.

Effective 1/1/2014 service limits for medically necessary outpatient physical therapy for adults (age 21 years and older) are as follows:

A. 15 visits per contract year (October 1-September 30) to restore a particular skill or function the member previously had but lost due to injury or disease and maintain that function once restored; and
B. 15 visits per contract year (October 1-September 30) to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

Refer to AMPM Exhibit 300-3A for more detail regarding Medicaid only members, QMB Dual and Medicare Primary (non-QMB Dual).

Covered physical therapy treatment services include, but are not limited to:

1. The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment,
2. The administration, evaluation and modification of treatment methodologies and instruction, and
3. The provision of instruction or education, consultation and other advisory services.

Physical therapy prescribed only as a maintenance regimen is excluded.

<u>Speech Therapy</u>

A qualified Speech-Language Pathologist (SLP) must be licensed by the Arizona Department of Health Services (ADHS) or a Speech-Language Pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified Speech-Language Pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed.

A qualified Speech-Language Pathology Assistant (SLPA) must be licensed by the Arizona Department of Health Services (ADHS). The SLPA must be identified as the servicing provider and bill for services under his or her individual NPI number. (A group ID number can be utilized to direct the payment.) SPLA's may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's attending physician for FFS members.

Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.

Speech therapy by qualified professionals may include the list below:

1. Articulation training
2. Auditory training
3. Cognitive training
4. Esophageal speech training
5. Fluency training
6. Language treatment
7. Lip reading
8. Non-oral language training
9. Oral-motor development, and
10. Swallowing training.

Respiratory Therapy

Respiratory therapists must be billed with the code S5180 Home health respiratory therapy, initial evaluation.

Respiratory therapists may not use CPT codes 94010 - 94799.
Physicians and hospitals may use CPT codes 94010 - 94799.

Respiratory Therapy Prior Authorization Requirements

The following written documentation must be received by the AHCCCS/DFSM UM/CM Department prior to the issuance of a PA number:

a. Nature, date, extent of injury/illness and initial therapy evaluation,
b. Treatment plan, including specific services/modalities of each therapy, and
c. Expected duration and outcome of each therapy provided.

Upon concurrent review and/or receipt of above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.

Progress notes may be requested by the AHCCCS/DFSM Utilization Management/Care Management Dept. (UM/CM) every 10 days, as evidence of member progress for continued authorization (when there is no concurrent review).

Billing for Services

HCBS providers must bill for services on a CMS 1500 claim form. Claims for services will be compared with the case manager's authorization for the services. The criteria match includes:

- Provider ID
- Member ID
- Date(s) of Service
- Procedure Code
- Units of Service

If a nursing facility, HCBS, or therapy claim does not match the information on the Case Manager Service Plan, the claim will be denied.

ALTCS Dental Services

Effective date of service 10/1/2017, in accordance with A.R.S. 36-2907, an emergency dental benefit has been granted to members 21 years of age and older in an annual amount not to exceed $1,000.00 per member per contract year (October 1st to September 30th) for emergency dental care and emergency extractions. This benefit is in addition to the $1,000.00 benefit already available to ALTCS members. See AMPM Policy 310-D1 Dental Services for Members 21 Years of Age and Older.

Effective date of service 10/01/2016, the dental benefit has been restored for ALTCS members age 21 and older for medically necessary dental services.

ALTCS members may receive medically necessary dental benefits up to $1,000.00 per member per contract year (October 1st to September 30th) for diagnostic, therapeutic and preventative care. See AMPM Policy 310-D2 ALTCS Dental Services. The dental policy for ALTCS members under age 21 is described in FFS Chapter 10 and AMPM Policy 430.

ALTCS members are eligible for services as outlined in FFS Chapter 10 and AMPM Policy 310-D1 for members age 21 and older. Services that fall into the services' limitations and exceptions as outlined in the above chapter and policy would not count towards the $1,000.00 ALTCS dental benefit limit.

The contract year limit is member specific and remains with the member if the member transfers between Managed Care Organizations or between Fee-For-Service and Managed Care. It is the responsibility of the ALTCS Contractor or the Tribal ALTCS Case Manager transferring the member to notify the receiving entity regarding the current balance of the dental benefits.

Benefit coverage and limitations include:

- Unused benefit dollars do not "carry over" into the next contract year.

- Dental services performed by Indian Health Service (IHS) or a 638 Tribal facility are also subject to the $1,000.00 limit.
- Frequency limitations and services that require prior authorization still apply.
- Dentures are covered and will count towards the $1,000.00 limit.
- General anesthesia will be covered and will count towards the $1,000.00 limit.
- Physician performing general anesthesia on an ALTCS member for a dental procedure will be covered and will count towards the $1,000.00 limit.

In rare instances an ALTCS member may have an underlying medical condition that necessitates that services provided under the ALTCS dental benefit be provided in an Ambulatory Surgical Center (ASC) or an outpatient hospital and may require general anesthesia. In those instances, the facility and anesthesia charges are subject to the $1,000.00 limit.

Informed Consent

Please refer to AMPM 310-D2 Arizona Long Term Care System Adult Dental Services for further information regarding informed consent requirements.

Notification Requirements for Charges to Members

Please refer to AMPM 310-D2 Arizona Long Term Care System Adult Dental Services for further information regarding notification requirements for charges to members.

Billing for ALTCS Dental Services

Dentists will bill on the ADA form with the dental service codes. The ALTCS benefit will be subject to the Dental FFS Rates and Codes found at
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/Dental.html

Physicians performing general anesthesia will bill on the CMS 1500 with the appropriate CPT/HCPCS codes. Reimbursement will be subject to the FFS Physician fee schedule.

Ambulatory Surgical Center will bill on the CMS 1500 with the appropriate CPT/HCPCS codes and modifiers. Reimbursement will be subject to the FFS ASC fee schedule.

Outpatient facility surgical services will be billed on the UB-04 with appropriate revenue codes and CPT/HCPCS codes. Reimbursement will be subject to the FFS OPFS pricing.

Share of Cost (SOC)

ALTCS members who receive long term care services may be responsible for paying a portion of the cost of their care. This payment liability is called share of cost (SOC).

The SOC calculation is a final step in the completion of the ALTCS application. SOC is calculated by subtracting certain expenses and deductions from the member's gross income. Calculations differ for members residing in nursing facilities and those receiving HCBS.

HCBS members have a personal needs allowance deducted from their income which usually is equal to the maximum income allowed for eligibility. Therefore, these members rarely have a SOC. Occasionally, an HCBS member will have income that is not counted toward eligibility in addition to other types of income or may receive a reduced personal needs allowance. In this case, the member may have a SOC.

Members in a nursing facility have a personal needs deduction of 15 per cent of the SSI federal benefit rate (which changes each January) and frequently have a SOC.

Deductions for spousal, family, or home maintenance; medical insurance premiums; and non-covered medical expenses may reduce the amount of a member's SOC. Because a member's income and expenses may fluctuate from month to month, SOC is calculated monthly.

ILLEGAL INCENTIVES/REMUNERATIONS

Providers offering gift cards, free lunches or other cash in kind inducements to have the member select their services are prohibited by Federal Criminal Penalties Statute 42 USC 1320a-7b(b)(2).

Among other activities not permitted, this law 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.

Revision History

Date	Description of changes	Page(s)
5/04/2018	Clarification added to billing for case management services. It was changed from “The Tribal Contractors receive a monthly capitation for case management services, based on the number of tribal ALTCS members enrolled. All other services are provided and reimbursed on a fee for service basis,” to, “The Tribal Contractors receive a monthly capitation for case management services, based on the number of tribal	3

	ALTCS members enrolled. Providers and Tribal Contractors are prohibited from billing for Case Management Services (T1016). All other services are provided and reimbursed on a fee for service basis." The word 'recipient' was changed to 'member.'	All
1/23/2018	Phone number removed	1
10/1/2017	Dental Occupational Therapy Format Changes	10-11 9 All
10/1/2016	ALTCS Dental Services eff 10/01/2016 Updated Physical Therapy limits to conform to AMPM	11-13 9
10/01/2015	New format Orthotics update eff 08/01/2015 "ICD-9" replaced with "ICD"; removed @ attachment, added as chapter Exhibit Removed @ attachment, added as chapter Exhibit	All 3 Exh 21-1 Exh 21-2
12/18/2013	Language updated per AMPM Exhibit 21-2 addresses updated	All Exh 21-2

Exhibit 21-1 Sample ALTCS

Exhibit 21-1

SAMPLE ALTCS AUTHORIZATION LETTER

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Douglas A. Ducey
Governor

Thomas J. Betlach
Director

October 1, 2015

654321
PROVIDER NAME
PROVIDER ADDRESS
CITY, STATE ZIP

CORRESPONDENCE REQUEST NUMBER: 314748 LTC PA LTR (PROVIDER APPROVAL)
LONG TERM CARE KEY INFORMATION: A12345678199

TO PROVIDER NAME:

THIS IS YOUR AUTHORIZATION CONFIRMATION FOR THE SERVICE(S) WHICH REQUIRE AUTHORIZATION FROM THE ARIZONA LONG-TERM CARE SYSTEM (ALTCS) ADMINISTRATION. THESE SERVICES HAVE BEEN APPROVED. RECEIPT OF THIS NOTIFICATION IS NOT A GUARANTEE OF PAYMENT.

PROVIDER ID/NAME : 654321 (PROVIDER NAME)
RECIPIENT ID/NAME :A123456789 (EARP, WYATT DOB: 10/01/66 SEX: M)
RECIPIENT DATE OF BIRTH : 10/01/66
SERVICE CODE : T1019 (PERSONAL CARE SERVICES, PER 15 MINUTES)
DIAGNOSIS CODE : R68.89
SERVICE DATE FROM : 09/22/2015
SERVICE DATE THROUGH : 09/26/2015
UNITS APPROVED : 48
CASE MANAGER ID : 999999
CASE MANAGER NAME : LAST NAME, FIRST NAME
CASE MANAGER PHONE NUMBER : 5209991234

NOTE: THE AUTHORIZATION (PA) NUMBER HAS BEEN ELIMINATED. NO PA NUMBER IS REQUIRED ON THE CLAIM FORM. RECEIPT OF THIS NOTICE NOW SERVES AS PROOF THAT AUTHORIZATION WAS PROVIDED BY THE CASE MANAGER FOR SERVICE(S) TO BE RENDERED.

BILLING QUESTIONS SHOULD BE DIRECTED TO THE AHCCCS CLAIMS CUSTOMER SERVICE UNIT AT (602) 417-7670 option #4 OR 1-800-794-6862.

ANY QUESTIONS PERTAINING TO THE SERVICE(S) DELIVERED TO AN ALTCS RECIPIENT SHOULD BE DIRECTED TO THE ACTUAL CASE MANAGER WHO REQUESTED THE SERVICE(S)

SINCERELY,

AHCCCS ADMINISTRATION

Arizona Health Care Cost Containment System
Fee-For-Service Provider Manual

Exhibit 21-2 ~ ALTCS Offices

Arizona Health Care Cost Containment System Fee-For-Service Provider Manual

CASA GRANDE 500 N. Florence St. Casa Grande, AZ 85222 (520) 421-1500 Toll Free: 1-855-277-0260 FAX: (877) 666-0874	**CHINLE** Tseyi Shopping Center US Hwy 191 P.O. Box 1942 Chinle, AZ 86503 (928) 674-5439 Toll Free: 1-888-800-3804 FAX: (877) 660-1450
COTTONWOOD 1 N. Main St. Cottonwood, AZ 86326 (928) 634-8101 Toll Free: 1-855-873-0393 FAX: (877) 666-5208	**FLAGSTAFF** 2717 N. Fourth St, Ste 130 Flagstaff, AZ 86004 (928) 527-4104 Toll Free: 1-800-540-5042 FAX: (877) 663-5213
GLOBE/MIAMI Cobre Valley Plaza 2250 Hwy 60, Suite H Miami, AZ 85539-9700 (928) 425-3165 Toll Free: 1-888-425-3165 FAX: (877) 666-5219	**KINGMAN** 519 E. Beale St., Suite 130 Kingman, AZ 86401 (928) 753-2828 Toll Free: 1-888-300-8348 FAX: (877) 667-5239
LAKE HAVASU CITY 2160 N. McCulloch Blvd., Suite # 105 Lake Havasu City, AZ 86403 (928) 453-5100 Toll Free: 1-800-654-2076	**PHOENIX** 801 E. Jefferson St., MD # 1600 Phoenix, AZ 85034 (602) 417-6600 FAX: (602) 253-6385
PRESCOTT 3262 Bob Drive, Suite # 11 Prescott, AZ 86305 (928) 778-3968 Toll Free: 1-888-778-5600 FAX: (877) 666-5269	**SIERRA VISTA** 820 E. Fry Blvd, Sierra Vista, AZ 85635 (street address) 1010 N. Finance Center Dr., Suite # 201 Tucson, AZ 85710 (mailing address) Ph:520-459-7050 (Option 1) FAX:1-877-660-5342 Toll Free: 1-888-782-5827
TUCSON 1010 N. Finance Center Dr., Suite #201 Tucson, AZ 85710 (520) 205-8600 (Option 1) Toll Free: 1-800-824-2656 FAX: (877) 666-5353	**YUMA** 3850 W. 16th Street, Suite AYuma, AZ 85364 (928) 782-0776 FAX (877) 666-5382 Toll Free: 1-855-419-6527

CHAPTER 22 ~ NURSING FACILITY SERVICES

Chapter 22 ~ Nursing Facility Services

Revision Dates: 2/2/2018; 10/1/2003

General Information

The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to providers. For answers to specific questions regarding covered services, limitations, and exclusions, please refer to the AHCCCS Medical Policy Manual available at:
https://www.azahcccs.gov/shared/MedicalPolicyManual/

Nursing facilities provide care for the chronically ill and for those recuperating from illness who need 24-hour nursing care, but not hospitalization. Many nursing facilities offer several levels of care and various specialized services such as therapies. A limited number of facilities provide services to patients with extensive rehabilitation needs, problems due to wandering behavior, or serious respiratory problems.

AHCCCS covers medically necessary nursing facility services for Fee-For-Service acute care members, who have not been determined eligible for ALTCS services, for a period not to exceed 90 days per contract year (October 1 through September 30) when the following requirements are met:

- A physician has ordered nursing facility services in lieu of hospitalization.
- The medical condition of the member is such that, if nursing facility services are not provided, it would result in hospitalization of the individual.
- Services cannot be effectively provided in the home or in an Indian Health Service (IHS) facility due to lack of appropriate equipment or qualified staff.
- For hospitalized members, the hospital personnel have coordinated patient teaching, discharge planning, and transfer in a timely manner.
- The member needs care or constant monitoring by a registered nurse.
- The member requires assistance with care that cannot be self-administered or provided by a caregiver in the home.

Each facility is responsible for coordinating the delivery of ancillary services, including medical services, pharmaceutical services, therapies, diagnostic services, emergency services, and medically necessary transportation.

The following services are commonly included in the nursing facility per diem rate. The list includes but is not limited to:

- Nursing services, including rehabilitative and restorative services which include:
    - Administration of medication;
    - Tube feedings;
    - Personal care services (assistance with bathing, grooming, and laundry);
    - Routine testing of vital signs;
    - Assistance with eating;
    - Maintenance of catheters; and
    - Over the counter medications and laxatives.
- Social services, activity and recreational services, and spiritual services;
- Rehabilitation therapies;
- Nutritional and dietary services including, but not limited to, preparation and administration of special diets and adaptive tools for eating;
- Medical supplies and durable medical equipment;
- Overall management and evaluation of care plan;
- Observation and assessment of a member's changing condition;
- Room and board services including, but not limited to, support services such as food preparation, personal laundry, and housekeeping;
- Administrative physician visits solely for the purpose of meeting state licensure; and
- Non-prescription, stock pharmaceuticals.

The following items are also included in the per diem rate. The list includes but is not limited to:

- Accucheck monitors
- Alternating pressure mattress and pump
- Bedside commode
- Canes (all types)
- Crutches
- Cushions
- Emesis basins
- Feeding pumps
- Foot cradles
- Geri-chairs (all non-customized)
- Heating pads
- Hospital beds (electric and manual)
- Nebulizers
- Lifts
- Suction machines
- IV poles
- Walker (all non-customized)
- Water mattress
- Wheelchairs (all non-customized)

Items included in the per diem rate may not be separately billed. Covered services that are not part of the per diem rate may be billed when ordered by the attending physician and specified in the case management plan.

Limitations

The following limitations apply to nursing facility services for ALTCS members.

- Private rooms in nursing facilities are limited to medical conditions that require isolation per physician orders.
- Respite care is limited to 600 hours per contract year.
- Therapeutic leave days are limited to nine days per contract year.
- Bed hold days for members admitted to a hospital for a short stay are limited to 12 days per contract year.
- Services or items requiring authorization for which authorization has not been obtained are not covered.
- Services rendered in institutions for the treatment of tuberculosis for individuals ages 21 – 64 are not covered.
- Services rendered in institutions for the treatment of mental disease for individuals ages 21 – 64 are limited to 15 days per admission and no more than 60 days per year.
- Services provided in a facility or area of a facility not certified for such services are not covered.
- Services provided to individuals in a facility who require a level of care (as determined by the PAS and reassessment process) below the level of care they are receiving are not covered.

SHARE OF COST

ALTCS members are required to contribute toward the cost of their care. This share of cost (SOC) is calculated by subtracting certain expenses and deductions from the member's gross income. Members in nursing facilities have a deduction for personal needs equal to 15 per cent of the SSI federal benefit rate (which changes each January) and frequently have a SOC.

When a member's eligibility for ALTCS is approved, a notice is generated which identifies the amount of SOC the member owes. SOC change notices are sent to nursing facilities for any changes to the SOC amount.

BILLING FOR SERVICES

Prior authorization must be obtained from the AHCCCS PA Unit before admission of an acute care member unless the member becomes retroactively eligible for AHCCCS. Initial authorization will not exceed the member's anticipated fee-for-service enrollment period or a medically necessary length of stay, whichever is shorter. Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.

Facilities must obtain initial authorization from the ALTCS case manager before admission of an ALTCS member unless the member becomes retroactively eligible. Ongoing authorization for services must be obtained from the ALTCS case manager.

Long term care facilities cannot submit claims that overlap months. The member's SOC is calculated on a monthly basis, and claims that overlap two or more calendar months cannot be processed accurately.

AHCCCS only pays for the date of admission up to, but not including, the date of discharge, unless the patient expires.

Long term care facilities must bill for room and board services on the UB-04 claim form. The table below summarizes the allowable revenue codes and bill types, effective with dates of service on and after March 1, 2009.

Revenue Codes		Allowable Bill Types
190	Subacute General	86X , 650-608
191	Subacute Care Level I	110 – 179, 211 – 228, 650-668
192	Subacute Care Level II	110 – 179, 211 – 228, 650-668
193	Subacute Care Level III	110 – 179, 211 – 228, 650-668
194	Subacute Care Level IV	110 – 179, 211 – 228, 650-668
199	Other Subacute Care	650-668
183	LOA – Therapeutic (For home visit by member)	211 – 228, 650-668
185	LOA – Bed hold (For short-term hospitalization)	211 – 228, 650-668

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-04 claim forms using the appropriate bill types and patient status codes.

Example 1:

A member residing in a skilled nursing facility is hospitalized on April 11. The member is discharged from the hospital on April 14 and returns to the nursing facility that day. The member remains in the nursing facility through April 30. When billing for the month of April, the nursing facility would submit the following three claims to AHCCCS:

First claim

Dates: 04/01 - 04/10 Bill Type: 212
Revenue code: 192 Patient status: 30

Second claim

Dates: 04/11 - 04/13 Bill Type: 213
Revenue code: 185 Patient status: 02

Third claim

Dates: 04/14 - 04/30 Bill Type: 214
Revenue code: 192 Patient status: 30

The AHCCCS allowed amount is the lesser of:

Nursing facility per diem X number of days billed – SOC

or

Billed charges - SOC

Facilities must bill AHCCCS for the entire amount due for care for the month or partial month, including SOC. AHCCCS will automatically subtract the SOC from the AHCCCS allowed amount and pay the balance. If the facility bills for the care minus the required SOC collection, AHCCCS will still deduct the SOC amount, creating a double deduction for the month.

Example 2:

Provider incorrectly submits claim with SOC deducted from billed charges.

Dates of service: June 1 – 30 Total charges: $2,405
Member's SOC: $878 Billed charges: $1,527 ($2,405 - $878)

AHCCCS allowed amount	$1,527
SOC deducted by AHCCCS	- 878
Payment to provider	$ 649

When Medicare is the primary payer, AHCCCS will pay the full Medicare coinsurance amount minus any other third party payment and share of cost (SOC). Payment will equal the full Medicare coinsurance amount for the covered days.

The Medicare allowed amount includes all ancillary services covered under the Medicare per diem. Providers should not bill separately for those ancillary services.

NOTE: See Chapter 9, Medicare/Other Insurance Liability, for detailed information on billing nursing facility claims with Medicare.

References

For additional information regarding nursing facilities please refer to AMPM 310-R, Nursing Facility Services.
For additional information regarding institutional services for ALTCS members please refer to AMPM 1210, Institutional Services and Settings.

For information on the requirements for nursing facilities for resident assessment, nurse's aid training and competency evaluation program, and Pre-Admission Screening and Resident Review (PASRR) please refer to AMPM 1220, Federally Mandated Programs for Nursing Facilities and attachments A, B, and C.

Revision History

Date	Description of changes	Page(s)
2/2/2018	Updated respite care hour limits Formatting updates	3 All

CHAPTER 23 ~ HOSPICE SERVICES

Chapter 23 ~ Hospice Services

Revision Dates: 10/1/2018 10/1/2003

General Information

AHCCCS covers End of Life Care for acute care and ALTCS members who meet the specified medical criteria/requirements. Hospice services provide palliative and supportive care for terminally ill ALTCS, KidsCare, and EPSDT members and their families or caregivers in order to ease the physical, emotional, spiritual and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

A physician must certify that the member is terminally ill. Hospice care is limited to those members who are in the final stages of a terminal illness (i.e., members who have a prognosis of death within six months).

The initial physician certification is effective for 90 days. If the member continues to need services, the physician must recertify for a second 90-day period. Subsequent re-certifications for 60-day periods are required if the member continues to require hospice services.

Hospice services are provided in the member's own home, a Home and Community Based Service (HCBS) approved alternative residential setting as specified in AMPM Policy 1230, or in the following inpatient settings when conditions of participation are met as specified in 42 C.F.R. 418:

1. Hospital,
2. Nursing care institution, and/or
3. Free standing hospice.

A hospice uses a medically-directed interdisciplinary care team of professionals and volunteers to meet the physical, psychological, social, spiritual, and other special needs, which are experienced during the final stages of illness, dying and bereavement.

A comprehensive list of covered hospice services can be found in AMPM 310-J, Hospice Services.

Hospice services may be provided in the home on an intermittent, regularly scheduled, and/or an on-call, around-the-clock basis according to member and family needs, as long as a member's end of life needs are able to be met.

Authorization Requirements

Hospice services require prior authorization. For information on Prior Authorization please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual and to AMPM 820, Prior Authorizations.

Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process, which can be found at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

For Tribal ALTCS members, hospice services are prior authorized by the Tribal ALTCS Case Manager.

Billing Requirements

Hospice providers must bill for services on the UB-92 claim form using bill types 81X - 82X. The third digit must be 1 through 4 or 6 through 8.

Payment is made to a hospice provider for only one of four revenue codes. AHCCCS reimbursement rates for the four levels of service are all-inclusive rates that include durable medical equipment, medication, and other health care services (physician) related to the member's terminal illness.

Members requiring medical services not related to the terminal illness may receive them without having payment for these services included in the all-inclusive rate. Acute medical care services in this instance are non-inpatient services provided to ALTCS eligible members who are not covered by Medicare. Acute medical care services must be coordinated between the primary care physician and the case manager.

The following revenue codes may be billed to AHCCCS.

NOTE: Medicare claims with A, B, C, or D in the third digit cannot be processed. They refer only to the Notice of Election for Medicare.

- Revenue Code 0651 (Routine Home Care Day)
    - A routine home care day is a day during which a member is at home (or in a nursing facility) and not receiving continuous care.
    - Reimbursement is the lesser of either the hourly rate multiplied by the hours billed *or* the per diem rate.

- When hospice care is furnished to a fee-for-service member in a nursing facility, the hospice should bill only the routine home care rate.
    - The nursing facility is reimbursed directly by AHCCCS for the room and board and other services furnished by the facility.

- Revenue Code 0652 (Continuous Home Care Day)
    - A continuous home care day is a day during which a member receives services consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis as necessary to maintain terminally ill members at their places of residence. A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.
    - Home health aide, homemaker services, or both may also be provided on a continuous basis.
    - Continuous home care is not available to nursing facility residents.
    - Reimbursement is the lesser of either the billed charge *or* the AHCCCS hourly rate multiplied by the number of hours billed.
    - Revenue Code 0655 (Inpatient Respite Care Day)
    - An inpatient respite care day is a day during which a member receives care in an approved facility on a short-term basis. Institutional (inpatient hospice) services may be delivered at the provider’s site or through subcontracted beds in an institutional setting such as a hospital or nursing facility when the member's condition is such that care can no longer be rendered in the member's home.
    - The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
        - For the date of discharge, the appropriate home care rate is paid.
        - If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.
        - Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.
    - Revenue Code 0656 (General Inpatient Care Day)

- A general inpatient care day is a day on which a member receives general inpatient care for pain control, or acute or chronic symptom management that cannot be managed in other settings.
- The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
    - For the date of discharge, the appropriate home care rate is paid.
    - If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.

- For dates of service on or after January 1st, 2016 G0154 has been replaced with the following:

  G0299 (Direct skilled nursing services of a registered nurse – RN – in the home health or hospice setting).

  G0300 (Direct skilled nursing of a licensed practical nurse – LPN – in the home health or hospice setting.

References

For additional information on hospice definitions, scope of service, licensure standards, limitations and requirements please refer to AMPM 310-J.

For additional information on the Prior Authorization process, please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual and to AMPM 820, Prior Authorizations. Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process, which can be found at:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html

Revision History

Date	Description of changes	Page(s)
10/1/2018	The General Information section was updated with clarifying language	1
	The list of services covered by hospice was replaced with a reference to AMPM 310-J, which fully lists all services.	1
	An Authorization Requirements section was added, including a link to the new FFS PA webpage.	2
	The Revenue Codes were updated to 4 digits.	2-3
	Information on codes G0299 and G0399 was added.	
	References section added.	3-4

		4
09/1/2016	Formatting updated	All

CHAPTER 24 ~ TRANSPLANTS

Chapter 24 ~ Transplants

REVISION DATES: 1/31/2018; 09/30/2015

General Information

This chapter offers general guidance to providers.

For specific information regarding covered transplant services, requirements, limitations, and exclusions refer to:

- AHCCCS Medical Policy Manual (AMPM) Policy 310-DD
- Reinsurance Policy Manual
- Arizona Administrative Code
  - A.A.C. R9-22-201 et. seq
  - A.A.C. R9-22-203 describes experimental services
  - A.A.C. R9-22-206 delineates covered and excluded transplants for Adults.

The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at:

https://www.azahcccs.gov/shared/MedicalPolicyManual/.

The Reinsurance Policy Manual is available at:

https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/.

The AHCCCS website also offers a link to the Arizona Administrative Codes. The AHCCCS website is available at:

https://www.azahcccs.gov

AHCCCS covers medically necessary transplants for members. In order to be covered, a transplant must be medically necessary, not experimental, and not for the purposes of research. Transplant services must be federally and state reimbursable.

Although transplant coverage is limited for individuals age 21 and older (adults), AHCCCS covers all medically necessary, non experimental transplants for individuals under the age of 21 under the EPSDT Program. For transplantation coverage limits for adults please refer to AMPM Policy 310-DD.

Members of the Federal Emergency Services Program (FES) are not eligible to receive transplant services.

Billing Requirements

AHCCCS contracts with providers to provide covered transplant services to eligible members.

The specialty contract specifies the inpatient, outpatient, and ancillary services that are included for transplants, and the payment amount to be received for the services provided.

The provider must notify the AHCCCS Division of Health Care Management (DHCM) that an AHCCCS member requires a transplant procedure.

DHCM will negotiate the contract terms with the provider, unless there is already a contract in place for the services to be provided.

The contractor shall submit a packet of all individual claims for all transplant related services, as a transplant service billing component. The contractor shall submit this packet using the coversheet included in the specialty contract.

The contractor is responsible for billing AHCCCS within six months of the end date of each of the transplant service billing components. Timeliness of the claim submission for each billing component of the transplant will be based on the received date for the complete set of claims related to the component.

Claims initially received beyond the six month time frame will be denied.

Under certain circumstances, when a service is outside of the transplant components that can be billed to reinsurance, those services may be billed to Fee-For-Service. If a Fee-For-Service claim is initially received within the six month time frame, the Contractor has up to twelve months from the end date of the billing component to resubmit the claim and achieve clean claim status or to adjust a previously processed claim. If a claim does not achieve clean claim status or is not adjudicated correctly within twelve months of the end date of the billing component, AHCCCS is not liable for payment.

Please note that there is a difference in timeline submission for the transplant component claims going to reinsurance and the services that can be billed to Fee-For-Service. For further information regarding where components should be billed please see the Reinsurance Policy Manual.

- Both reinsurance and Fee-For-Service claims must be initially submitted within six months of the date of service.
- Fee-For-Service claims may be resubmitted after the initial claim submission and must achieve clean claim status, including full adjudication of the claim, within twelve months of the date of service.
- Per the Reinsurance Policy Manual, reinsurance claims may be resubmitted after the initial claim submission and must achieve clean claim status, including full

adjudication of the claim, within fifteen months of the date of service. It can take up to 45 days to process and adjudicate a reinsurance claim, so these claims should be submitted at least 45 days prior to the fifteen month deadline.

All medically necessary services provided to the transplant member, that are related to the transplant, should be billed using the appropriate diagnosis codes, CPT and HCPC procedure codes, and revenue codes to meet clean claim status.

Fee-For-Service transplant packages should be sent to:

AHCCCS Administration

ATTN: Reinsurance Finance Unit

Mail Drop 6100

P.O. Box 1700

Phoenix, AZ 85002

Refer to the Specialty Contract for additional claim submission requirements.

Pricing and Reimbursement

Services will be reimbursed based on the terms of the specialty contract.

DHCM will provide the Reinsurance Department with the payment requirements, including the provider name and number under which claims are to be submitted.

DHCM will review the case stage or the component package submitted, and the services will be paid according to the terms of the contract.

Medically necessary covered transplant related services that are not included in the transplant contract should be billed to AHCCCS Fee-For-Service and are subject to prior authorization requirements. See Policy 310-DD for covered transplant related services.

The Contractor agrees to bill and accept payments from AHCCCS for Fee-For-Service members. Payments will be consistent with the rate schedule included with the specialty contract, state and federal law, and the terms of the agreement.

References

For information on transplants please refer to the following references:

- AMPM Policy 310-DD, Covered Transplants and Related Immunosuppressant Medications
- The AHCCCS Contracts, including specialty contracts.
- The Reinsurance Policy Manual, which is available at:
  https://www.azahcccs.gov/PlansProviders/HealthPlans/Reinsurance/

- Arizona Administrative Code
  - A.A.C. R9-22-201 et. seq
  - A.A.C. R9-22-203
  - A.A.C. R9-22-206

Revision History

Date	Description of changes	Page(s)
1/31/2018	Updated clean claim submission timeframe Updated references Updated difference in timelines between FFS and Reinsurance claim submissions Updated FFS Address Formatting	2 1 & 3 2 3 All
09/30/2015	New format Removed benefit lists/chart and added reference to current coverage in AMPM 310-DD Updated billing and reimbursement sections to conform to current specialty contract language	All

CHAPTER 25 ~ CLAIMS PROCESSING

Chapter 25 ~ Claims Processing

Revision Dates: 10/1/2018; 12/08/2011

General Information

All claims submitted to AHCCCS are extensively edited by the AHCCCS claims processing system.

The editing process begins when the system checks the claim form to ensure that all required fields have been filled in and that no completed fields are filled out incorrectly. Incorrectly filled out fields include, but are not limited to, the following:

- The use of letters instead of numbers when numbers are required (and vice versa); and/or
- Not entering a valid 9-digit AHCCCS ID, beginning with an A; and/or
- Not including the entire required data set, such as when a provider uses 6 digits for an NPI instead of 10; and/or
- Invalid diagnosis code.

If the **required fields** are not completed or if *any* fields are completed incorrectly, an error code will be assigned to the claim.

- For example, if the date "December 10, 2003" should be recorded as 12/10/2003 (MM/DD/YYYY format) and the claim is received with 2003/12/10, the edit will create a failure for an invalid date.

The system also confirms that a provider ID, an ordering provider ID (for CMS 1500 forms), a member ID, date(s) of service, a place of service code (for CMS 1500 forms), diagnosis code(s), procedure/revenue/NDC code(s), and billed charges are present on the claim.

After editing for completeness and correctness of the data submitted, the system edits to ensure that the data fields are valid and logical. The most important of these edits ensures that:

- The provider ID number is a valid AHCCCS registered provider on the date of service delivery;
- The provider has the authority to provide and bill for this service;
- The member is on file, eligible, and entitled to the service;
- The service was covered by AHCCCS on the date it was delivered; and
- Diagnosis and procedure codes were valid for the date of service.

Another set of edits ensures that the claim complies with AHCCCS policy requirements. These include:

- Prior authorization is obtained if required;
- The claim is reviewed by AHCCCS medical staff before payment, if required; and

- The service is allowed for the member's age and gender.

. The claims processing system reviews the claim for any service limitations, duplicates, and checks whether the member, provider, date of service, and procedure/diagnosis on the claim are the same as on a previously paid claim.

Editing Process

The claims system attempts to apply all edits during a single processing cycle. However, if certain data fields are missing, incorrect or invalid, completion of the entire processing cycle may not be possible.

When claims are processed in the system they are run through the editor, where the business rules are applied. The system will try to run through all the business rules and list all denial edits. However, if a crucial edit is encountered (such as a **required** field being found blank) the editing process for the rest of the claim will be **stopped**. The review of the claim does not proceed past the field that failed the editing process, and only the crucial edit that failed will be listed on the remit. This includes, but is not limited to, missing, incorrect or invalid data.

> Note: If there are other fields that are blank, filled out incorrectly, or invalid appearing *after* the field that failed the initial editing process, these will not be caught by the system until *after* the provider makes the initial field correction and sends the **replacement** claim back in for review.

Once the edit has been corrected and resubmitted by the provider the editing process may continue and may encounter other critical edits. This may cause the claim to deny and be reported on the remit.

For additional information on how to submit a replacement claim, please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual. For additional information on the remit, refer to Chapter 27, Understanding the Remittance Advice of the Fee-For-Service Provider Billing Manual.

Examples of edit codes:

- H001.1 - Service Provider ID - Field Is Missing
- H001.3 - Service Provider ID - Field Is Not On File
- L023.1 -Diagnosis Code #1 – Invalid for Recipient Age & Gender
- L023.2 -Diagnosis Code #1 – Invalid for Recipient Age
- L023.3 -Diagnosis Code #1 – Invalid for Recipient Gender

If one or more edits fail during the editing process, there are two possible outcomes:

1. The claim may stop processing and "pend" for internal review when the error detected concerns data or procedures that may be resolved by AHCCCS staff.
    - When a claim requires Medical Review t will pend internally until Medical Review screens the services being billed.
    - Internally pended claims are generally handled without input from the provider. The exception is when medical documentation is requested for a claim under review
2. The claim may be denied. Please see the Fee-For-Service Provider Billing Manual, Chapter 26, Correcting Claim Errors for further information.
    - If the data required for adjudication is complete, but the service does not meet AHCCCS policy requirements, the claim will deny without payment.

      For example, if a provider was not registered or if a member was not eligible on the date of service, the claim will deny.

AHCCCS' intention is to process all clean claims in a timely manner, normally within 30 days. A claim is considered "clean" on the date the following conditions are met:

- All required information has been received by AHCCCS, *and*
- The claim meets all AHCCCS submission requirements, *and*
- The claim is legible enough to permit electronic image scanning, *and*
- Any errors in the data provided have been corrected, *and*
- All medical documentation required for medical review has been provided.

A ***Claim Reference Number (CRN)*** is assigned to all claims when they are initially submitted to AHCCCS. The first five characters of the CRN represent the Julian date that the claim was initially received on by AHCCCS. The remaining numbers make up the claim document number that is assigned by AHCCCS.

When submitting documentation (e.g., Medicare EOB) following the initial submission of a claim, the CRN assigned when the claim was first submitted should be provided. This is required so that AHCCCS is able to link the new documentation to the claim.

> Note: Please see the References Section for information on the 275 Transaction Insight Portal and how to upload attachments. Itemized statements from hospitals, AHCCCS Daily Trip Reports, and additional documentation may be submitted through this portal.

Providers also must provide the initial CRN when replacing (resubmitting/adjusting) or voiding a claim. If a claim is resubmitted without the CRN, the claim will be treated as a first-time

submission and may not pass the 6- month initial claim filing deadline or the 12-month clean claim filing deadline. If the initial CRN is not provided, the claim also may be denied as a duplicate of an existing claim.

Pricing of Claims

When the editing process is completed and no errors are found on the claim, it will proceed to pricing and payment.

The AHCCCS claims processing system prices claims using the following pricing hierarchy:

1. AHCCCS reimburses the Medicare coinsurance and deductible, minus any other third party payments, for Medicare-covered services for members with Medicare.
2. If the provider has negotiated a settlement with the AHCCCS Office of Administrative Legal Services the claim is priced in accordance with the negotiated settlement.
3. If there is a provider-specific rate on file for the service, covered charges are priced at 100 percent of billed charges or the provider-specific rate, whichever is less, except when acute general hospital inpatient pricing methodology is used.
4. If there is no provider-specific rate for the service, the system determines if there is a capped fee on file for the procedure.

   If there is a capped fee for the service, covered charges are priced at 100 percent of the billed charges or the capped fee for service, whichever is less

   AHCCCS had adopted a facility/non-facility rate differential similar to the Medicare format. The facility/non-facility rate structure assigns a reimbursement rate for a given AHCCCS-covered procedure code based on the billed place of service (POS) code.

   The following POS codes are defined as a facility for purposes of the facility/non-facility rate structure:

19	21	22	23	24	26	31	34
41	42	51	52	53	56	61	

5. The system determines if a specific rate has been prior authorized.

   If there is a prior authorized rate on file for the provider, member, date of service, and service being billed, the claim is priced at 100 percent of covered billed charges or the prior authorized amount, whichever is less.

6. If none of the above pricing methodologies have been applied at this point, the claim may be reimbursed at either 58.66 per cent of covered billed charges or for outpatient hospital or ambulatory surgical centers at the covered bill charges times the cost-to-charge ratio. .

Once a claim is priced, applicable discounts, penalties, insurance payments, etc. are applied to the allowed amount to arrive at a final reimbursement amount.

References

For additional information on submitting documentation via the Transaction Insight Portal please visit the Provider Training webpage at:

https://www.azahcccs.gov/Resources/DFSMTraining/index.html

Or the Transaction Insight Portal Web Upload Attachment Guide at:

https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2018/TransactionInsight_TI_PortalWebUploadAttachmentGuide.pdf

Revisions/Update History

Date	Description of Change(s)	Page(s)
10/1/2018	Clarifications added to General Information section, including additional information being added to the editing process and what the system looks for: *"The editing process begins when the system checks the claim form to ensure that all required fields have been filled in and that no completed fields are filled out incorrectly. Incorrectly filled out fields include, but are not limited to, the following:* • *The use of letters instead of numbers when numbers are required (and vice versa); and/or*	1-2

	• *Not entering a valid 9-digit AHCCCS ID, beginning with an A; and/or* • *Not including the entire required data set, such as when a provider uses 6 digits for an NPI instead of 10; and/or* • *Invalid diagnosis code."* Editing Process extensively updated. New verbiage added includes: *"The system attempts to apply all edits during a single processing cycle. However, if certain data fields are missing, incorrect or invalid, completion of the entire processing cycle may not be possible.* *When claims are processed in the system they are run through the editor, where the business rules are applied. The system will try to run through all the business rules and list all denial edits. However, if a crucial edit is encountered (such as a* ***required*** *field being found blank) the editing process for the rest of the claim will be* ***stopped****. The review of the claim does not proceed past the field that failed the editing process, and only the crucial edit that failed will be listed on the remit. This includes, but is not limited to, missing, incorrect or invalid*	2-3

	data. Note: If there are other fields that are blank, filled out incorrectly, or invalid appearing after the field that failed the initial editing process, these will not be caught by the system until after the provider makes the initial field correction and sends the ***replacement*** *claim back in for review.* *Once the edit has been corrected and resubmitted by the provider the editing process may continue and may encounter other critical edits. This may cause the claim to deny and be reported on the remit."* Claim Reference Number (CRN) section updated. Clarification added to AHCCCS Claims Processing Hierarchy and Pricing Claims sections. References Section Added "Recipient" changed to "member" throughout. References section added	3 4 5 All that are not system edit definitions. 5

CHAPTER 26 ~ CORRECTING CLAIM ERRORS

Chapter 26 ~ Correcting Claims Errors

REVISION DATES: 10/1/2018; 10/01/2015

GENERAL INFORMATION

All claims submitted to the AHCCCS Administration are extensively edited by the AHCCCS claims system. When a claim fails an edit, an error record is created for that claim. All failed edits related to the claim denial are displayed on the Remittance Advice with an edit number, decimal point, and a single digit that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice.

Status Checks Online

AHCCCS has a web application that allows AHCCCS registered providers to check the status of claims using the Internet. To create an account and begin using the application, providers must go to the following web address:

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

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

> Note: When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the **master account holder**. For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration.

Providers can check the status of a claim using the member's AHCCCS ID number and the date of service. The Claim Status page allows providers to view the claim status history, edit history, and accounting summary.

Other services available at AHCCCS Online are:

- Online Claim Submissions
- Checking Online Claims Status
- Member Eligibility and Enrollment Verification
- Newborn Notifications
- Prior Authorization Inquiry
- Prior Authorization Submission
- Provider Information Updates (such as correspondence address updating)

Understanding Common Billing Errors

A relatively small number of errors account for the vast majority of pended and denied claims. It is important to understand the nature of these errors and the actions to be taken to resolve them. This section presents a summary of common denial or disallowance edits, including the error

number, error message, a brief description of the error, and a brief statement of the action required. This summary is not all-inclusive.

V005 Prior Authorization

These edits relate to the validity of the authorization, from the status of the authorization to the procedure and units billed. The following section further describes the edits needed to match the billed service to the authorized service.

V005.1 Prior Authorization; PA Not Active (Cs, Evnt, Actvty)

The AHCCCS system does not show a valid, active prior authorization for the service(s) and date(s) of service(s) billed. Contact the AHCCCS Prior Authorization Unit or the ALTCS Case Manager, as appropriate. (Please see the references section at the bottom of the chapter for contact information.)

V005.2 Prior Authorization; PA Units Exceeded

Total units for all claims billed under this authorization exceed the units allowed. The AHCCCS Claims System will pay the number of units remaining and cutback the excess. Contact the AHCCCS PA Unit or ALTCS Case Manager, as appropriate, to determine if the number of authorized units can be increased to cover the services billed.

V005.3 Prior Authorization; PA Units Consumed

All units have been billed and paid prior to this claim. Contact the AHCCCS PA Unit or ALTCS Case Manager, as appropriate, to determine if there should be units remaining or if units can be added. (See References Section at bottom of chatper for contact information for PA.)
.

V005.6 Prior Authorization; PA Not Found

No authorization for the service for the period. Review the authorization letter and determine if the correct combination of service and dates of service were billed.

V005.7 Prior Authorization; Primary Proc Code Not Approved

Provider billed an incorrect procedure code. Verify if the service billed is the same as displayed on the authorization letter. Contact the AHCCCS PA Unit or ALTCS Case Manager if the authorized service needs to be changed to another code. Otherwise, resubmit the claim with the correct procedure code that was authorized.

L019 Diagnosis Code #1 Test

This edit relates to the validity of the diagnosis code entered on the CMS 1500 claim form. The following further describe the edits related to the diagnosis code.

L019.1 Diagnosis Code #1 Has Missing Reference Code

L019.2 Diagnosis Code #1 Has Invalid Reference Code

L019.3 Diagnosis Code #1 Is Missing

L019.4 Diagnosis Code #1 Has Invalid Format

L019.5 Diagnosis Code #1 Is Not On File

For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD diagnosis code and entered correctly on the claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

H094 UB-04 Primary Diagnosis

This edit relates to the validity of the diagnosis code entered on the UB-04 claim form. The following further describe the edits related to the diagnosis code.

H094.1 Primary Diagnosis Code - Field Is Missing

H094.2 Primary Diagnosis Code - Field Is Invalid Format

H094.3 Primary Diagnosis Code - Field Is Not On File

For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD diagnosis code and entered correctly on the claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

L023 Age/Gender Test for Diagnosis Code #1

This edit relates to the validity of the diagnosis code entered on the CMS 1500 claim form as it relates to the member's age and/or gender. The following further describe the edits.

L023.1 Diagnosis Code #1 - Invalid For Recipient Age and Gender

L023.2 Diagnosis Code #1 - Invalid For Recipient Age

L023.3 Diagnosis Code #1 - Invalid For Recipient Gender

For all of the edits, determine if the correct diagnosis was used for the member. If the diagnosis is correct, contact Claims Customer Service and request a review of the diagnosis. If the diagnosis is incorrect, enter the correct diagnosis and resubmit the claim.

L001 Procedure Code Test

This edit relates to the validity of the procedure code entered on the CMS 1500 claim form. The following further describe the edits related to the procedure code.

L001.1 Procedure Code - Field Is Missing

L001.2 Procedure Code - Field Is Invalid Format

L001.3 Procedure Code - Field Is Not On File

For all of the procedure code edits, verify that the procedure code was entered on the claim, that the code was entered in the correct format, and that the code is a valid five-digit CPT or HCPCS code.

L060 Procedure Modifier #1

This edit relates to the validity of the first procedure modifier entered on a line of the CMS 1500 claim form. The following further describe the edits related to the procedure modifier.

L060.1 Procedure Modifier #1 - Field Is Missing

L060.2 Procedure Modifier #1 - Field Is Invalid Format

L060.3 Procedure Modifier #1 - Field Is Not On File

For all of the edits, verify that the first procedure modifier was entered on the claim line, that the modifier was entered in the correct format, and that the modifier is valid for the procedure code billed on that line. To determine if a modifier is valid, contact the AHCCCS Claims Customer Service Unit. If the modifier is not appropriate for the procedure, providers may request a review.

L067 Medicare Crossovers (CMS 1500)

L067.1 Recipient Has Part B; Medicare Must Be Indicated, Is Missing

If an AHCCCS member has Medicare coverage, the provider must bill Medicare first. Please refer to Chapter 9, Medicare/Other Insurance Liability for information on Medicare and other insurance.

L077 Service Provider Status Test (CMS 1500)

This edit relates to the service provider's ability to bill for the service indicated on a CMS 1500 claim.

L077.1 Service Provider Status Not Active; Not Authorized to Bill for Service

Either the service provider was not enrolled as an active provider with AHCCCS on the date of service, the service provider was not licensed/certified to provide the specific service on the date of service, or the procedure may not be billed by the service provider's provider type. Providers should contact AHCCCS Provider Registration for assistance. (Please see the references section at the bottom of the chapter for contact information.)

H200 Service Provider Status Test (UB-04)

This edit relates to the service provider's ability to bill for the service indicated on a UB-04 claim.

H200.1 Service Provider Status Not Active; Not Authorized to Bill for Service

This edit indicates that the service provider was not enrolled as an active provider with AHCCCS on the date of service, the service provider was not licensed/certified to provide the specific service on the date of service, or the procedure may not be billed by the service provider's provider type. Providers should contact the AHCCCS Provider Registration for assistance.

L078 Billing Provider Status Test (CMS 1500)

This edit relates to the billing provider's ability to bill for the service indicated on a CMS 1500.

L078.1 Billing Provider Status Not Active; Not Authorized To Bill For Service

The billing provider's AHCCCS ID was terminated prior to or during the claim dates of service. Contact Provider Registration for reinstatement procedures.

L016 Category of Service (CMS 1500)

This edit relates to the provider's ability to perform a service based on AHCCCS policy.

L016.1 Category of Service - Not Found For Provider

L016.3 Category of Service - Provider Is Not Authorized

For both category of service edits, verify that the correct procedure was billed. If there is no error in the procedure billed on the claim and the provider believes that the service was billed correctly, the provider should contact the AHCCCS Provider Registration.

H211 Billing To Service Provider Relationship

This edit relates to the billing provider's ability to bill on behalf of the service provider identified on the claim.

H211.1 Billing Provider Not Valid Group ID - Invalid Combination of Codes

The provider submitted a claim with both a service provider ID and a group billing ID. If a group billing ID is present on the claim, the AHCCCS system will check for a provider authorized affiliation.

For that affiliation to be valid, the provider must have notified Provider Registration in writing that a specific group is authorized to bill for the provider's services.

Contact Provider Registration to determine if the necessary authorization has been made. If not, Provider Registration will send the provider a form to complete and return. The affiliation may be retroactively established at the provider's request.

H216 Recipient Eligibility/Enrollment (UB-04)

This edit relates to the member's eligibility for the services billed on the UB-04 claim form.

H216.1 Recipient Not Elg/Enrl For Entire DOS; Invalid Eligibility

H216.2 Recipient Not Elg/Enrl For Entire DOS; Invalid Enrollment

For all member eligibility edits, the member is either not AHCCCS eligible or not eligible for the service(s) on the date(s) of service. Verify the member's AHCCCS ID number and eligibility standing with the AHCCCS the Division of Member Services (DMS). (Please see the references section at the bottom of the chapter for contact information.) . See Chapter 2, Eligibility.

L099 Recipient Eligibility/Enrollment (CMS 1500)

This edit relates to the member's eligibility for the services billed on the CMS 1500 claim.

L099.1 Recipient Not Elg/Enrl For Entire DOS; Invalid Eligibility

L099.2 Recipient Not Elg/Enrl For Entire DOS; Invalid Enrollment

For all member eligibility edits, the member is either not AHCCCS eligible or not eligible for the service on the date(s) of service. Verify the member's AHCCCS ID number and eligibility standing with the AHCCCS Division of Member Services (DMS). See Chapter 2, Eligibility.

H199 Timeliness Test (UB-04)

This edit relates to the timeliness requirement for submitting UB-04 claims to AHCCCS.

H199.4 Claim Received - Past 6 Month Limit

The initial claim for services was received by AHCCCS more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. For hospital claims, the end date of service is the date of discharge. If the claim was originally submitted within the six-month time frame, resubmit the claim with the CRN of the previously denied claim.

H199.2 Claim Received - Past 12 Month Limit, Deny

A resubmission of a denied claim was received by AHCCCS more than 12 months from the end date of service or date of retro-eligibility posting. For hospitals, the end date of service is the date of discharge. Verify the From and Through dates of service entered on the claim.

L076 Timeliness Test (CMS 1500)

This edit relates to the timeliness requirement for submitting CMS 1500 claims.

L076.4 Claim Received - Past 6 Month Limit

The initial claim for services was received by AHCCCS more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. If the claim was originally submitted to AHCCCS within the appropriate six-month time frame, resubmit the claim with the CRN of the previously denied claim.

L076.2 Claim Received - Past 12 Month Limit, Deny

A resubmission of a denied claim was received by AHCCCS more than 12 months from the end date of service or date of retro-eligibility posting. Verify the From and Through dates of service entered on the claim form.

Note: Refer to the section “Resubmission, Replacement, Void” in Chapter 4, General Billing Rules, for the AHCCCS required fields on the various claim forms. If information is missing (failure to complete specific claim form fields) the resubmission/replacement won’t link to the original claim causing the resubmission/replacement to be denied as a duplicate or for timely filing.

As other edits are encountered, providers should contact the AHCCCS Claims Customer Service Unit for assistance.

References

For additional information on the **PA process** and for contact information for **the Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU)**, which does prior authorization, please visit:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html

TO OUTREACH PROVIDER REGISTRATION:

In Maricopa County: 602-417-7670 and select option 5
Outside Maricopa County: 1-800-794-6862
Out-of-State: 1-800-523-0231

To outreach the Division of Member Services (DMS):

Providers may call the Interactive Voice Response (IVR) within Maricopa County at (602) 417-7200 and all other counties at 1-800-331-5090. There is no charge for this service.

A provider may use their National Provider ID (NPI) to verify a member's eligibility, enrollment via the provider IVR. The provider's IVR allows unlimited verification information by entering demographic information or the member's AHCCCS ID Number, without having to wait in the phone queue.

This allows providers access to the AHCCCS Prepaid Medical Management Information System (PMMIS) for up-to-date eligibility and enrollment. Verification can be made for a single day or for a date range within the two years of the placed phone call.

Providers may also request a faxed copy of eligibility for their records via the IVR.

Provider may also use the AHCCCS Online Portal to verify eligibility and claim information at:

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

Revision History

Date	Description of changes	Page(s)
10/1/2018	The link to AHCCCS Online was updated (Master Account Holder information added) The following was added to the Status Checks Online section: "Note: When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the	1 1

	master account holder. For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration." The "Other Services Available at AHCCCS Online" section was clarified Clarification was added to V005 – Prior Authorization. UB-92 updated to UB-04 Edits V00.5.4 and V005.5 descriptions have been removed due to lack of use. The Understanding Common Billing Areas section was comprehensively updated. The edits had more detail added to provide additional clarification for providers. Clarifications were added to the following edits: • V005 • L019 • L067 • L077 • H200 • L016 • H216 • L099 L067.2 edit removed as it has not been utilized in over 5 years. A References Section with contact information for DFSM's CMSU (the PA area), Provider Registration, and the Division of Member Services (DMS) was added Changed "recipient" to "member" Formatting .	 1 2 3 2 1-7 4 7-8 All (except edits) All
10/01/2015	New format "ICD-9" replaced with "ICD	All

CHAPTER 27 ~ UNDERSTANDING THE REMITTANCE ADVICE

Chapter 27 ~ Understanding the Remittance Advice

REVISION DATES: 2/28/2019; 10/22/2018; 09/19/2005

GENERAL INFORMATION

The *AHCCCS Fee-for-Service Remittance Advice* provides information about claims adjudicated by the AHCCCS Division of Fee For Service Management (DFSM) , including claims paid or voided, claims which were denied, and in process and adjusted claims.

The Remittance Advice is generated weekly, and the paper Remittance Advice is mailed to the billing provider. If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each.

This chapter primarily addresses the Paper Remittance Advice. For providers interested in requesting Electronic Remittance Advice (ERA) setup (recommended), please see the below section on the 835 Remittance Advice.

For information related to the HIPAA-compliant 835 transaction, please consult the Implementation Guide and/or 835 Claim Remittance Advice Companion Document for the 835 transaction available on the AHCCCS website at:
https://www.azahcccs.gov/Resources/EDI/EDITechnicaldocuments.html

835 REMITTANCE ADVICE

Please note that the AHCCCS Companion Document is intended to supplement, but not replace, the Implementation Guide for the 835 transaction. It can be found on the AHCCCS website at:
https://www.azahcccs.gov/Resources/EDI/EDITechnicaldocuments.html

Providers who have completed the necessary registration and testing processes may download a HIPAA-compliant 835 electronic remittance advice for both paid and denied claims from a secure AHCCCS internet website, and may store the remittance in either electronic or hardcopy format on their internal systems.

Who may request ERA setup?

AHCCCS considers the provider their trading partner, and a request for electronic remittance advice (ERA) or 835 transaction setup must come from an authorized individual from within the provider's organization; **it cannot be initiated by the provider's clearinghouse, software vendor, or billing service.**

For clarification purposes, the authorized individual must be someone from within the provider's own organization that has the authority to accept the electronic Trading Partner

Agreement (TPA) executed from the Community Manager (CM) web portal. Only the provider can accept the TPA as it is a contractual agreement between the provider and AHCCCS. **The provider's CM account activation cannot be done by the provider's clearinghouse, software vendor, or billing service.**

How can a provider request ERA setup?

The AHCCCS Information Services Division, EDI Customer Support, is the first point of contact for questions related to electronic transactions or to request transaction setup. The preferred method of contact is email.

Note: If providing PHI data, please make sure your email is secured.

All inquiries will result in the assignment of a Service Request or Incident for AHCCCS reporting purposes. Contact information:

Email: EDICustomerSupport@azahcccs.gov
Telephone Number: (602) 417-4451
Hours: 7:00 AM – 5:00 PM Arizona Time, Monday through Friday

What information will AHCCCS need?

AHCCCS will require the following information from providers, in order to set them up for the Electronic Transaction Process:

- Customer Name
- Provider Name
- Customer Email Address
- AHCCCS 6 digit Provider ID and/or NPI
- Will the provider be retrieving their own ERA/835 or be using a clearinghouse to retrieve the ERA/835 on the provider's behalf?
- If a clearinghouse is to be used, provide the name of that clearinghouse.

Note: The remaining information in this Chapter applies only to the Paper Remittance Advice.

PAPER REMITTANCE ADVICE

The AHCCCS paper remittance advice is broken up into two general packages or sections.

1) The *Non-Facility Remittance Advice* section, which reports information related to services billed on the CMS 1500, UB ADA claim forms; and
2) The *Facility Remittance Advice* section, which reports information related to services billed on the UB claim form.

Providers may receive an Acute Remittance, a Long Term Care Remittance, a KidsCare Remittance or all three within a Remittance Advice package. The terms Acute, Long Term Care, and KidsCare designate the eligibility category of the members and do not refer to the

type of provider. There will be only one payment issued for any combination of invoices paid.

REMITTANCE SECTIONS

Each Remittance Advice package is divided into seven sections:

- Paid claims
- Adjusted claims
- Denied claims
- Voided claims
- Claims in process
    - This section includes claims pending or reported on a previous Remittance and still in process.
- Processing Notes
    - This page provides an alphabetical listing of denial reason codes and pricing explanation codes.
    - Each is listed only once even if it applies to multiple claims.
- Grievance Process
    - This page informs providers of their grievance rights. For additional information pleaser refer to Chapter 28, Claim Disputes.

Providers who would like to request a duplicate paper copy of the remittance advice may contact the Division of Business and Finance (DBF) at:

- **Metro Phoenix (602, 480, & 623 area codes): 602-417-5500**
- **Toll Free: 877-500-7010**

Please note that there is a charge for a duplicate remittance advice of $4.00 per page. Duplicate paper copies are only available to providers receiving paper remittances, and not to providers receiving electronic 835s.

Providers receiving the electronic 835 remittance, who would like to request a duplicate 835, must contact the help desk at 602-417-4451 for assistance.

ADDRESS PAGE

The ***Address Page*** of the Remittance Advice (Exhibit 27-1) displays the billing provider's name, ID and pay-to mailing address, as well as the Invoice Date and Payment Date.

Information reported on the Address page includes:

- REPORT ID
- PROGRM ID
- BILLING PROVIDER ID number plus locator codes and name

- TAX ID of the billing provider.
- INVOICE DATE
- PAYMENT DATE
- BILLING PROVIDER NAME
- PAY-TO MAILING ADDRESS

FINANCIAL SUMMARY

The ***Financial Summary*** page (Exhibit 27-2) reports payment and invoice data. If all claims are in process or denied, the page will indicate "No Active Invoices."

Information reported on the Financial Summary page includes:

- REPORT ID
- PROGRM ID
- BILLING PROVIDER ID number plus locator codes and name
- TAX ID of the billing provider.
- PAYMENT DATE is the check date.
- PAY FOR CATEGORY.
    - Acute, Long Term Care, and KidsCare totals (as applicable) are printed on separate lines.
- CHECK NUMBER.
- INVOICE DATE is the date the invoice was created.
- INVOICE NUMBER links payments to the services that generated the payment.
    - A is for Acute services
    - L is for Long Term Care services
    - K is for Kids Care services
    - M is for FQMB
    - N is JDOC
    - J is MDOC
    - C is BKFS
    - B is BFFS
- TYPE column will indicate "CR" if the provider has a credit.
- GROSS AMOUNT is the total remitted for each Pay Category.
    - A negative Gross total on an invoice lines means it is a credit.
        - This may mean there is no payment on this remittance. However, there can still be a payment for the other invoices if there are more than one. The total payment will be the net of credits and debits.
    - When there is only one invoice: Gross Amount and Net Amount are usually equal unless there is a credit memo (negative invoices or recouped claims).
    - When there is more than one invoice: When two invoices are submitted, the Net Amount reflects the total for both invoices.
- DISCOUNT is never used for AHCCCS fee-for-service providers.
- NET AMOUNT is the check/EFT amount for each Pay Category.

NON-FACILITY PAID CLAIMS

The ***Paid Claims*** section for non-facility claims (Exhibit 27-3) displays the following data:

- INVOICE DATE is the date AHCCCS processed the claims for payment.
- BILLING PROVIDER ID number plus locator codes and name.
- SERVICE PROVIDER ID number plus locator codes and name.
- NPI for both billing and servicing providers.
- INVOICE NUMBER matches the number on the Financial Summary.
- CHECK/EFT NUMBER matches the number on the Financial Summary.
- PAYMENT DATE is the date of the reimbursement check/EFT.
- TAX ID of the billing provider.
- FORM TYPE will be 1500 or Dental.
- AHCCCS ID of the member.
- NAME of the member as recorded in the AHCCCS system.
- PATIENT ACCOUNT NUMBER is the number entered on the claim in the patient account number field. At times this may be the same as the AHCCCS ID.
- CRN is the AHCCCS Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- STATUS DATE is the most recent date the claim was adjudicated (attained "Paid" status).
- SERVICE CD/MODIFIER is the CPT/HCPCS procedure code submitted on the claim.
    - Any procedure modifier would be printed below the procedure code.
- DATES OF SERVICE displays the From and Through dates of service submitted on the claim.
    - If dates are the same, only one date is displayed.
- BILLED AMOUNT submitted on the claim.
- BILLED UNITS reflects the number of units submitted on the claim.
- ALLOWED UNITS reflects the AHCCCS allowed number of units.
- ALLOWED AMOUNT may be based on the AHCCCS capped fee, a provider specific rate, Medicare Coinsurance and Deductible, etc.
- NET PAID AMOUNT is the ALLOWED AMOUNT minus any deductions.
- PRICE EXPL is the pricing explanation code.
- Definitions are printed on the Processing Notes page.
- An asterisk (*) next to a code denotes how the ALLOWED AMOUNT was determined (e.g., MCC = Medicare Coinsurance, MAX = maximum allowed charge/capped fee, etc.).

The following summary is listed at the end of each Non-facility Paid Claims section:

- NUMBER OF CLAIMS is the total number of claims in the Paid Claims section.
- TOTAL BILLED AMOUNT is the total amount for all claims in the Paid Claims section.

- TOTAL REMIT AMOUNT is the total paid amount for all claims in the Paid Claims section.

```
REPORT ID:                                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROGRAM ID:                                           NON-FACILITY REMITTANCE ADVICE
                                                      PAID CLAIMS - INVOICE DATE:

BILLING PROVIDER:                                       NPI:                          INVOICE NUMBER:
SERVICE PROVIDER:                                       NPI:                          CHECK NUMBER:
                                                                                      PAYMENT DATE:
       TAX ID:
       FORM TYPE:  FORM 1500

AHCCCS ID   NAME                          CRN            SERVICE CD/   DATES OF     BILLED AMOUNT      ALLOWED
RECIPIENT   PATIENT ACCOUNT NUMBER        SCORE DATE      MODIFIER     SERVICE       BILLED UNITS        UNITS
-------------------------------------------------------------------------------------------------------------------

A########   Last Name, First Name         ##############  99231                          75.00          1.00          40.00
A########   Patient Account #             MM/DD/YYYY                                      1.00                        ----------
                                                                                                                      40.00

 PRICE EXPL: *AHA
-------------------------------------------------------------------------------------------------------------------
                                                                                    |
NUMBER OF CLAIMS:                  1
TOTAL BILLED AMOUNT:            75.00
TOTAL REMIT AMOUNT:             40.00
```

NON-FACILITY DENIED CLAIMS

The ***Denied Claims*** section for non-facility claims (Exhibit 27-4) displays much of the same data as the Paid Claims section.

Because no payment is made to the provider, the CHECK NUMBER, INVOICE DATE, INVOICE NUMBER, TYPE, GROSS AMOUNT, DISCOUNT, AND NET AMOUNT are not displayed on the Financial Summary page.

- Please note, if the remittance only has denied claims on it, the Financial Summary Page will show no active invoices and no other information on it.

Because no payment is made to the provider, the INVOICE NUMBER, CHECK NUMBER, AND PAYMENT DATE fields are not displayed in the Denied Claims section.

- Please note that the above holds true only if the remittance contains only denied claim information. However, if the same remittance has paid and denied claims on it, the PAYMENT NUMBER, INVOICE DATE, INVOICE NUMBER, AND GROSS and NET AMOUNTS will also appear.

The Denied Claim section adds a REASON CDS field that lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Providers should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Non-facility Denied Claims section:

- THE NUMBER OF CLAIMS in the Denied Claims section.
- TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

```
REPORT ID:                                        ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROGRAM ID:                                         NON-FACILITY REMITTANCE ADVICE
                                                              DENIED CLAIMS

BILLING PROVIDER:                                     NPI:
SERVICE PROVIDER:                                     NPI:

      TAX ID:
      FORM TYPE:  FORM 1500
```

AHCCCS ID	RECIPIENT	NAME	PATIENT ACCOUNT NBR	CRN	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILL
A########	A########	Last Name, First Name	T#######CLAIM	###############	97110 GP	MM/DD/CCYY	30.00
REASON CDS: H001.7 L013.1							
A########	A########	Last Name, First Name	T#######CLAIM	###############	97110 GP	MM/DD/CCYY	225.0
REASON CDS: H001.7							

```
NUMBER OF CLAIMS:      2
TOTAL BILLED AMOUNT:   255.00
```

NON-FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for non-facility claims (Exhibit 27-5) displays much of the same data as the Paid Claims section.

The Adjusted Claims section adds a PREVIOUSLY PAID field that displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of each Non-facility Adjusted Claims section:

- NUMBER OF CLAIMS is the total number of claims in the Adjusted Claims section.
- TOTAL BILLED AMOUNT for all claims in the Adjusted Claims section.
- TOTAL REMIT AMOUNT for all claims in the Adjusted Claims section.

```
REPORT ID:                                   ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROGRAM ID:                                    NON-FACILITY REMITTANCE ADVICE
                                             ADJUSTED CLAIMS - INVOICE DATE:

BILLING PROVIDER:   Provider ID     Billing Provider Name     NPI:                    INVOICE NUMBER:
SERVICE PROVIDER:   Provider ID     Servicing Provider Name   NPI:                    CHECK NUMBER:
                                                                                      PAYMENT DATE:
      TAX ID:
      FORM TYPE:  FORM 1500

AHCCCS ID   NAME                          CRN              SERVICE CD/   DATES OF     BILLED AMOUNT      ALLOWED
RECIPIENT   PATIENT ACCOUNT NUMBER        SCORE DATE        MODIFIER     SERVICE       BILLED UNITS        UNITS
-------------------------------------------------------------------------------------------------------------------
A########   Last Name, First Name         ##############   Billed Code   MM/DD/CCYY
A########   T########CLAIM               MM/DD/CCYY       Modifier                     145.66             2.00          57.20   ALLO
                                                                                        2.00                           57.20-  PREV
                                                                                                                    ----------
                                                                                                                       0.00   NET
 PRICE EXPL: *AHA
-------------------------------------------------------------------------------------------------------------------
```

NON-FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims (Exhibit 27-6) displays much of the same data as the Paid Claims section.

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than the amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are “backed out” and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

> **NOTE:** The credit balance has not been recouped if there is no payment with the remittance and there are voided claims. Until there are further claims to recoup the credit balance from, the funds are not considered recouped. A provider will have an aging credit in the system if there were no claims paid or claims paid for less than what was voided. The funds will not be considered recouped until there is no longer an aging credit balance.

The following summary is listed at the end of each Non-facility Voided Claims section:

- NUMBER OF CLAIMS in the Voided Claims section.
- TOTAL BILLED AMOUNT for all claims in the Voided Claims section.
- TOTAL RECOUPED AMOUNT for all claims in the Voided Claims section.

```
REPORT ID:                                        ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROGRAM ID:                                         NON-FACILITY REMITTANCE ADVICE
                                                   VOIDED CLAIMS - INVOICE DATE:

BILLING PROVIDER:                                     NPI:                          INVOICE NUMBER:
SERVICE PROVIDER:                                     NPI:                          CHECK NUMBER:
                                                                                    PAYMENT DATE:
       TAX ID:
       FORM TYPE:  FORM 1500

AHCCCS ID   NAME                          CRN            SERVICE CD/   DATES OF      BILLED AMOUNT      ALLOWED
RECIPIENT   PATIENT ACCOUNT NUMBER        SCORE DATE      MODIFIER     SERVICE        BILLED UNITS        UNITS
-------------------------------------------------------------------------------------------------------------------

A#######    Last Name, First Name          CRN Number     00400        MM/DD/YYYY     2000.00            4.00          0.
A#######    Account Number                 MM/DD/YYYY     AA                                4.00                    200.
                                                                                                                    --------
                                                                                                                     200.

 PRICE EXPL: *AHA
 REASON CDS: MD034
 COMMENTS:   DENIED ADJUSTMENT OF PREVIOUS PAYMENT
-------------------------------------------------------------------------------------------------------------------

NUMBER OF CLAIMS:                 1
TOTAL BILLED AMOUNT:           2000.00
TOTAL RECOUPED AMOUNT:          200.00-
```

NON-FACILITY CLAIMS IN PROCESS

The *Claims in Process* section (Exhibit 27-7) of the Remittance Advice for non-facility claims displays all claims that have not been adjudicated (as of that week's invoice date). The Claims in Process section displays much of the same data described previously.

The Claims in Process section does not display any payment or edit information because the claims have not been adjudicated.
Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.
The following summary is listed at the end of each Non-facility Claims in Process section:

- NUMBER OF CLAIMS is the total number of claims in process.
- TOTAL BILLED AMOUNT is for all the claims in process.
- **NOTE:** If there are multiple servicing providers with claims in process then the TOTAL BILLED AMOUNT will show under each service provider and not all combined.

REPORT ID:
PROGRAM ID:

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
NON-FACILITY REMITTANCE ADVICE
CLAIMS IN PROCESS

PAGE:
RUN:

BILLING PROVIDER: NPI:
SERVICE PROVIDER: NPI:

TAX ID:
FORM TYPE: FORM 1500

AHCCCS ID	RECIPIENT NAME	PATIENT ACCOUNT NBR	CRN	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT	BILLE
A########	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	
A########	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	

NUMBER OF CLAIMS: 15
TOTAL BILLED AMOUNT: 300.00

NON-FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* (Exhibit 27-8) section displays the following data:

- BILLING PROVIDER ID number plus locator codes and name.
- TAX ID number of the billing provider.
- NPI of the billing provider.
- NOTE is an alphabetical listing of processing codes (denial or void reason codes, pricing method codes, etc.).
    - Each code is listed only once even if applicable to multiple claims.
- TYPE lists the type of code.
    - M = Pricing Method
    - P = Pricing Type
    - R = Reason Code
    - T = Tier
    - X = Modifier
- DESCRIPTION is the description of a processing note code.

Examples:

H199.4 R CLAIM RECEIVED PAST 6 MONTH LIMIT
H079.7 R BILLING PROVIDER ID NOT VALID FOR PROVIDER
AHA P AHCCCS ALLOWED
SUB M SUBMITTED AMOUNT FROM CLAIM

FACILITY PAID CLAIMS/INPATIENT

The *Paid Claims* section for inpatient facility claims (Exhibit 27-9) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- BILLING PROVIDER ID number plus locator codes and name.
- SERVICE PROVIDER ID number plus locator codes and name.
- NPI of the billing and servicing provider IDs.
- INVOICE NUMBER matches the number on the Financial Summary .
- CHECK NUMBER matches the number on the Financial Summary.
- PAYMENT DATE is the date of the reimbursement check.
- TAX ID of the billing provider.
- The FORM TYPE will be Inpatient (includes inpatient hospital and nursing home).
- AHCCCS ID of the member.
- NAME of the recipient as recorded in the AHCCCS system.
- PATIENT ACCOUNT NUMBER is the number you entered on the claim in the patient account number field.
- PRICE EXPL is the pricing explanation code.
  - Definitions are printed on the Processing Notes page.
  - An asterisk (*) next to a code denotes how the ALLOWED AMOUNT was determined (e.g., MCC = Medicare Coinsurance, MAX = maximum allowed charge/capped fee, etc.).
- CRN is the AHCCCS Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- STATUS DATE is the most recent date the claim was adjudicated (attained “Paid” status).
- DATES OF SERVICE displays the From and Through dates of service submitted on the claim.
  - If dates are the same, only one date is displayed.
- BILLED AMOUNT submitted on the claim.
- BILLED UNITS reflects the number of units submitted on the claim.
- ALLOWED UNITS reflects the AHCCCS allowed number of units.
- ALLOWED AMOUNT may be based on the AHCCCS capped fee, Medicare Coinsurance and Deductible, etc.
- NET PAID AMOUNT is the ALLOWED AMOUNT minus any deductions.
- The PRICE EXPL field will display:
  - For hospital inpatient claims, tier(s) into which the claim was classified are displayed (e.g., MAT = Maternity tier).

  - For hospital claims, discount and penalty percentages also are displayed.
  - For nursing home claims, codes may indicate PDM (per diem) or MCC (Medicare Coinsurance).
- TIER DATA displays the inpatient tier classification(s), number of accommodation days billed, AHCCCS allowed days for tier(s), and reason codes for any disallowed and cutback days.
- BILLED UNITS reflects accommodation days for inpatient claims.
- ALLOWED UNITS reflects accommodation days for inpatient claims.

The following summary is at the end of each Paid Claims section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.
- TOTAL REMIT AMOUNT for all claims in the section.

```
BILLING PROVIDER:                                    NPI:                          INVOICE NUMBER:
SERVICE PROVIDER:                                    NPI:                          CHECK NUMBER:
                                                                                   PAYMENT DATE:
      TAX ID:
      FORM TYPE:  INPATIENT

AHCCCS ID      NAME                          CRN              DATES OF       BILLED AMOUNT        ALLOWED
RECIPIENT      PATIENT ACCOUNT NUMBER        STATUS DATE      SERVICE         BILLED UNITS          UNITS
-------------------------------------------------------------------------------------------------------------------
A########      Last Name, First Name         CRN              MM/DD/YYYY      54,000.00             3.00          10,000.00
A########      Account Number                MM/DD/YYYY       MM/DD/YYYY       3.00                                300.00-
                                                                                                              -----------
                                                                                                                9,700.00

 PRICE EXPL: *AHA          (Q5 - 1%)
```

FACILITY PAID CLAIMS/OUTPATIENT

The *Paid Claims* section for outpatient facility claims (Exhibit 27-10) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- BILLING PROVIDER ID number plus locator codes and name.
- SERVICE PROVIDER ID number plus locator codes and name.
- NPI of the billing and servicing provider IDs.
- INVOICE NUMBER matches the number on the Financial Summary .
- CHECK NUMBER matches the number on the Financial Summary.
- PAYMENT DATE is the date of the reimbursement check.
- TAX ID of the billing provider.
- The FORM TYPE will be Outpatient (includes outpatient hospital, dialysis facilities, hospice, and birthing centers).
- The PRICE EXPL field will display:
    - For hospital claims, discount and penalty percentages also are displayed at the claim level.
    - Definitions are printed on the Processing Notes page.
  - BILLED UNITS reflects actual line billed units for each revenue code line for outpatient claims with dates of service on or after 7/1/2005.

- ALLOWED UNITS reflects actual line allowed units for outpatient claims with dates of service on or after 7/1/2005.

```
BILLING PROVIDER:                                   NPI:                          INVOICE NUMBER:
SERVICE PROVIDER:                                   NPI:                          CHECK NUMBER:
                                                                                  PAYMENT DATE:
      TAX ID:
      FORM TYPE:  OUTPATIENT

AHCCCS ID      NAME                          CRN              DATES OF        BILLED AMOUNT        ALLOWED
RECIPIENT      PATIENT ACCOUNT NUMBER        STATUS DATE      SERVICE          BILLED UNITS          UNITS
-------------------------------------------------------------------------------------------------------------------------------
A########      Last Name, First Name         CRN              MM/DD/YYYY      4200.00              5.00          450.00
A########      Account Number                MM/DD/YYYY       MM/DD/YYYY      5.00                                 2.50-
                                                                                                                447.50
-------------------------------------------------------------------------------------------------------------------------------
```

FACILITY DENIED CLAIMS

The *Denied Claims* section for facility claims (Exhibit 27-11) displays much of the same data as the Paid Claims section.

Because no payment is made to the provider, the INVOICE DATE, INVOICE NUMBER, PAYMENT DATE, and CHECK NUMBER fields are not displayed in the Denied Claims section.

- NOTE: If the remittance only has denied claims on it, the Financial Summary Page will show no active invoices and no other information on it.
- NOTE: The above holds true only if the remittance contains only denied claim information. However, if the same remittance has paid and denied claims on it, the PAYMENT NUMBER, INVOICE DATE, INVOICE NUMBER, AND GROSS and NET AMOUNTS will also appear.

The REASON CDS field lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Providers should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Denied Claims section:

NUMBER OF CLAIMS in the Denied Claims section.

- TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

```
REPORT ID:                                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROGRAM ID:                                             FACILITY REMITTANCE ADVICE
                                                                DENIED CLAIMS

BILLING PROVIDER:                                    NPI:
SERVICE PROVIDER:                                    NPI:

       TAX ID:
       FORM TYPE:  INPATIENT

AHCCCS ID    RECIPIENT    NAME                       PATIENT ACCOUNT NBR    CRN                DATES OF SERVICE          BILLE
-------------------------------------------------------------------------------------------------------------------------------
 A########    A########    Last Name, First Name      #########             ############       MM/DD/CCYY   MM/DD/CCYY   $4,000.0
 REASON CDS: H210.9  H229.1  H258.1
-------------------------------------------------------------------------------------------------------------------------------

NUMBER OF CLAIMS:                 1
TOTAL BILLED AMOUNT:              4,000.00
```

FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for facility claims (Exhibit 27-12) displays much of the same data as the Paid Claims section.

The PREVIOUSLY PAID field displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of the Adjusted Claims section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.
- TOTAL REMIT AMOUNT for all claims in the section.

FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims (Exhibit 27-13) displays much of the same data as the Paid Claims section:

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are “backed out” and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

The following summary is listed at the end of each Voided Claims section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.
- TOTAL RECOUPED AMOUNT for all claims in the section.

```
REPORT ID:                                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROGRAM ID:                                         FACILITY REMITTANCE ADVICE - MDOC FEE FOR SERVICE
                                                     VOIDED CLAIMS - INVOICE DATE:

BILLING PROVIDER:                                       NPI:                          INVOICE NUMBER:
SERVICE PROVIDER:                                       NPI:                          CHECK NUMBER:
                                                                                      PAYMENT DATE:
       TAX ID:
       FORM TYPE:  OUTPATIENT

AHCCCS ID      NAME                              CRN                DATES OF        BILLED AMOUNT          ALLOWED
RECIPIENT      PATIENT ACCOUNT NUMBER            STATUS DATE        SERVICE          BILLED UNITS            UNITS
-------------------------------------------------------------------------------------------------------------------------------------
A########      Last Name, First Name             CRN Number         MM/DD/YYYY          30,000.00                1.00            10,000.00-
A########      Account Number                    MM/DD/YYYY         MM/DD/YYYY               1.00                                   500.00
                                                                                                                              -----------
                                                                                                                                 9500.00-

 PRICE EXPL: *AHA          (Q5 - 1%)
 REASON CDS: EV100 --LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE01, LINE01, LINE01, LINE01, LI
 REASON CDS: EV100 --LINE01, LINE01, LINE01, LINE01, LINE02, LINE02, LINE02, LINE02, LINE02, LINE02, LINE02

Number of Claims:          1
Total Billed Amount:    30000.00
Total Recouped Amount:   9500.00
```

FACILITY CLAIMS IN PROCESS

The *Claims in Process* section (Exhibit 27-14) of the Remittance Advice for facility claims displays all claims that have not been adjudicated. The Claims in Process section displays much of the same data described previously:

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of the Claims in Process section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in process.
- TOTAL BILLED AMOUNT for all claims in process.

REPORT ID:
PROGRAM ID:

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
FACILITY REMITTANCE ADVICE
CLAIMS IN PROCESS

BILLING PROVIDER: NPI:
SERVICE PROVIDER: NPI:

TAX ID:
FORM TYPE: INPATIENT

AHCCCS ID	RECIPIENT	NAME	PATIENT ACCOUNT NBR	CRN	DATES OF SERVICE		BILLE
A########	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	30,000.0
A########	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	78,900.0
COMMENTS:	OUTLIER REQUESTED, NOT QUALIFIED						
A########	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	50,000.0

Number of Claims: 3
Total Billed Amount: 158,900.00

FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* section for both Acute and Long Term Care claims displays the same type of information as does the Processing Notes section for non-facility claims (Exhibit 27-8).

GUIDANCE ON REVIEWING THE REMITTANCE ADVICE

Here are some suggestions for working the AHCCCS Remittance Advice to reconcile claims billed to the AHCCCS Administration and the status of those claims.

1. Review the Paid Claims section of the Remittance Advice to determine which claims have been paid and if those claims were paid correctly. Any errors, such as claims that have not paid the correct number of units, should be resubmitted (if within timely filing guidelines), noting **the original** CRN. (See Chapter 4, General Billing Rules, for information on resubmitting a paid claim.)

   NOTE: The CRN on the originally submitted claim is REQUIRED on resubmissions.

2. Review the Adjusted Claims section of the Remittance Advice. This section will report any claims submitted by the provider as adjustments because they were not paid correctly. If problems still exist with a claim, it may be submitted again if within the timely filing guidelines. This section also will report any claims that were adjusted by AHCCCS as a result of an audit or review.

   NOTE: AHCCCS highly recommends that resubmissions should be done using the AHCCCS Online Provider Portal. (https://azweb.statemedicaid.us)

3. Review the Voided Claims section of the Remittance Advice. This section will report any claims submitted by the provider as a voided transaction. There are many reasons a

claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that AHCCCS can recoup its payment. This section also will report any claims that were voided by AHCCCS as a result of an audit or medical review recoupment.

4. Review the Denied Claims section of the Remittance Advice. Review each denial reason and determine the action necessary to correct the claim. (See Chapter 4, General Billing Rules, for information on resubmitting a denied claim.)

   Providers who have questions about the status of their claim should contact the AHCCCS Claims Customer Service Unit:

   - (602) 417-7670 (Phoenix Area)
   - (800) 794-6862 (In state)
   - (800) 523-0231 (Out of state)**

   **Customer Service Agents cannot provide billing guidance.

   Providers who have questions on delayed payments, checks, or the remittance advice may contact the Division of Business and Finance (DBF) at:

   - Metro Phoenix (602, 480, & 623 area codes): 602-417-5500
   - Toll Free: 877-500-7010

References

835 Claim Remittance Advice Companion Guide:
https://www.azahcccs.gov/Resources/EDI/EDITechnicaldocuments.html

Revision History

Date	Description of changes *All page numbers correspond to page numbers in the individual chapters.	Page(s)
2/28/2019	General Information Section – Clarifications added and link to the 835 Claim Remittance Advice Companion Document updated. Link added for 835 AHCCCS Companion Documents FAQs added regarding the Electronic Remittance Advice • Who may request ERA setup? • How can a provider request ERA setup? • What information does AHCCCS require to set up the Electronic Transaction Process? Clarification added to the paper remittance advice section reading as, “There will be only one payment issued for any combination of invoices paid.”	1 1 2-3 2 2 2-3 3

	Contact information (to request a duplicate paper remittance advice) for the Division of Business and Finance added. Address Page section updated Financial Summary section updated Non-Facility Paid Claims section updated Non-Facility Denied Claims section updated Non-Facility Adjusted Claims section updated with an example Non-Facility Voided Claims section updated with an example Non-Facility Claims in Process section updated Non-Facility Claims Processing Notes section updated Facility Paid Claims/Inpatient section updated Facility Paid Claims/Outpatient section updated Facility Denied Claims section updated Facility Voided Claims section updated Facility Claims In Process section updated Guidance on Reviewing the Remittance Advice section updated	4 4 5-7 6-8 8-9 10-11 11-12 12-13 14 14-16 16-17 17-18 19-20 20-21 21-22
10/22/2018	References Section Added Formatting	10 All

Exhibit 27-1

SAMPLE REMITTANCE ADVICE – ADDRESS PAGE

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 1
PROGRAM ID: FI04L400                       REMITTANCE ADVICE - REMIT TO ADDRESS                     RUN: 11/29/2003

BILLING PROVIDER:   654321  01

    INVOICE DATE:   11/29/2003
    PAYMENT DATE:   12/02/2003

                                                                                  PROVIDER NAME
                                                                                  STREET ADDRESS OR P.O. BOX
                                                                                  ANYTOWN                  AZ
                                                                                                 99999

** PLEASE CALL PROVIDER SERVICES FOR QUESTIONS OR CLARIFICATION ABOUT THE CONTENTS OF THIS PACKAGE **
** PROVIDER SERVICES MAY BE REACHED AT  (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0231 (OUR-OF-STATE) **

PLEASE  RETAIN  THIS  COPY  FOR  YOUR  RECORDS  SINCE  ONLY  ONE  COPY  OF  THE  REMITTANCE  ADVICE  WILL  BE  SENT.

IF  ADDITIONAL  COPIES  ARE  REQUESTED,  THERE  WILL  BE  A  $2.00  CHARGE  PER  PAGE.
```

Address page shows billing provider's name and Pay-To mailing address

Exhibit 27-2

SAMPLE REMITTANCE ADVICE – FINANCIAL SUMMARY

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 2
PROGRAM ID: FI04L400                       REMITTANCE ADVICE - FINANCIAL SUMMARY                        RUN: 11/29/2003
001549                                          INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   PROVIDER NAME

      TAX ID:       999999999
PAYMENT DATE:       12/02/2003

                                CHECK    INVOICE
PAY FOR CATEGORY                NUMBER     DATE       INVOICE NUMBER     TYPE      GROSS AMOUNT     DISCOUNT      NET AMOUNT
-------------------------------------------------------------------------------------------------------------------------------
ACUTE FEE-FOR-SERVICE           48746    11/29/2003   A0200000000001                  1033.21          .00         1033.21
TOTALS                                                                                 1033.21          .00         1033.21
-------------------------------------------------------------------------------------------------------------------------------
```

- **Financial Summary page provides summarized check and invoice information**
- **If provider had claims for Acute and Long Term Care recipients, LTC totals would be shown on a separate line below Acute totals**
- **Totals for KidsCare claims also would be shown on a separate line**
- **If all claims are in process or denied, Financial Summary page will indicate "No Active Invoices"**
- **Gross Amount and Net Amount (Check Amount) will be equal unless TYPE column shows "CR" indicating provider has a credit balance**

Exhibit 27-3

SAMPLE REMITTANCE ADVICE – PAID NON-FACILITY CLAIMS

```
REPORT ID:  FI04W400                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                          PAGE:  9
PROGRAM ID: FI04L400                             NON-FACILITY REMITTANCE ADVICE - ACUTE                            RUN:  11/29/2003
001549                                           PAID CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   H0LLIDAY, DOC                                  INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                                  CHECK NUMBER:    48746
                                                                                PAYMENT DATE:    12/02/2003

        TAX ID:      999999999
        FORM TYPE:   FORM 1500

AHCCCS ID      NAME                      CRN              SERVICE CD/     DATES OF    BILLED AMOUNT    ALLOWED
RECIPIENT      PATIENT ACCOUNT NUMBER    SCORE DATE        MODIFIER       SERVICE     BILLED UNITS       UNITS
-----------------------------------------------------------------------------------------------------------------------------
A12007007      BOND, JAMES               03310000100801   99223           10/09/2003        150.00       1.00    29.00   ALLOWED AMOUNT (*)
A12007007      007                       11/26/2003                                          1.00                 --------
                                                                                                                   29.00   NET PAID AMOUNT
PRICE EXPL:    SUB   *MCC
-----------------------------------------------------------------------------------------------------------------------------
A12007007      BOND, JAMES               03310000103701   99233           10/10/2003        400.00       5.00    72.00   ALLOWED AMOUNT (*)
A12007007      007                       11/26/2003                       10/14/2003          5.00                 --------
                                                                                                                   72.00   NET PAID AMOUNT
PRICE EXPL:    SUB   *MCC
-----------------------------------------------------------------------------------------------------------------------------
A61743893      HOLMES, SHERLOCK          03310000100801   99233           10/09/2003        300.00       3.00   222.00   ALLOWED AMOUNT (*)
A61743893      12714-350493              11/26/2003                       10/11/2003          3.00                 --------
                                                                                                                  222.00   NET PAID AMOUNT
 PRICE EXPL:   MAC   *AHA
-----------------------------------------------------------------------------------------------------------------------------
A21742813      KURIYAKIN, ILYA           03310000100801   90828           10/24/2003        800.00       5.00   680.00   ALLOWED AMOUNT (*)
A21742813      12224-489133              11/26/2003                       10/28/2003          5.00                 270.00-  OTHER INSURANCE
                                                                                                                 --------
                                                                                                                  410.00   NET PAID AMOUNT
 PRICE EXPL:   SUB   MAC    *AHA
-----------------------------------------------------------------------------------------------------------------------------
A21742813      PEELE, EMMA               03310000100801   99233           10/24/2003        290.00       3.00   146.00   ALLOWED AMOUNT (*)
A21742813      12714-350493              11/26/2003                       10/26/2003          3.00                 --------
                                                                                                                  146.00   NET PAID AMOUNT
 PRICE EXPL:   SUB   *MCC   *MCD
-----------------------------------------------------------------------------------------------------------------------------

NUMBER OF CLAIMS:            5
TOTAL BILLED AMOUNT:   1,940.00
TOTAL REMIT AMOUNT:      879.00
```

- **PRICE EXPL(anation) codes are listed on Processing Notes page**
- **Asterisk (*) before PRICE EXPL code shows how Allowed Amount was determined (e.g., MCC = Medicare Coinsurance, MCD = Medicare Deductible, AHA = AHCCCS Allowed)**
- **Allowed Amount is listed first, followed by any deductions (e.g., other insurance)**
- **Last page of Paid Claims section lists totals**

Exhibit 27-4

SAMPLE REMITTANCE ADVICE – DENIED NON-FACILITY CLAIMS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 11
PROGRAM ID: FI04L400                      NON-FACILITY REMITTANCE ADVICE - ACUTE                       RUN: 11/29/2003
                                                      DENIED CLAIMS

BILLING PROVIDER:   654321  01   H0LLIDAY, DOC
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC

        TAX ID:     999999999
        FORM TYPE:  FORM 1500

                                                                                SERVICE CD/    DATES OF
AHCCCS ID   RECIPIENT   NAME              PATIENT ACCOUNT NBR   CRN             MODIFIER       SERVICE    BILLED AMOUNT  BILLED UNITS
-------------------------------------------------------------------------------------------------------------------------------------
A15116678   A15116678   BONNEY, WILLIAM   BTK96007              03310000102301   90828          10/22/2003       160.00          1.00
 REASON CDS:   H077.2
-------------------------------------------------------------------------------------------------------------------------------------
A12003210   A12003210   CLANCY, KEP       96-007L               03310000100801   99245          10/17/2003        96.00          1.00
 REASON CDS:   H094.1    L017.1    L019.1
-------------------------------------------------------------------------------------------------------------------------------------
A21110770   A21110770   EARP, WYATT       XYX96089              0331000020170    99233          10/02/2003       255.00          3.00
 REASON CDS:   L017.1    10/04/98
-------------------------------------------------------------------------------------------------------------------------------------
A12345678   A12345678   JANE, CALAMITY    ABC96027              03310000100801   99223          10/12/2003       150.00          1.00
 REASON CDS:   L019.1
-------------------------------------------------------------------------------------------------------------------------------------
A12345678   A12345678   JANE, CALAMITY    ABC96027              03310000100802   99233          10/13/2003        85.00          1.00
 REASON CDS:   L019.1
-------------------------------------------------------------------------------------------------------------------------------------
A12007007   A12007007   BOND, JAMES       XYX96033              03310000100801   99233          10/15/2003        85.00          1.00
 REASON CDS:   H094.1
-------------------------------------------------------------------------------------------------------------------------------------
```

- **Explanations of denial REASON CDS are listed on Processing Notes page**
- **Multiple denial reasons can be reported**
- **Last page of Denied Claims section lists totals**

```
NUMBER OF CLAIMS:           6
TOTAL BILLED AMOUNT:    831.00
```

Exhibit 27-5

SAMPLE REMITTANCE ADVICE – ADJUSTED NON-FACILITY CLAIMS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 12
PROGRAM ID: FI04L400                      NON-FACILITY REMITTANCE ADVICE - ACUTE                        RUN: 11/29/2003
001549                                  ADJUSTED CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC                          INVOICE NUMBER:  A0200000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                          CHECK NUMBER:    48746
                                                                        PAYMENT DATE:    12/02/2003

       TAX ID:      999999999
       FORM TYPE:   FORM 1500

AHCCCS ID      NAME                    CRN             SERVICE CD/   DATES OF    BILLED AMOUNT    ALLOWED
RECIPIENT      PATIENT ACCOUNT NUMBER  SCORE DATE       MODIFIER     SERVICE     BILLED UNITS       UNITS
-----------------------------------------------------------------------------------------------------------------------------
A61743893      HOLMES, SHERLOCK        03310000100801   99233        10/09/2003        300.00        3.00     222.00  ALLOWED AMOUNT(*)
A61743893      12714-350493            11/26/2003                    10/11/2003          3.00                  148.00- PREVIOUSLY PAID
                                                                                                              --------
                                                                                                                74.00  NET PAID AMOUNT
 PRICE EXPL:   MAC   *AHA
-----------------------------------------------------------------------------------------------------------------------------
A21742813      KURIYAKIN, ILYA         03310000100801   90828        10/24/2003        800.00        5.00     680.00  ALLOWED AMOUNT(*)
A21742813      12224-489133            11/26/2003                    10/28/2003          5.00                  544.00- PREVIOUSLY PAID
                                                                                                              --------
                                                                                                               136.00  NET PAID AMOUNT
 PRICE EXPL:   SUB   MAC   *AHA
-----------------------------------------------------------------------------------------------------------------------------
A21742813      PEELE, EMMA             03310000100801   99233        10/24/2003        290.00        3.00     146.00  ALLOWED AMOUNT(*)
A21742813      12714-350493            11/26/2003                    10/26/2003          3.00                  190.00- PREVIOUSLY PAID
                                                                                                              --------
                                                                                                                44.00- NET PAID AMOUNT
 PRICE EXPL:   SUB   *MCC  *MCD
-----------------------------------------------------------------------------------------------------------------------------
```

- **New Allowed Amount is listed first**
- **Previously Paid Amount is "backed out" as negative**
- **Net Paid Amount shows the difference**
- **Net Paid Amount will be negative if the adjusted Allowed Amount is less than the original Allowed Amount**
- **Last page of Adjusted Claims section lists totals**

```
NUMBER OF CLAIMS:            3
TOTAL BILLED AMOUNT:   1,390.00
TOTAL REMIT AMOUNT:      166.00
```

Exhibit 27-6

SAMPLE REMITTANCE ADVICE – VOIDED NON-FACILITY CLAIMS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 13
PROGRAM ID: FI04L400                       NON-FACILITY REMITTANCE ADVICE - ACUTE                       RUN: 11/29/2003
001549                                   VOIDED CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC                          INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                          CHECK NUMBER:    48746
                                                                        PAYMENT DATE:    12/02/2003

       TAX ID:      999999999
       FORM TYPE:   FORM 1500

AHCCCS ID      NAME                    CRN             SERVICE CD/    DATES OF    BILLED AMOUNT    ALLOWED
RECIPIENT      PATIENT ACCOUNT NUMBER  SCORE DATE       MODIFIER      SERVICE     BILLED UNITS       UNITS
-------------------------------------------------------------------------------------------------------------------------------
A12007007      BOND, JAMES             03310000100801   99223         10/09/2003        150.00        1.00      29.00-  ALLOWED AMOUNT(*)
A12007007      007                     11/26/2003                                                     1.00    --------
                                                                                                              29.00-  NET PAID AMOUNT
PRICE EXPL:SUB   *MCC
-------------------------------------------------------------------------------------------------------------------------------
A12007007      BOND, JAMES             03310000103701   99233         10/10/2003        400.00        5.00      72.00-  ALLOWED AMOUNT(*)
A12007007      007                     11/26/2003                     10/14/2003          5.00              --------
                                                                                                              72.00-  NET PAID AMOUNT
PRICE EXPL:SUB   *MCC
-------------------------------------------------------------------------------------------------------------------------------
```

- New Allowed Amount is listed first as a negative
- Any previous deductions would be "backed out" as positive
- Net Paid Amount shows amount recouped
- Last page of Voided Claims section lists totals

```
NUMBER OF CLAIMS:            2
TOTAL BILLED AMOUNT:       550.00
TOTAL RECOUPED AMOUNT:     101.00
```

Exhibit 27-7

SAMPLE REMITTANCE ADVICE –NON-FACILITY CLAIMS IN PROCESS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 14
PROGRAM ID: FI04L400                      NON-FACILITY REMITTANCE ADVICE - ACUTE                        RUN: 11/29/2003
                                                   CLAIMS IN PROCESS

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC

        TAX ID:     999999999
        FORM TYPE:  FORM 1500
```

AHCCCS ID	RECIPIENT	NAME	PATIENT ACCOUNT NBR	CRN	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT	BILLED UNITS
A15116678	A15116678	BONNEY, WILLIAM	BTK96007	03310000102301	90828	10/22/2003	160.00	1.00
A12003210	A12003210	CLANCY, IKE	96-007L	03310000100801	99245	10/17/2003	96.00	1.00
A21110770	A21110770	EARP, WYATT	XYX96089	0331000020170	99233	10/02/2003	255.00	3.00
A12345678	A12345678	JANE, CALAMITY	ABC96027	03310000100801	99223	10/12/2003	150.00	1.00
A12345678	A12345678	JANE, CALAMITY	ABC96027	03310000100802	99233	10/13/2003	85.00	1.00
A12007007	A12007007	BOND, JAMES	XYX96033	03310000100801	99233	10/15/2003	85.00	1.00

- **There is no SCORE DATE field because claims have not reached adjudicated status of Paid, Denied, Adjusted, or Voided**
- **Section includes claims reported as in process in previous Remittances**
- **Last page of Claims In Process section lists totals**

```
NUMBER OF CLAIMS:          6
TOTAL BILLED AMOUNT:     831.00
```

Exhibit 27-8

SAMPLE REMITTANCE ADVICE – PROCESSING NOTES

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 15
PROGRAM ID: FI04L400                       REMITTANCE ADVICE - PROCESSING NOTES                        RUN: 11/29/2003

BILLING PROVIDER:   654321  01   H0LLIDAY, DOC

        TAX ID:     999999999
        FORM TYPE:  FORM 1500

NOTE      TYPE    DESCRIPTION
----      ----    ------------------------------------------------------------------------------------------------------------

                  ** PLEASE CALL PROVIDER SERVICES FOR FURTHER EXPLANATION OF ANY DESCRIPTION **

                  ** PROVIDER SERVICES MAY BE REACHED AT (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0231 (OUT-OF-STATE) **

AHA       P       AHCCCS ALLOWED AMOUNT

H077.2    R       SERVICE PROVIDER LOCATION CODE IS INVALID

H094.1    R       PRIMARY DIAGNOSIS CODE FIELD IS NOT ON FILE

H140.3    R       PRIMARY DIAGNOSIS CODE NOT COVERED FOR CONTRACT TYPE

L017.1    R       PLACE OF SERVICE CODE IS MISSING

L019.1    R       DIAGNOSIS REFERENCE CODE 1 IS MISSING

L067.1    R       RECIPIENT HAS PART B; MEDICARE DATA MUST BE INDICATED, IS MISSING

MAX       M       MAXIMUM ALLOWED CHARGE/CAPPED FEE

MCC       T       MEDICARE COINSURANCE

MCD       T       MEDICARE DEDUCTIBLE

PDM       M       PER DIEM

SUB       M       SUBMITTED AMOUNT FROM CLAIM


NOTE TYPES:   M = PRICING METHOD,   P = PRICING TYPE,   R = REASON CODE,   T = TIER,   X = MODIFIER
```

- **Remittance Advice Processing Notes is last section in package**
- **Alphabetical listing of processing note code descriptions (denial reasons, pricing methods, etc.)**
- **Each code listed only once even if applicable to multiple claims**

Exhibit 27-9

SAMPLE REMITTANCE ADVICE – PAID FACILITY INPATIENT CLAIMS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 3
PROGRAM ID: FI04L400                       FACILITY REMITTANCE ADVICE - ACUTE                          RUN: 11/29/2003
001549                                   PAID CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   ARIZONA HOSPITAL                          INVOICE NUMBER:  A0200000000001
SERVICE PROVIDER:   654321  01   ARIZONA HOSPITAL                          CHECK NUMBER:    48746
                                                                           PAYMENT DATE:    12/02/2003

      TPM ID:      999999999
      FORM TYPE:   INPATIENT

AHCCCS ID     NAME                          CRN            DATES OF      BILLED AMOUNT   ALLOWED
RECIPIENT     PATIENT ACCOUNT NUMBER        STATUS DATE    SERVICE        BILLED UNITS     UNITS
-----------------------------------------------------------------------------------------------------------------------
A12345678     OAKLEY, ANNIE                 033100001001   10/20/2003        760.00         1.00        760.00  ALLOWED AMOUNT  (*)
A12345678     O011617768-1                  11/26/2003     10/21/2003          1.00                   ---------
                                                                                                        760.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-----------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                033100002003   10/25/2003      1,520.00         2.00      1,520.00  ALLOWED AMOUNT  (*)
A87654321     J4176027943-1                 11/26/2003     10/27/2003          2.00                   ---------
                                                                                                      1,520.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-----------------------------------------------------------------------------------------------------------------------
A18273645     EARP, WYATT                   033100003003   10/19/2003        760.00         3.00      2,280.00  ALLOWED AMOUNT  (*)
A18273645     E0116543257-2                 11/26/2003     10/22/2003          3.00                   ---------
                                                                                                      2,280.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-----------------------------------------------------------------------------------------------------------------------
A11223344     YOUNGER, COLE                 033100004004   10/21/2003      2,280.00         1.00        760.00  ALLOWED AMOUNT  (*)
A11223344     Y0227188796-1                 11/26/2003     10/22/2003          3.00                   ---------
                                                                                                        760.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-----------------------------------------------------------------------------------------------------------------------
A43218765     CRAWFORD, KATY                033100005005   10/23/2003      6,080.00         8.00      6,080.00  ALLOWED AMOUNT  (*)
A43218765     C5522613008-1                 11/26/2003     10/31/2003          8.00                   ---------
                                                                                                      6,080.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-----------------------------------------------------------------------------------------------------------------------
A18273645     JAMES, JESSE                  033100006006   10/28/2003      1,520.00         2.00      1,520.00  ALLOWED AMOUNT  (*)
A18273645     J7158700699-1                 11/26/2003     10/30/2003          2.00                   ---------
                                                                                                      1,520.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-----------------------------------------------------------------------------------------------------------------------
                                                                                                                 ----------
```

- **PRICE EXPL(anation) codes are listed on Processing Notes page**
- **Asterisk (*) before PRICE EXPL code shows how Allowed Amount was determined (e.g., AHA = AHCCCS Allowed, PDM = Per Diem)**

Exhibit 27-10

SAMPLE REMITTANCE ADVICE – PAID FACILITY OUTPATIENT CLAIMS

```
REPORT ID:  FI04W400-1                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                          PAGE: 3
PROGRAM ID: FI04L400                          FACILITY REMITTANCE ADVICE - FEE FOR SERVICE                          RUN: 04/26/2005
                                                PAID CLAIMS - INVOICE DATE: 04/23/2005


BILLING PROVIDER:  991353   01   SAGE MEMORIAL HOSPITAL                                INVOICE NUMBER:  B9999402135301
SERVICE PROVIDER:  991353        SAGE MEMORIAL HOSPITAL                                CHECK NUMBER:    19584
                                                                                       PAYMENT DATE:    04/27/2005
          TAX ID:  999314364
      FORM TYPE:  OUTPATIENT
                                                                  DATES OF
AHCCCS ID       NAME                              CRN              SERVICE/            BILLED   BILLED    ALLOWED      ALLOWED      PRICE EXPL
RECIPIENT       PATIENT ACCOUNT NUMBER            STATUS DATE      SERVICE             AMOUNT    UNITS     UNITS       AMOUNT
  ----------------------------------------------------------------------------------------------------------------------------------------------
----
XXX980030   BEGAY, ALVIN H                     YY111600007900  04/14/2005
XXX980030   VV65753441                         04/21/2005      04/14/2005                                                   XXX XXX XXX XXX XXX
                                               YY111600007901  300 36415              13.00      1.0       1.0          7.53   XXX XXX XXX XXX XXX
                                               YY111600007902  305 85025              58.00      1.0       1.0         33.61   XXX XXX XXX XXX XXX
                                                 ----------------------------------------------------------------------------------------------
----
SUBTOTALS:     NUMBER OF LINES PER CLAIM:     2                                                                  +/-      0.41   DISCOUNT/PENALTY
OVERALL
               TOTAL BILLED AMOUNT:       71.00                                                                  --------------
               TOTAL REMIT AMOUNT:        40.73                                                                          40.73   NET PAID AMOUNT
--------------------------------------------------------------------------------------------------------------------------------------------------
----
GRAND TOTALS:  NUMBER OF CLAIMS:              1
               TOTAL BILLED AMOUNT:       71.00
               TOTAL REMIT AMOUNT:        40.73
```

- **PRICE EXPL(anation) codes are listed on Processing Notes page**

Exhibit 27-11

SAMPLE REMITTANCE ADVICE – DENIED FACILITY CLAIMS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 5
PROGRAM ID: FI04L400                       FACILITY REMITTANCE ADVICE - ACUTE                          RUN: 11/29/2003
001549                                                DENIED CLAIMS

BILLING PROVIDER:   654321  01   ARIZONA HOSPITAL
SERVICE PROVIDER:   654321  01   ARIZONA HOSPITAL

        TAX ID:      999999999
        FORM TYPE:   OUTPATIENT

AHCCCS ID  RECIPIENT  NAME                    PATIENT ACCOUNT NBR  CRN             DATES OF SERVICE     BILLED AMOUNT  BILLED UNITS
-------------------------------------------------------------------------------------------------------------------------------------
A17520033  A17520033  DOS PASSOS, JOHN        147A321              033100050001  10/24/2003  10/26/2003      1,520.00          2.00
 REASON CDS:   H154.3
-------------------------------------------------------------------------------------------------------------------------------------
A17650082  A17650082  HAWTHORNE, NATHANIEL    148C123              033100010113  10/29/2003  10/30/2003        760.00          1.00
 REASON CDS:   H140.3   H141.3   H142.3
-------------------------------------------------------------------------------------------------------------------------------------
A17050080  A17050080  HEMINGWAY, ERNEST       168B456              033100010212  10/01/2003  10/02/2003        760.00          1.00
 REASON CDS:   L027.1
-------------------------------------------------------------------------------------------------------------------------------------
A17030074  A17030074  IRVING, WASHINGTON      148D789              033100010212  10/23/2003  10/26/2003      2,280.00          3.00
 REASON CDS:   L027.1
-------------------------------------------------------------------------------------------------------------------------------------
525465421  525465421  STEIN, GERTRUDE         150L654              033100777763  10/04/2003  10/06/2003      1,520.00          2.00
 REASON CDS:   H082.3
-------------------------------------------------------------------------------------------------------------------------------------
```

- **Explanations of denial REASON CDS are listed on Processing Notes page**
- **Multiple denial reasons can be reported**
- **Last page of Denied Claims section lists totals for inpatient and outpatient claims**

```
NUMBER OF CLAIMS:            5
TOTAL BILLED AMOUNT:   6,840.00
```

Exhibit 27-12

SAMPLE REMITTANCE ADVICE – ADJUSTED FACILITY CLAIMS

```
REPORT ID:  FI04W400                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                          PAGE: 6
PROGRAM ID: FI04L400                             FACILITY REMITTANCE ADVICE - ACUTE                                 RUN: 11/29/2003
001549                                        ADJUSTED CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   ARIZONA HOSPITAL                                   INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   ARIZONA HOSPITAL                                   CHECK NUMBER:    48746
                                                                                    PAYMENT DATE:    12/02/2003

        TAX ID:      999999999
        FORM TYPE:   INPATIENT

AHCCCS ID     NAME                            CRN            DATES OF      BILLED AMOUNT   ALLOWED
RECIPIENT     PATIENT ACCOUNT NUMBER          STATUS DATE    SERVICE        BILLED UNITS     UNITS
-------------------------------------------------------------------------------------------------------------------------------
A12345678     OAKLEY, ANNIE                   033100001001   10/20/2003       2,280.00        3.00        2,280.00   ALLOWED AMOUNT (*)
A12345678     O011617768-1                    11/26/2003     10/23/2003           3.00                      760.00-  PREVIOUSLY PAID
                                                                                                         -----------
                                                                                                          1,520.00   NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                  033100001001   10/26/2003       2,280.00        2.00        1,520.00   ALLOWED AMOUNT (*)
A87654321     J4176027943-1                   11/26/2003     10/29/2003           3.00                    2,280.00-  PREVIOUSLY PAID
                                                                                                         -----------
                                                                                                            760.00-  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------------
```

- **New Allowed Amount is listed first**
- **Previously Paid Amount is "backed out" as negative**
- **Net Paid Amount shows the difference**
- **Net Paid Amount will be negative if the adjusted Allowed Amount is less than the original Allowed Amount**
- **Last page of Adjusted Claims section lists totals for**

```
NUMBER OF CLAIMS:            2
TOTAL BILLED AMOUNT:   4,560.00
TOTAL REMIT AMOUNT:      760.00
```

Exhibit 27-13

SAMPLE REMITTANCE ADVICE – VOIDED FACILITY CLAIMS

```
REPORT ID:  FI04W400                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                                PAGE: 7
PROGRAM ID: FI04L400                             FACILITY REMITTANCE ADVICE - ACUTE                                       RUN: 11/29/2003
001549                                        VOIDED CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   ARIZONA HOSPITAL                                   INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   ARIZONA HOSPITAL                                   CHECK NUMBER:    48746
                                                                                    PAYMENT DATE:    12/02/2003

        TAX ID:     999999999
        FORM TYPE:  INPATIENT

AHCCCS ID     NAME                            CRN           DATES OF      BILLED AMOUNT   ALLOWED
RECIPIENT     PATIENT ACCOUNT NUMBER          STATUS DATE   SERVICE        BILLED UNITS     UNITS
-------------------------------------------------------------------------------------------------------------------------------
A12345678     OAKLEY, ANNIE                   033100001001  10/20/2003        760.00        1.00          760.00-  ALLOWED AMOUNT (*)
A12345678     O011617768-1                    11/26/2003    10/21/2003          1.00                    ---------
                                                                                                          760.00- NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                  033100002003  10/25/2003      1,520.00        2.00        1,520.00-  ALLOWED AMOUNT (*)
A87654321     J4176027943-1                   11/26/2003    10/27/2003          2.00                    ---------
                                                                                                        1,520.00- NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------------
```

- **New Allowed Amount is listed first as a negative**
- **Any previous deductions would be "backed out" as positive**
- **Net Paid Amount shows amount recouped**
- **Last page of Voided Claims section lists totals for inpatient and outpatient claims**

```
NUMBER OF CLAIMS:              2
TOTAL BILLED AMOUNT:     2,280.00
TOTAL RECOUPED AMOUNT:   2,280.00
```

Exhibit 27-14

SAMPLE REMITTANCE ADVICE –FACILITY CLAIMS IN PROCESS

```
REPORT ID:  FI04W400                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                          PAGE: 5
PROGRAM ID: FI04L400                             FACILITY REMITTANCE ADVICE - ACUTE                                 RUN: 11/29/2003
001549                                                   CLAIMS IN PROCESS

BILLING PROVIDER:   654321  01   ARIZONA HOSPITAL
SERVICE PROVIDER:   654321  01   ARIZONA HOSPITAL

        TAX ID:     999999999
        FORM TYPE:  INPATIENT
```

AHCCCS ID	RECIPIENT	NAME	PATIENT ACCOUNT NBR	CRN	DATES OF SERVICE		BILLED AMOUNT	BILLED UNITS
A17520033	A17520033	COBB, TYRUS RAYMOND	147A321	033100050001	10/24/2003	10/26/2003	1,520.00	2.00
A17650082	A17650082	GEHRIG, LOUIS	148C123	033100010113	10/29/2003	10/30/2003	760.00	1.00
A17050080	A17050080	RUTH, GEORGE HERMAN	168B456	033100010212	10/01/2003	10/02/2003	760.00	1.00
A17030074	A17030074	WILSON, HACK	148D789	033100010219	10/23/2003	10/26/2003	2,280.00	3.00

- **There is no STATUS DATE field because claims have not reached adjudicated status of Paid, Denied, Adjusted, or Voided**
- **Section includes claims reported as in process on previous Remittances**
- **Last page of Claims In Process section lists totals for inpatient and outpatient claims**

```
NUMBER OF CLAIMS:            4
TOTAL BILLED AMOUNT:   5,320.00
```

CHAPTER 28 ~ CLAIM DISPUTES

Chapter 28 ~ Claim Disputes

REVISION DATES: 10/1/18; 7/24/2018; 12/30/2015; 04/26/2013; 05/31/2012

General Information

Providers should exhaust all authorized processing procedures before filing a claim dispute with the AHCCCS Office of Administrative Legal Services (OALS). It is recommended that providers follow these guidelines before filing a claim dispute.

If the provider has not received a Remittance Advice identifying the status of the claim, the provider should utilize AHCCCS Online at http://www.azahcccs.gov to view the claim's status to determine whether the claim has been received and processed.

Once at the website home page, click on the icon for Plans/Providers (blue tab at top of the screen). A link on the Provider Website (AHCCCS Online) allows providers to create an account so that they can check the status of their claims.

Providers should allow 14 days following claim submission before inquiring about a claim. However, providers should inquire well before 6 months from the date of service because of the initial claim submission time frame and the time frame for filing a claim dispute.

If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated until the claim is paid or denied. A delay in processing a claim by the AHCCCS Administration may be cause for OALS to entertain a claim dispute on a pended claim provided all claim dispute deadlines are met.

If the provider has exhausted all authorized processing procedures and still has a disputed claim, the provider has the right to file a claim dispute with OALS.

Time Limits for Filing a Dispute

A provider must institute any claim dispute challenging the claim denial or adjudication within 12 months from the ending date of service; the date of a member's eligibility posting; or, for a hospital inpatient claim, within 12 months from the date of discharge; or within 60 days after the date of the denial of a timely claim submission, whichever is later. The date of receipt by OALS is considered the date the claim dispute is filed.

If action is taken on a timely submitted, clean claim fewer than 60 days before the expiration of the 12 month deadline or after the 12 month deadline has passed, the provider will be allowed 60 days from the date of the adverse action to file a claim dispute. The date of the "adverse action" is the status date for the claim as printed on the Remittance Advice.

Example:

03/06/2013	Date of service
05/15/2013	Initial claim denied by AHCCCS
12/16/2013	Date of resubmission of denied claim
03/04/2014	Claim is denied by AHCCCS (adverse action date)
03/06/2014	12-month claim dispute deadline (clean claim)
05/05/2014	Special 60-day claim dispute deadline

Because the denial of the claim was less than 60 days from the 12-month deadline, the provider is given 60 days from the date of the adverse action (03/04/2014) to file a claim dispute.

Claim Dispute Process

A claim dispute must be submitted in writing. It should be mailed to:

AHCCCS Office of Administrative Legal Services
Mail Drop 6200
P.O. Box 25520
Phoenix, AZ 85002

The claim dispute also may be hand delivered to:

AHCCCS Office of Administrative Legal Services
701 E. Jefferson Street, 3rd Floor
Phoenix, AZ 85034

Providers also may submit a claim dispute via fax at (602) 253-9115.

The claim dispute must state in detail the factual and legal basis for the claim dispute and the relief requested (e.g., payment, specific claim denial, quick pay discount). Claim disputes lacking specificity will be denied. The provider should include any documents which support the facts of the case.

Upon receipt of a claim dispute, OALS sends a letter of acknowledgment to the provider. This letter should be retained for reference.

The provider will receive a written Notice of Decision from OALS which will approve, deny, or partially approve the disputed claim.

If a provider disagrees with the Notice of Decision, the provider may request a state fair hearing. Requests for a state fair hearing must be filed in writing no later than 30 days from receipt of the Notice of Decision.
The written request must be received by OALS no later than 30 days from the date of receipt of the written Notice of Decision. If the 30th day falls on a Saturday, Sunday, or legal holiday, the claim dispute must be received no later than the next working day.

Approving a Claim Dispute

If OALS determines that the original claim denial was in error, the claim is forwarded from OALS directly to the AHCCCS Claims Unit for reprocessing. Providers should ***not*** resubmit the claim to AHCCCS with a copy of the written Notice of Decision from OALS.

Approving a claim dispute does not:

- Guarantee payment, or
- Constitute a waiver of all claim filing requirements and conditions.

Claims that were a part of a claim dispute approval may still not be payable for other reasons.

Claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied or an edit may fail, even though the claim dispute has been approved for other reasons.

If the provider receives an additional denial, unrelated to the initial dispute that was previously approved through OALS, the provider should contact the AHCCCS Claims Customer Service Unit. The provider must reference the previous claim dispute number and indicate that the claim was forwarded by OALS.

Hearing Process

All AHCCCS hearings are conducted by the Arizona Office of Administrative Hearings, an independent state agency. An administrative law judge from the Office of Administrative Hearings will conduct the hearing, decide the facts, apply law, and make a recommendation to the AHCCCS Director.

If a hearing is scheduled, the AHCCCS Administration will notify the provider in writing of a hearing date, time, and location.

Requests and motions concerning the case must be submitted in writing to the assigned administrative law judge. All requests and motions also must be copied to any other party and the AHCCCS Administration.

Requests to reschedule a hearing must be submitted in writing to the Arizona Office of Administrative Hearings. All requests to conduct hearings telephonically must be submitted in writing to the Office of Administrative Hearings.

Subpoenas must be submitted to the Office of Administrative Hearings for the assigned administrative law judge's approval. Subpoena forms and instructions for completing the forms are available from the Office of Administrative Hearings.

The administrative law judge's recommendation will be forwarded to the AHCCCS director. The AHCCCS Administration will issue a director's decision. A petition for a re-hearing must be submitted within 30 days of the director's decision. The director will determine whether to amend the decision or order a re-hearing.

Office of Administrative Hearings
1740 W. Adams Street
Lower Level
Phoenix, AZ 85007
Telephone: (602) 542-9826
Fax: (602) 542-9827
Website: www.azoah.com

Disputes Not Related to Claims

Disputes unrelated to claims denial (e.g., enforcement of a policy, recoupment actions, or unfavorable decision by AHCCCS) must be filed in writing and received by no later than 60 days after the date of the adverse action.

Any documents that support the facts of the case should be included. The dispute should state in detail the factual and legal basis, and the relief requested. Failure to do so may constitute cause for denial of the dispute.

If a written Notice of Decision is issued, the provider may submit a written hearing request as described earlier. Some cases may be referred directly for a hearing.

Claim Dispute Submission Suggestions

In recent years, reimbursement for medical services has become increasingly more complex. The following are a few suggestions to help you through the claim dispute process.

- If a provider files a claim dispute concerning nonpayment, but payment is made before a written Notice of Decision is made, the provider should submit a letter to withdraw the dispute.

  Once the claim is paid, if the provider is dissatisfied with reimbursement, a claim dispute may then be filed within the required time frames.

- Claim disputes for members enrolled in a health plan on the date of service in dispute must be filed with the health plan.

- If a provider believes that the AHCCCS Claims Customer Service Unit provided erroneous information, the claim dispute must specify the following:

1. The date of the call made to AHCCCS,
2. The approximate time the call was made to AHCCCS, and
3. The name or operator number of the AHCCCS operator who provided the information.

Note: Failure to provide the date and time of the call and the name of the AHCCCS operator may result in denial of the claim dispute.

- All claim disputes must be filed with specificity.

  The request must state why the claim dispute is being filed and why the provider believes that the claim was not processed properly.
  Failure to do so may constitute cause for denial of the claim dispute.

Dispute Avoidance

Prior to filing an appeal it may be possible for AHCCCS to review the claim through the reconsideration process.
If the provider receives a Remittance Advice from AHCCCS and believes that a claim was denied inappropriately or paid incorrectly, the provider can contact the Claims Customer Service Unit. The provider must provide the Claims Customer Service representative with the following:

- Provider ID number and/or Provider NPI
- Member's AHCCCS ID number
- Date(s) of service in question
- Claim Reference Number (CRN)
- Denial reason

NOTE: This process does not take the place of the claim dispute procedure outlined in this chapter nor does it extend the claim dispute filing deadlines.

For additional information on avoiding the dispute process, please refer to Chapter 26, Correcting Claim Errors, of the Fee-For-Service Provider Billing Manual.
For complete information on the replacement and reconsideration process please refer to Chapter 4, General Billing Rules, of the Fee-For-Service Provider Billing Manual.

REVISION HISTORY

Date	Description of Changes	Page(s)
10/1/2018	"On-line" changed to "online" to correct the AHCCCS Online provider portal name.	1
7/24/2018	*The below updates do not represent a change in processes currently occurring. Clarifying language was added to the Claim Dispute Process chapter. Clarifying language was added to the Approving a Claim Dispute section. The Hearing Process section was updated Updated the address for the Office of Administrative Hearings The Claim Dispute Submission Suggestions section had clarifying language added (changed from 'date' to 'The date of the call made to AHCCCS')	 2-3 3-4 4

	The section on Claim Dispute Process for Claims with Behavioral Health Diagnosis was removed, as ADHS/DBHS is no longer a part of the process Dispute Avoidance section updated with clarifying language Formatting Changes “member” to “member” throughout.	4 5 All 5-6 All All
12/30/2015	New format chapter Updated address for BH disputes not involving IHS or 638 providers	All 3
04/26/2013	Update by OALS; language/grammar corrections	All