CHAPTER 1 ~ INTRODUCTION TO AHCCCS

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

USE OF THIS MANUAL

The AHCCCS *IHS/Tribal Provider Billing Manual is* for IHS and Tribally owned and/or operated 638 facilities and providers. It 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 also is available online at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.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 Indian Health Service (IHS) and tribal providers' billing staffs and contracted billers with information about AHCCCS, coverage of specific services, and requirements for the completion and submission 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 IHS and tribal 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 the 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 more specific 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.

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 (such as an AIHP member) or enrolled with a health plan or program contractor. The term "contractor" refers to both health plans and program contractors.

AHCCCS reimburses IHS and Tribally owned and/or operated 638 providers/facilities on a Fee-For-Service basis for services provided to American Indian members, who are eligible for AHCCCS or ALTCS, when the following criteria are met:

- The member must be Title XIX (Medicaid) eligible; and
- The member must be enrolled with the American Indian Health Program (AIHP) or one of the AHCCCS Complete Care (ACC) health plans or program contractors; and

- The services must be provided directly by the IHS or 638 tribally owned and/or operated provider/facility.

Note: If the member is a KidsCare (Title XXI) member, the claim must be sent to the member's enrolled health plan and not to the AHCCCS' Division of Fee-For-Service Management's (DFSM) Prior Authorization Department. This department will be referred to as DFSM throughout the remainder of the billing manual.

Note: If the member is enrolled with a health plan or program contractor (such as an ACC plan), then any services provided off-reservation must be billed to the member's health plan or program contractor and not to AHCCCS.

For information on whether or not a service qualifies for reimbursement at the All-Inclusive Rate (AIR) please refer to the individual chapter within this manual pertaining to the service in question.

AHCCCS FEE-FOR-SERVICE PROGRAMS AND 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:

1. Placing the member's health, including mental 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.

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 American Indian 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

The AHCCCS acute care program 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.

AHCCCS 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.

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

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

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.

No Prior Authorization is required for Title XIX members receiving services at an IHS or 638 facility. Title XXI (KidsCare) and Tribal ALTCS members may require PA for certain services.

For information on Prior Authorization please refer to Chapter 6, Prior Authorization, of the IHS/Tribal 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 in the Fee-For-Service Provider Billing Manual for a quick reference to important telephone numbers.

Revision History

Date	Description of changes	Page(s)
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	2-3 5 All

	Care (ACC) health plans" "MCOs" removed throughout.	 All
4/26/18	Prior Authorization section added, including a link to the PA webpage.	7
3/9/18	AHCCCS Fee-For-Service Populations section updated Emergency Services section added AHCCCS Covered Services section updated for Emergency Services, Acute Care Services, and ALTCS Services Contact Telephone Numbers section added Formatting	3 3-4 4-5 7 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; 12/29/17; 12/22/17

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 serving 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 per cent 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.

INTEGRATION

On October 1, 2018 AHCCCS integrated physical and behavioral health care for some members. This is referred to as AHCCCS Complete Care (ACC). These members will have all of their providers listed under one network, which will be managed and paid for by their single health care plan. The following members will see no change:

- ALTCS members (EPD and DES/DD);
- Foster care children receiving services through the Comprehensive Medical Dental Program (CMDP); and
- Adults with a Serious Mental Illness (SMI) designation.

For additional information on integration please visit the AHCCCS website.

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 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 application and sends 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/Alsakan 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.

4. 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.

5. 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

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

7. 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 service.

NOTE: Rate Codes can be referenced on the AHCCCS website

Revision History

Date	Description of changes	Page(s)
10/1/2018	Integration section added. 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.	3 5
12/29/2017	Hospital Presumptive Eligibility (HPE) Section Added	5-6
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; 3/15/2018; 2/9/2018; 1/24/2018; 12/29/2017; 11/1/2017

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 AHCCCS policies and procedures for provider participation.

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 it is not limited to:

- The 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 Fillers);
- Non=Emergency Transportation Providers;
- Organ Procurement Organization (OPOs);
- Outpatient Physical Therapy, Occupational Therapy, and Sspeech 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 or non-physicians 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 Medicaid State Agency, the fee for Arizona may be waived. The enrollment fee is effective as of 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 “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 offense forms, attestations, etc.);
- Submit documentation of their applicable licenses, certificates, and/or CMS certification;
- Submit documentation of their National Provider Identification (NPI) Number (if applicable); and
- Submit a Disclosure of Ownership if registering as a company or facility.

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

Phoenix area: (602) 417-7670 (Option 5)

In-state: 1-800-794-6862 (Option 5)

Out of state: 1-800-523-0231, Ext. 77670

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

This can also be reached by going to the AHCCCS website at www.azahcccs.gov. Once there click on the "Plans/Providers" tab and choose the "Provider Registration" option. Once on the "AHCCCS Provider Registration" page, in the left hand column under "New Proivders" 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

Mail Drop 8100
P.O. Box 25520
Phoenix, AZ 85002

Documentation Requirements for Electing 638 FQHC Status

Any Tribal 638 Clinic electing to become a Tribal 638 FQHC must submit written notification to the AHCCCS Administration's Provider Registration Section. The written notification must include:

- The name of the Tribal 638 Clinic electing to change its designation,
- The full address of the Tribal 638 Clinic,
- The date that the Tribal 638 Clinic is requesting the designation change to go into effect, and
- A signature from one of the authorized signers on record for the provider, within the provider's current provider profile.

Notification of election to become a 638 FQHC may be mailed or faxed. If mailing, mail to:

AHCCCS Provider Registration
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

If faxing, fax to:

Attention: AHCCCS Provider Registration
602-256-1474

There is no cost to the provider to elect to change from a Tribal 638 Clinic to a Tribal 638 FQHC.

If a provider has not been previously registered with AHCCCS, the provider will need to follow all existing new provider registration steps.

Documentation Requirements for American Indian Medical Homes (AIMH)

Any IHS or Tribal 638 facility wishing to do so may elect to become an American Indian Medical Home (AIMH). For providers electing this option, the provider must:

- Complete the AIMH Registration Form;
- Have a Primary Care Case Management (PCCM) accreditation from the National Committee for Quality Assurance (NCQA) or another appropriate accreditation body;
- Sign a National IHS Improving Patient Care (IPC) program annual attestation;
- Be willing to enter into an AIMH Intergovernmental Agreement (IGA); and
- Be able to provide members with 24 hour access to a care team.

Eligible IHS/638 Provider Types:

- 02 – Hospital
- 05 – Clinic (excluding dental providers)
- IC – Integrated Clinic
- C2 – Federally Qualified Health Center (FQHC)
- 29 – Community/Rural Health Center (RHC)

Required documentation that must be submitted to AHCCCS includes:

- The AIMH Registration Form;
- The AIMH Application Request Form (if faxing it is the fax cover sheet);
- The AIMH Intergovernmental Agreement (IGA);
- Supporting documents for service level and accreditation;
- The Electronic Data Interchange (EDI) checklist; and
- W9 Form.

The required documentation to elect to become an AIMH may be faxed, emailed, mailed or hand delivered to AHCCCS. The AIMH Registration Form can be found at: https://www.azahcccs.gov/AmericanIndians/Downloads/AIMHProviderPacketSubmissionDocuments/AIMHProviderRegistrationForm.pdf

If faxing, the AIMH Application Request Form must be included as the packet's cover sheet and can be found at: https://www.azahcccs.gov/AmericanIndians/Downloads/AIMHProviderPacketSubmissionDocuments/AIMHApplicationFaxRequestForm.pdf

Additional information about the AIMH may be found on the AHCCCS website at: https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/

The AIMH will be required to submit a renewal application and an AIMH IGA renewal amendment annually. In addition to the renewal application, if there is a change in tier level the AIMH shall submit the appropriate documentation and any additional supporting documents as requested by AHCCCS.

AHCCCS Provider Registration Application Approval

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

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

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

- Provider Agreement

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

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

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

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

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

AHCCCS Provider Types

All AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. The AHCCCS Provider Registration Unit will help providers identify 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 licensure 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 licensure 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 PROVIDER 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 the AHCCCS Administration and the provider.
  The agreement's form and content are consistent with Medicaid regulations, and no changes may be made to the language 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 stipulations in 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 the AHCCCS Administration 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.

  IHS providers do not require an Arizona license, as long as the provider has a valid license in another state.

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

- CMS Certification for Tribal Providers

- 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.

REGISTRATION OF IHS PROVIDERS

An IHS facility must be a federally qualified and certified in order to be registered as an AHCCCS provider. Services provided by the facility must be in accordance with the inter-governmental agreements that are in place between IHS, AHCCCS and/or CMS.

Individual IHS providers are registered under one of 14 provider types:

- MD - Physician

- DO - Physician Osteopath

- Podiatrist

- Dentist

- Psychologist

- Optometrist

- Physician Assistant
- Nurse Practitioner
- Certified Nurse-Midwife
- Speech Therapist
- Occupational Therapist
- Physical Therapist
- Certified Registered Nurse Anesthetist
- Respiratory therapist

Each IHS Area Office or IHS facility must maintain a roster of its AHCCCS-registered individual providers. As staff changes occur, including both staff additions and deletions, each IHS Area Office or IHS facility must notify AHCCCS of those changes. Each IHS Area Office or IHS facility is responsible for informing AHCCCS when one of its AHCCCS-registered providers terminates IHS employment.

Each physician and mid-level practitioner must complete a Provider Application packet and AHCCCS Provider Agreement. The “Pay To” address on the Provider Application must list the IHS facility with which the provider is employed, the facility address, and facility tax identification number.

A copy of the provider’s current license must be attached with the application. An Arizona license is not required if the provider has a current, valid license from another state.

REGISTRATION OF TRIBAL PROVIDERS

Because tribal providers are located on Indian reservations where the Arizona Department of Health Services (ADHS) does not have jurisdiction, these providers do not have ADHS facility licenses. In place of the ADHS facility licensure, CMS certification is required.

The tribal provider must complete the CMS certification form (available from Provider Registration) and submit the form to AHCCCS with the application. The authorized representative for the tribe must sign the certification and recertification forms indicating that the tribe certifies that the provider meets the same standards as all other AHCCCS providers and that the tribe assumes full liability for the certified provider. If someone other than the tribal chairman signs the form, CMS will need documentation to show that the person signing the form has the authority to sign for the tribe.

The Provider Registration staff will review the provider application and CMS certification submittal and forward it to CMS for its approval. CMS will notify Provider Registration that the tribe is certified to provide services. Provider Registration then will notify the tribe of CMS' certification or recertification.

On the initial certification, Provider Registration will notify the tribal provider of the AHCCCS provider ID number once the registration process is complete.

Tribal providers seeking recertification should request the forms from Provider Registration at least 90 days before the current certification expires.

BILLING PROVIDERS AND GROUP BILLING PROVIDERS

An AHCCCS-registered IHS facility or a tribal facility or organization wishing to act as the financial representative for a provider or group of providers, who have authorized this 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 AHCCCS Registration Number.

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 tribal administrator or the IHS facility administrator must sign the group biller application form.

The service (rendering) provider's AHCCCS provider ID number must appear on each claim, even though a group billing number may be used for payment.

The servicing (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.

IHS group billers must use the facility's "pay-to" address and tax ID number.

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.

  - 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 want 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 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 should 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 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 information on the verification letter is correct, the provider need not respond.

- 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.

- 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 Department 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, a provider must maintain and make available all records and information including, but not limited to, medical and financial records, relating to the AHCCCS program. 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.

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 provider status.

- Inactivity

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

- Termination for Cause

  The AHCCCS Administration has the right to 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 or ALTCS or the Medicaid program in other states may 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, is suspended, or lapses, the provider's participation may 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 postpayment)
- Filing a complaint with licensing/certifying boards or agencies or with 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

Claims submitted for reimbursement at the All Inclusive Rate must be submitted on the UB-04 Claim Form. Claims submitted for professional services, not to be reimbursed at the AIR, must be submitted on the CMS-1500 Claim Form. Dental claims, not to be reimbursed at the AIR, must be submitted on the ADA Dental Claim Form.

UB-04, FL01
The name and service location of the provider submitting the bill.

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.
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.)

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

	The Billing Providers & Group Billing Providers section was updated Correspondence, Pay-To, and Service Addresses section updated The Tax Identification Number section was updated. Changes to Information on File section as updated. Licensure/Certifications section as added Agencies/Companies section was added. An Incentives section was added. Physician/Mid-Level Practitioner Registration section was added. Locum Tenens section was added. Attendant Care section was added. The Terminations section was updated. Claim Types section was added. General Formatting & Updates	9 10 11 11-12 12 13 13 13-14 14 15 15 17 All
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; 1/16/2018; 09/14/2016; 09/17/2015; 01/22/2014

GENERAL INFORMATION

This chapter contains general information related to 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 IHS/Tribal 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 AHA 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.

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 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, 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 to 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

Claim submission time frames differ for IHS 638 facilities, dependent upon the member's enrollment.

In accordance with A.A.C. R9-22-703 (B)4 "Unless a shorter time is specified in contract, the AHCCCS Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later." A clean claim must be submitted within 12 months from the date of service or discharge date or eligibility posting.

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

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

For hospital inpatient claims, "date of service" means the date of discharge of the patient.

KidsCare Members

Title XXI (KidsCare) members follow the same timeframe guidelines as other Fee-For-Service members. 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.

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.

ALL INCLUSIVE RATE (AIR) LIMITS

Multiple AIRs may *not* be billed on the same claim, for either the same date or different dates of service. If multiple AIRs are billed on the same claim then the *entire* claim will be denied.

Up to 5 AIR claims may be billed per member, per day, so long as each individual AIR claim is for a visit that is **a separate and distinct service**.

- Note: If multiple prescriptions are filled the provider is not able to bill 1 AIR *per* prescription. The provider may only bill 1 AIR per member, per facility for pharmacy services, per day. That 1 AIR will cover *all* prescriptions for the member filled that day at the *same* facility.

  Example of AIRs that are separate and distinct services:
  - A member comes in for a 10:00AM appointment with their PCP, then immediately after the PCP appointment they have a dental appointment with a different attending provider. This would count as two (2) separate clinic visits and two (2) AIRs may be billed for this.
  - Immediately after the PCP and dental appointments that same member, on the same day, goes to the pharmacy and has three (3) prescriptions filled. One (1) AIR may be billed for *all three (3)* prescriptions.

- In this example three (3) AIRs would be billed for the member on that same date of service: one (1) AIR for the PCP appointment, one (1) AIR for the dental appointment, and one (1) AIR for all three (3) prescriptions.

PRIOR QUARTER COVERAGE ELIGIBLE

Effective 1/1/2014, AHCCCS is required to expand the time period 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, 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, or
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) for Title XXI (KidsCare) members. Effective 10/1/2015, the current PBM is OptumRx, and further information regarding the PBM can be found in Chapter 10, Pharmacy, of the IHS/Tribal 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.

When providers are billing for prenatal services for members eligible under HPE, for services performed during the HPE period, the provider should bill the AHCCCS Administration for prenatal visits utilizing the appropriate E&M code on a CMS 1500 claim form.

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 global delivery guidelines are not met the services should be billed utilizing the appropriate codes on CMS 1500 claim form. For further information refer to the section on Obstetrical Services in Chapter 10, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual. ,

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 12 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, 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/coinsurance amount when Medicare pays first.

For further information on QMB Only please refer to Chapter 7, Medicare/Other Insurance Liability, of the IHS/Tribal 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

For additional information on remittance advice, please refer to Chapter 18, Understanding the Remittance Advice, of the IHS/Tribal Provider Billing Manual.

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 17, Correcting Claim Errors, of the IHS/Tribal 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 0xx8

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

If the "Remarks" field 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 to the member. 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 all other third party coverage and bill all third party payers **prior** to billing AHCCCS.

  NOTE: For further information please refer to Chapter 7, Medicare/Other Insurance Liability, of the IHS/Tribal 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 and IHS referral 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 and attached records for adults to determine if the service provided was emergent.

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.

The time span allowed for submission 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 19, Claim Disputes, of the IHS/Tribal Provider Billing Manual.

Additional Billing Rules

Multiple Page Claims

Do not submit double-sided, multiple-page paper 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).

- To ensure that all pages of a multiple-page, UB-04 paper 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 "001" total should be entered on the last page only.**

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 IHS/Tribal 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.

Change 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.

Reimbursement of inpatient claims is based on the rate in effect on the admission date.

If a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rate, 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, 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.

<u>Example:</u>

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 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual.

Adult (age 21 and older) dental claims must have the dental notes attached for review.

Dental claims for members under age 21 through the EPSDT Program do not require records to be submitted with the claim. However, AHCCCS may request dental records for review of the services.

While it is not possible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation.

CMS 1500 Claims		
Billing For	**Documents Required**	**Comments**
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	
Hysterectomy	Completed consent form	
Sterilization	Completed consent form	
Medical procedures	Procedure report, & history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.
UB-04 Claims		

Billing for	Documents Required	Comments
Observation	Refer to IHS Chapter 9 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
Hysterectomy	Completed consent form	
Sterilization	Completed consent form	
Dental Claims		
Billing for	**Documents Required**	**Comments**
Adult dental services	Dental treatment notes	
EPSDT dental services	Not required	May be requested for dental review

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 (Exceptions as listed above)
- 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 IHS/Tribal 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 IHS/Tribal 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	All

	handwriting on claims.' Handwriting (legible) may be permitted.	
4/13/2018	Information on providers needing to be registered with AHCCCS in order to receive payment added.	17
2/9/2018	Social Determinants of Health section added Exhibit 4-1, Social Determinants of Health ICD-10 Code List added	17-18 Exhibit 4-1
1/16/2018	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 Claim Submission Time Frames section updated Claim Submission Time Frames for KidsCare members section updated All Inclusive Rate 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 2-3 3 3 4-6 5-6 7-10 10 14-16 All All
09/14/2016	Correction to ARS §36-2901 from (H) to correct section (G) Grammar correction, PBM section	2 4
09/17/2015	New format HPE section added Effective 10/1/2015 new Pharmacy Benefit Manager: OptumRx Grammar, language corrections Added language re: failing to resubmit/replace with prior CRN indicated Dental records language added Records chart updated	All 4 4 multiple multiple 12 13
1/22/14	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 ~ CLAIM FORM REQUIREMENTS

Chapter 5 ~ Claim Form Requirements

REVISION DATE: 11/23/2018; 11/1/2018; 10/1/2018; 1/16/2018; 06/03/2016; 03/31/2016; 10/15/2015 CORRECTIONS; 09/17/2015 EFFECTIVE 10/01/2015; 12/01/2014; 05/29/2014

General Information

Claims for services must be submitted to the AHCCCS Administration on the correct form for the type of service billed. This chapter outlines the requirements for completing the CMS 1500, UB-04 and American Dental Association (ADA) 2012 claim forms.

This chapter applies to ***paper*** CMS 1500, UB-04, and ADA claims submitted to AHCCCS.

- 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.

The **CMS 1500 claim form** is used to bill for:

- IHS/638 tribal claims for individual provider services,
- Emergency and non-emergency transportation services,
- FQHC services,
- Ambulatory surgical centers,
- Independent laboratories,
- Durable medical equipment, and
- KidsCare *outpatient* services.

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

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

The **UB-04 claim form** is used to bill for:

- IHS/638 Facility Inpatient and Outpatient Claims for Title XIX (Medicaid) for reimbursement at the AIR,
- *Inpatient* Title XXI (KidsCare) members,
- Nursing facility services,
- Free-standing birthing centers,
- Hospice services,
- Residential treatment center services, and
- Dialysis facility services.

Revenue codes appropriate for the services provided are used to bill facility line-item services.

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

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

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.

General Information on Claim Submissions

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 the following must occur:

- On the CMS 1500 claim form, 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.**

- On the UB-04 claim form **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.**
- **On the ADA 2012 claim form 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.**

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 replaces 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 (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.

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

NOTE: This section applies to ***paper*** CMS 1500 (02/12) claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide.

1. Program Block — Required

Check the second box labeled "Medicaid."

MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
☐ *(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. Check 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**

Enter the policy or group number of the other insured.

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**

Check "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 c. OTHER ACCIDENT?	
☐ YES ☒ NO	

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

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

15. Other Date **Not required**

16. Dates Patient Unable to Work in Current Occupation **Not required**

17. Qualifier / Name of Provider or Other Source **Required if applicable**
If applicable, enter the appropriate Qualifier:

DN Referring Provider
DK Ordering Provider*
DQ Supervising Provider

Then 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 providers 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 Referring Provider **Required**

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

19. Additional Claim Information **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 (principal diagnosis, secondary diagnosis, 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.

Field A is the Principal Diagnosis.

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

22. Medicaid Resubmission Code **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 resubmitted 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 6, Authorizations, of the IHS/Tribal 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**

Effective 07/01/2016 for IHS/tribally operated 638

Enter the NDC Qualifier N4 in the first 2 positions, followed by the 11-digit NCD *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:

- F2 International Unit
- GR gram
- ML milliliter
- UN 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: 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 From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 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 place of service listing.

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C EMG	D PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 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 DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place Of Service	C EMG	D PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) 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 (Field 24G) 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 provider and avoid delay or denial of payment.

24. A						B	C	D				
DATE(S) OF SERVICE						Place		PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				
From			To			of	EMG					
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)		DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan
CPT/HCPCS	MODIFIER				
		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.

24G. 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 (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family 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 # (SHADED AREA) – Use for Taxonomy Code Reporting **Required if applicable**

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 7, Medicare/Other Insurance Liability, of the IHS/Tribal 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 # (NON SHADED AREA) – RENDERING PROVIDER ID # **Required**

Rendering Provider's 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	F	G	H	I	J

DIAGNOSIS POINTER	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	ID QUAL	RENDERING PROVIDER ID #
					Taxonomy Code
				NPI	**0000000000**

25. Federal Tax ID Number **Required**

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

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

26. Patient 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 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

Completing the UB-04 Claim Form

The following instructions explain how to complete the ***paper*** UB-04 claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

1. Provider Data **Required**

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

Example 1 (Inpatient):

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

Example 2 (Outpatient):

2.	3a PATIENT CONTROL NO.	4. TYPE OF BILL
	3b MED REC #	131

Example 2 (Dental):

2.	3a PATIENT CONTROL NO.	4. TYPE OF BILL
	3b MED REC #	131

Note: Bill Type 131 is used for both outpatient and dental visits.

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 revenue code(s) that describe the service(s) provided. See *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.

Example 1 (Billing for Clinic Visit):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0510		
2			
3			
4			

Example 2 (Billing for Dental):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0512		
2			
3			
4			

Example 3 (Billing for Urgent Clinic):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0516		

2			
3			
4			

Example 4 (Billing for Pharmacy):

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES
1	0519		
2			
3			
4			

43. Revenue Code Description / NDC code* (effective 7/1/16) Required/NCD if applicable

***Effective 07/01/2016 -NDC information will be **required** for outpatient pharmacy claims.

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

* For outpatient pharmacy clinic claims report the NDC on the UB04 claim form, entering 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 or spaces.
- 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 4 (Correct Example):

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

Example 5 (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**

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes (See Chapter 15, Dialysis Services, fo the FFS Provider Billing Manual). Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

HCPCS/Rates are not required for NDC lines on outpatient pharmacy clinic claims.

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
1	0519	N400074115278 ML10		1.00
2				
3				

45. Service Date **Required**

The dates indicated 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 equal to each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

Note: if the Service Date is *outside* the date span in Field 6, Statement Covers Period, the claim will deny.

46. Service Units **Required**

If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) 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.

Enter the number of units for AIR

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES	**46. SERV. UNITS**

1	0519	N400074115278 ML10		**1**
2				
3				

Note: Only 1 AIR can be billed per UB-04. If more than 1 AIR per claim is billed then the entire claim will deny.

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.**

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 **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 your 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 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 **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 you have questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Eligibility).

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 **Required**

Enter "AIHP"

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 6, Authorizations, of the IHS/Tribal 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. 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 **Required**

Enter the p**rincipal** *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. 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/YYYY 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 IHS/Tribal Provider Billing Manual.

76. Attending Provider Name and Identifiers **Required if applicable**

Effective 01/01/2016 this will be ***required.***

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 **Not required**

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.	13-17
	The order of the examples in Field 16 was updated, so that midnight (12 a.m.) is now first.	21
	Clarification and examples added to Field 43 on the UB-04 form. 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.	23-15

	The ADA 2012 claim form instructions were removed (please refer to the FFS Provider Billing Manual, Chapter 7, Billing on the ADA 2012 Claim Form instructions for this).	35-48
11/1/2018	Examples added to the Type of Bill section. Examples added to the Rev Code section.	18 22-23
10/1/2018	The General Information section was updated regarding HIPAA-compliant 837D transaction process. The section on services the CMS-1500 claim form is used to bill for was updated. The section on services the UB-04 claim form is used to bill for was updated. Clarification added to the General Information section, including that this chapter applies to paper claims only, the preferred font type and size, and information on what can make a claim deny. Information for the CMS 1500, ADA 2012, and UB-04 regarding fields 24A-J (CMS 1500), 42-48 (UB-04), and 24-31 (ADA 2012) as follows: (the appropriate fields for each form) **"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."** Under the Completing the CMS 1500 Claim Form section: Reworded the information (no content change) for clarity: "Effective 4/1/2014, the revised CMS 1500 (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 1 2 3 3 3-17
10/1/2018	Examples updated throughout section. Clarification added to field 1a. Clarification added to field 3. Clarification added to field 4. Clarification added to field 5. Clarification added to field 6. Clarification added to field 7. Clarification added to field 9a. Clarification added to field 11d. Clarification added to field 12. Clarification added to field 13. Clarification added to field 17.	

10/1/2018	Field 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 21 so it now reads as: "**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. " Clarification added to field 22. It was updated to read as 7 or 8 rather than A or V. Clarification added to field 23. "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 6, Authorizations, of the IHS/Tribal Provider Billing Manual for information on prior authorization." A NOTE regarding field 24 (A-J) and multi-page claim submissions. It now reads: "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."** Clarification added to field 24. Clarification added to field 24A.	

10/1/2018	Clarification added to field 24B. Clarification added to field 24C. Clarification added to field 24D. Clarification added to field 24E. The following was added: "Do not separate letters with commas. Clarification added to field 24J. Clarification added to field 25. Clarification added to field 28. Clarification added to field 31. Clarification added to field 32b. Clarification added to field 33b. Under the Completing the UB-04 Claim Form section: Examples updated throughout section. Clarification added to field 1. Clarification added to field 2. Clarification added to field 3a. Clarification added to field 3b. Clarification added to field 4. Clarification added to field 5. Clarification added to field 6. Clarification added to field 7. Clarification added to field 8. Clarification added to field 9. Clarification added to field 10. Clarification added to field 11. Clarification added to field 12. Clarification added to field 13. Clarification added to field 14. The following was added: "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" Clarification added to field 15. Clarification added to field 16 (examples added). Clarification added to field 17. Clarification added to field 18-28. Clarification added to field 29. Clarification added to field 39-41. Clarification added to field 42. Clarification added to field 43. Clarification added to field 44.	17-30

10/1/2018	Clarification added to field 47. The following clarification was added: "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."** Clarification added to field 50 and 50 (A-C) Clarification added to field 51. Clarification added to field 52. Clarification added to field 53. Clarifications added to fields 55 – 59. Clarification added to field 60 A. Clarification added to field 61. Clarification added to field 63. Clarification added to field 64. Clarification added to field 66. The following was added: "**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." Clarification added to field 67. Clarifications added to fields 69 -72. Clarification added to field 74. The following information was added: "**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	

10/1/2018	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 IHS/Tribal Provider Billing Manual." Clarifications added to fields 76-81A. Under the Completing the ADA 2012 Claim Form section: Examples updated throughout section. Individual Section 'images' added. Clarifications added to fields 1-15. (Names of fields were updated to match the ADA 2012 Claim Form and descriptions of what each field is had additional information added to them). Clarifications added to fields 19-23. **The following was added: "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.**" Clarification added to field 25. The following was added: "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.	30-44

10/1/2018	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." Clarification added to field 27. The following was added: "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." Clarification added to field 28. Clarification added to field 30. Clarification added to field 32. Clarification added to field 34. The following was added: "**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."** Clarification added to field 35. The following was added: "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)	

10/1/2018	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.**	

10/1/2018	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: o 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	

10/1/2018	○ 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." Clarifications added to fields 36-40. Clarification added to field 42. The following was added: "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." Clarification added to field 43. The following was added: "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 a dentures)." Clarifications added to fields 44-45. Clarifications added to fields 48-52. Clarification added to field 53. Clarification added to field 55. Clarification added to field 56. Clarification added to field 56a. The following was added: "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."	

1/16/2018	Clarification that only 1 AIR can be billed per UB-04 Updated UB-04 fields Formatting	14 All All
06/03/2016	UB-04 corrections to Fields 44, 46 and 47 as related to NDC billing requirements; UB-04 Field 61 changed from “FFS” to “AIHP”	13, 14 15
03/31/2016	UB-04 corrections to Fields 64 & 80	16
10/15/2015	Corrections to: CMS 1500 fields 17, 19, 24 UB-04 field 43, added AHCCCS Pharmacy website address for NDC billing information UB-04 fields 60, 71, 78, 79, 81 ADA field 35	 5, 6 12 14, 15 19
09/17/2015	ICD-9 changed to “ICD” ADA Form CHANGE: based on ADA manual, ICD diagnosis codes and related fields are “Required if Applicable”	All 18, 19
12/01/2014	Correction: added “Inpatient” to read *“Inpatient* Title XXI (KidsCare) members”	1
05/29/2014	New formatting Updated ADA form to 2012 version	All

CHAPTER 6 ~ AUTHORIZATIONS

Chapter 6 ~ Authorizations

Revision Dates: 10/1/2018; 4/26/18; 2/15/18

General Information

AHCCCS members enrolled with the American Indian Health Program (AIHP) may receive services from Indian Health Services (IHS), tribally operated 638 facilities, or AHCCCS Fee-for-Service providers. Prior authorization requirements may vary based on the type of service being received and the location of the service.

No Prior Authorization is required for Title XIX members receiving services at an IHS or 638 facility.

Title XXI (KidsCare) members and Tribal ALTCS/ALTCS members may require prior authorization for certain services.

For prior authorization of services for Title XXI (KidsCare) members enrolled in an AHCCCS Complete Care (ACC) health plan please contact the ACC health plan.

For Title XXI (KidsCare) members enrolled in the AIHP and receiving services at an IHS or 638 facility:

- For pharmacy related services please contact the Pharmacy Benefit Manager (PBM) for prior authorization requirements, and
- For all other services, no PA is required.

Note: The current PBM is Optum Rx.

Many ALTCS services require prior authorization from the member's case manager. For additional information regarding what services require prior authorization please refer to Chapter 14, ALTCS Services, of the IHS/Tribal Provider Billing Manual.

For specific information pertaining to prior authorization of services for Title XIX members obtained at non-IHS/638 facilities please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual.

Prior Authorization Grid

Program/Location Services Received At	IHS/638 Provider	Non-IHS/638 Provider
Title XIX Members	No PA Required	PA may be required
Title XXI (KidsCare) Members enrolled in an AHCCCS Complete Care (ACC) health plan	Contact the ACC health plan for PA requirements	PA may be required from the ACC health plan
Title XXI (KidsCare) Members enrolled in AIHP	No PA Required for non-pharmacy services. Contact the PBM for PA requirements for pharmacy services.	PA may be required from the AHCCCS Administration
ALTCS Members	PA may be required from the Case Manager	PA may be required from the Case Manager
Tribal ALTCS Members	PA may be required from the Tribal Case Manager	PA may be required from the Tribal Case Manager

Referrals

Referrals are not required from IHS/638 facilities.

References

Refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process and services that require PA for Title XIX members, when seen at a non-IHS/638 facility, and for Title XXI members, 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 IHS/Tribal Provider Billing Manual, Chapter 10, Pharmacy Services, for additional information about prior authorization for pharmacy services.

Refer to Exhibit 10-1 in the IHS/Tribal Provider Billing Manual, under the Pharmacy Services chapter, for the prior authorization form for OptumRx.

Refer to the Fee-For-Service Provider Billing Manual, Chapter 8, Prior Authorizations, for additional information about what services require prior authorization for Title XIX members when seen at a non-IHS/638 provider.

Revision History

Date	Description of Change(s)	Page(s)
10/1/2018	"MCO" changed to "AHCCCS Complete Care health plan"	All
4/26/18	The link to the FFS Prior Authorization webpage was added.	2
2/15/18	General Information section added Prior Authorization Grid Added References section added Updated links Formatting	1 2 2 All All

CHAPTER 7 ~ MEDICARE OTHER INSURANCE LIABILITY

Chapter 7 ~ Medicare Other Insurance Liability

Revisions: 1/11/2019; 10/1/2018; 4/13/2018; 3/1/2018

General Information

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 twelve months of the date of service* for Title XIX member and *within six months of the date of service* for Title XXI (KidsCare) members, even if payment from Medicare or Other Insurance has not been received.

If a claim is originally received with the initial time frame (12 months for Title XIX members and 6 months for Title XXI members), 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. 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 IHS/Tribal 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	The activities involved in determining Medicaid benefits (COB) 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:

1. The claim is for prenatal care for pregnant women; or
2. Preventive pediatric services, including EPSDT services and administration of vaccines under the Vaccines For Children (VFC) Program; or
3. 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 (AHSSS 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. Medical services provided through schools under the federal 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.

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 causes,
- A tortfeasor,
- 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 total paid by the multiple coverage plans is more than the AHCCCS Capped Fee-For-Service schedule then there will be no AHCCCS payment and 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 plan'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.

A.A.C. R-22-1003 Cost Avoidance:

- 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 (QMB) 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 IHS/Tribal 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 IHS/Tribal 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 form*. 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 / 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 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 CODE	AMOUNT		40 VALUE CODE CODE	AMOUNT		41 VALUE CODE 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				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 CODE	AMOUNT		40 VALUE CODE CODE	AMOUNT		41 VALUE CODE 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) 54B. (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 dually 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 and "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 no payment 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 first- or third-party 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 also 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 procedure 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 History

Date	Description of changes	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). References for copay payment added. QMB Dual definition updated to include copays (see definition for details)	5 5 6 6

	Non-QMB Dual definition clarified (no changes, just re-ordered for clarity) References section added Professional Claims section removed	6-7 13-14
4/13/2018	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 updated. FQHC/HRC Claims with Medicare/Other Insurance section added. Retroactive Posting of Medicare Eligibility section updated. Formatting	1 2 2 2 3 3 5 8-10 10-12 12-13 13 13-14 All

CHAPTER 8 ~ INDIVIDUAL PRACTITIONER SERVICES

Chapter 8 ~ Individual Practitioner Services

Revision Dates: 4/12/2019; 11/1/2018; 10/1/2018; 4/5/2018; 2/16/2018; 2/9/2018; 1/5/2018; 12/29/2017; 10/01/2017; 10/05/2016; 07/26/2016; 12/21/2015; 04/21/2014; 10/10/2013

General Information

Within limitations, AHCCCS covers medically necessary medical, behavioral health, and surgical services performed by licensed physicians and other individual practitioners employed by Indian Health Service (IHS) and tribes (638 facilities). Please refer to Chapter 3, Provider Records and Registration, for additional information about IHS and Tribal 638 providers.

Cosmetic surgery, experimental procedures, and unproven procedures are not covered.

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.

The AHCCCS Medical Policy Manual (AMPM) is available on the AHCCCS website at:
www.azahcccs.gov

Claims for Title XIX Members

When a provider is employed by an IHS/638 facility, for Title XIX members they will not be the billing provider on the submitted claims. Instead, the IHS/638 facility will be the billing provider when billing the AIR for those services rendered by that employed provider. The IHS/638 facility will use the UB04 claim form when billing the AIR.

Dental claims for Title XIX members, when completed in a hospital or clinic, should be billed on a UB04 claim form.

> Note: All claims being billed for reimbursement at the OMB All Inclusive Rate (AIR) should be billed on a UB04 claim form.

Multiple AIRs may *not* be billed on the same claim, for either the same date or different dates of service. If multiple AIRs are billed on the same claim then the *entire* claim will be denied.

Up to 5 AIR claims may be billed per member, per day, so long as each individual AIR claim is for a visit that is **a separate and distinct service**.

- Note: If multiple prescriptions are filled the provider is not able to bill 1 AIR *per* prescription. The provider may only bill 1 AIR per member, per facility for pharmacy

services, per day. That 1 AIR will cover *all* prescriptions for the member filled that day at the *same* facility.

Example of AIRs that are separate and distinct services:

- A member comes in for a 10:00AM appointment with their PCP, then immediately after the PCP appointment they have a dental appointment with a different attending provider. This would count as two (2) separate clinic visits and two (2) AIRs may be billed for this.
- Immediately after the PCP and dental appointments that same member, on the same day, goes to the pharmacy and has three (3) prescriptions filled. One (1) AIR may be billed for *all three (3)* prescriptions.
- In this example three (3) AIRs would be billed for the member on that same date of service: one (1) AIR for the PCP appointment, one (1) AIR for the dental appointment, and one (1) AIR for all three (3) prescriptions.

Claims for Title XXI (KidsCare) Members

Claims for Title XXI (KidsCare) members must be submitted to the member's ***enrolled health plan***. If the KidsCare member is enrolled in an AHCCCS Complete Care (ACC) health plan, submit the claim to that plan. If the KidsCare member is enrolled as FFS or AIHP, then submit the claim to AHCCCS.

Medical services provided to Title XXI (KidsCare) members must be billed on the CMS 1500 (02/12) claim form using appropriate CPT and HCPCS codes and procedure modifiers, if applicable.

Dental claims for services provided to Title XXI (KidsCare) members must be billed on the ADA 2012 form using CDT-4 codes.

The All Inclusive Rate (AIR) may not be billed for Title XXI (KidsCare) members. Claims for Title XXI (KidsCare) members are reimbursed at the fee schedule.

Correct Coding Initiative

AHCCCS follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on claims for the same provider, same member, and same date of service.

Correct coding means billing for a group of 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, and claims that fail the CCI edits are denied. 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, 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 one of the following modifiers, if appropriate:

   24, 25, 50, 57, 58, 59, 78, E1-E4, F1-F9, FA, LC, LD, RC, T1-T9, TA, RT, or LT.

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.

American Indian Medical Home (AIMH)

The AIMH Program provides Primary Care Case Management (PCCM) services, diabetes education, and care coordination for its AIHP enrolled members. AIMHs help to address health disparities between American Indians and other populations in Arizona by enhancing case management and care coordination. They provide their members with 24 hour access to their care team.

AIMHs do not separately bill for case management/care coordination services. AIMHs are reimbursed at a Per Member Per Month (PMPM) rate based on their AIMH service level and the number of AIHP members enrolled in the AIMH. For information on how to elect to become an AIMH, please refer to the AIMH section in Chapter 3, Provider Records and Registration, of the IHS/Tribal Provider Billing Manual.

Individual practitioners may provide services at an American Indian Medical Home (AIMH). There are no changes in regards to how a provider bills when they render services at or out of an AIMH. Providers should continue to bill as they normally would.

Case Management Services

- An American Indian Medical Home (AIMH) will **not** be eligible for reimbursement of T1016. AIMHs receive a Per Member Per Month (PMPM) rate for case management services, and cannot bill for T1016.

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 on the next claim line following the 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 time units (calculated from minutes billed) and multiplies the total by the established FFS rate to obtain the allowed amount.

Billing for Labor and Delivery Anesthesia

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 billed in addition to 01967.

- 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.

Two separate claims must be filed for **medically directed** anesthesia procedures - 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 AHCCCS Administrative Rule 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 Tribal 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 IHS/Tribal Chapter 14 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 (refer to AMPM Exhibit 431-1);
- Emergency dental services; and
- All medically necessary therapeutic dental services.

Prior Authorization Requirements for Dental Services

PA is not required for emergency dental services or for preventative/therapeutic dental services for EPSDT and KidsCare members.

Dental surgery services for EPSDT and KidsCare members do not 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 services for Title XXI (KidsCare) members on the ADA 2012 claim form using CDT-4 codes.

EPSDT dental claims for Title XIX members under age 21, when completed in a hospital or clinic, should be billed on a UB04 claim form.

Only oral surgeons registered as Provider Type 07 (Dentists) may use CPT Evaluation and Management (E/M) codes on the CMS 1500 (02/12) claim form to bill 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 EPSDT 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 plan requirements.

Informed Consent

Please see 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 see 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 see 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.

E/M codes for hospital discharge day management are used to report all services provided to a patient 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 you submit 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 claim will be denied.

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 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.

A well child visit is synonymous with an EPSDT visit and includes all EPSDT screenings and service requirements:

- 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

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).

EPSDT visits are paid at a global rate for the services specified in AMPM Policy 430.
No additional reimbursement is allowed.

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**,** 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.

Do **not** bill the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.

Because the vaccine is made available free of charge, do not bill for the vaccine itself.

Beginning with dates of service 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 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 modifier SL*
- 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 the Vaccines for Children Operations Guide found on the Arizona Department of Health Services (ADHS) website at www.adhs.gov.

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 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 <u>all</u> 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, must 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 must 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 must be 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 must sign and date the consent form.
- A copy of the signed Federal Consent Form *must* 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 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 service date 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 service date 10/1/2016

In accordance with Arizona Administrative Rule A.A.C. R9-22-215, AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, when ordered by a member's primary care provider, attending physician or practitioner, within certain limits, for eligible members.

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),
- 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 may be 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 that the member has either:
  - 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). 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 (HCAC) and Provider Preventable Condition (PPC)

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.

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.

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 an 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 persons 21 years old and older, AHCCCS covers health risk assessment and screening tests pursuant to AHCCCS Rule 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.

From 10/1/2010 through 9/30/2013 for adult member 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.

Certain preventive services such as immunizations, PAP smears, colonoscopies, and mammograms are covered for persons age 21 and older

Effective with date of service 10/1/2013 adult well visits and well exam coverage was re-instated.

Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) and KidsCare Program.

Preventive health risk assessment and screening tests services for non-hospitalized adults 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)
- HIV-screening
- Immunizations
- 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 <u>not covered</u> 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

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 in accordance with federal regulations 42 CFR 441.250 et seq.

Federal regulations 42 CFR 441.251 defines a *hysterectomy* as "a medical procedure or operation for the purpose of removing the uterus." *Sterilization* is defined by this regulation as "any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing."

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 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

All claims for hysterectomy services are subject to medical review.

A hysterectomy consent form (See Exhibit 8-1) or a hospital consent form that contains the same information as the hysterectomy consent form must be submitted with the claim. The form must state that the patient will be permanently incapable of having children.

The form must be signed and dated by the member, the physician who performs the hysterectomy, the person who obtains the member's consent and, if applicable, an interpreter.

For further detailed information regarding Prior Acknowledgement and Documentation, refer to AMPM Chapter 310-L and Chapter 820-L for authorization details.

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 a hospital, free-standing birthing center, or other licensed health care institution.

Licensed midwives must obtain prior authorization from the AHCCCS UM/CM Department. Documentation certifying risk status of the member's pregnancy must be submitted for PA 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. (Refer to the AHCCCS standardized assessment form and evaluation criteria found in AMPM Chapter 410, Exhibit 410-3.)

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 on the CMS 1500 (02/12) claim form.
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.

Prenatal and postpartum care is bundled into one service, and all services related to the care of the pregnant woman are included in this reimbursement rate.

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 should be billed on a separate line.

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 rate includes ***all*** OB visits prior to the delivery, the delivery, postpartum visits, all services associated with admission to and discharge from a hospital and corresponding 0510 clinic visits for OB care.

Evaluation and management (E/M) codes for office and/or hospital/clinic 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 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, delivery 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/Gyn when referred by the treating physician or practitioner;
- Consultation by an OB/Gyn 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.

Billing for other than total care:

- 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 only, 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 gestation.

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, 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 codes
Orthotics
Prosthetics
Temporary Q codes
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 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 providers may bill using the professional (26) and/or technical component (TC) modifiers.

- The laboratory portion of the claim must be billed with modifier TC.
- The professional component of the laboratory service must be billed with modifier 26.
- 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 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 responsible for compensating employees supervising the lab.

Refer to Chapter 9 Hospital and Clinic Services, Outpatient Facility Services for further information about the technical component (TC).

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.

In the event of a medical emergency, all documentation of medical necessity must be documented in the member's medical records and available upon request for audit. As a reference tool see the Certificate of Medical Necessity for Pregnancy Termination in the AHCCCS Medical Policy Manual (AMPM), Exhibit 410-4.

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 and 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.

Registered Dieticians

Registered Dietician services are covered for provider services billable under codes B4034-B9999, G0108 and G0109 (Medicare primary only), G0270, S9470 and 97802-97804.

Coverage is limited to:

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 Early and Periodic Screening, Diagnosis and Treatment 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.

Occupational, Physical and Speech Therapies

AHCCCS covers physical, occupational, speech and respiratory therapy services that are ordered by a physician, approved by, 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.

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:

1. Inpatient OT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility).
2. Outpatient

a. Outpatient OT services are covered for EPSDT and KidsCare members when medically necessary.
b. Outpatient OT services are covered for adult 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.

<u>Service limits will be applied to outpatient occupational therapy CPT codes 97001 – 97546 for AHCCCS enrolled members as follows</u>:

- 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 a 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 Physical Therapy Board of Examiners 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 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 Tribal ALTCS members in accordance with AMPM Policy 301-X as authorized by the Tribal 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 14.

Service limits prior to service date 1/1/2014

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:

1. AHCCCS members who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the member changes health plans. (Contract year is defined as October 1-September 30.)

2. For AHCCCS members, who are also Medicare members, refer to AMPM Chapter 300, Exhibit 300-3A and the ACOM Manual Policies 201 and 202 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.

Physical therapy prescribed only as a maintenance regimen is excluded.

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 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 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).

Authorized 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 a 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 or 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
Cognitive training	Non-oral language training
Esophageal speech training	Oral-motor development
Fluency training	Swallowing 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, and Teaching Physicians

A hospital may not submit a claim for professional services rendered unsupervised by a resident or student 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. Documentation must include whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care.

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 without 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 in writing 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 the lesser of 100% of the capped fee or billed charges.
- Each secondary surgical procedure is reimbursed at 50% 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.

All other surgical procedures are identified as secondary and priced at 50% 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, secondary procedures should be billed with the appropriate surgical assist modifier (80 or AS) and modifier 51.

When assistant surges are billing for Cesarean deliver assist, they must bill the code for deliver 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:

1. *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.

     Diagnostics, consultation, and treatment services are delivered through interactive audio, video, and/or data communication.
2. *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
Dermatology
Endocrinology
Hematology/Oncology
Home Health
Infectious Diseases
Neurology
Obstetrics/Gynecology
Oncology/Radiation
Ophthalmology
Orthopedics
Pain Clinic
Pathology
Pediatrics and Pediatric Subspecialties
Radiology
Rheumatology
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 services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) members, real time only. Covered behavioral health services include:

- 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.

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; and a trained telepresenter 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 include documentation that describes the service rendered.

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 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) * All page numbers correspond to the individual chapter and not to the Master PDF file.	Page(s)

4/12/2019	Naturopathic Physician section added.	24
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."	37
10/1/2018	"Managed Care" changed to "AHCCCS Complete Care (ACC)"	2
4/5/2018	Peripheral Nerve Blocks for Postoperative Pain Management on the Date of Surgery subsection added	7-8
2/16/2018	Section added on inability of AIMHs to bill for Case Management (T1016)	5
2/9/2018	Social Determinants of Health American Indian Medical Home (AIMH) section added	4 4-5
1/05/2018	Claims for Title XIX Members Claims for Title XXI (KidsCare) Members Vision Updates	1-2 2 43
12/29/2017	Family Planning 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 25 25 2; 36-38
10/0/2017	Dental Podiatry Occupational Therapy Formatting changes	7-9 14-16 27-29 All
10/05/2016	Update section Pregnancy Terminations to conform to AMPM; Anesthesia modifier AD updated Correction to PA Requirements for Dental Services Reference for ALTCS Dental restoration Update section Foot and Ankle Correction to section Physical Therapy service limits to conform to AMPM Update section Telemedicine Conditions and Limitations	5 7 9 9 16 34 43

07/26/2016	Correction - where to submit KidsCare claims	1
12/21/2015	Clarification language added to Obstetrical Services second paragraph, added language "… and corresponding 0510 clinic visits for OB care." 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	26 43
12/21/2015	New formatting Added Revision History to chapter	All
04/21/2014	Update EPSDT Oral Health Care to conform to AMPM Policy 431 effective 4/1/2014	10
10/10/2013	Language, formatting and grammar clean-up; AMPM policies cited where applicable Updated Prior Auth Unit name to UM/CM Effective 10/1/2013 adult well visits and well exam coverage re-instated OB clarification language added Radiology and Imaging clarification language added Added definitions to Rehabilitation Therapies to conform to AMPM policies	All All 20 23 30 31-35

CHAPTER 9 ~ HOSPITAL AND CLINIC SERVICES

Chapter 9 ~ Hospital and Clinic Services

REVISION DATES: 2/28/2019; 1/23/2018; 04/01/2017; 07/26/2016; 06/30/2016; 05/23/2016; 12/21/2015; 08/14/2014

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. Specific The *AHCCCS Medical Policy Manual (AMPM)* is available on the AHCCCS website at:

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

Inpatient Hospital Services

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 at Indian Health Service (IHS) and 638 tribal hospitals 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).

Personal comfort items are not covered.

Professional 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 an Inpatient Claim

Inpatient hospital claims from IHS and 638 tribal facilities must be submitted to the AHCCCS Administration on UB-04 claim forms (See Chapter 5, Claim Form Requirements for UB-04 billing instructions).

Inpatient services for Title XIX (Medicaid) and Title XXI (KidsCare) members are billed with two revenue codes:

100 – All-inclusive Room and Board

001 – Total Charges

IHS/638 facilities approved for an NICU rate with AHCCCS must use NICU revenue codes to bill for NICU services.

All UB04 data fields must be completed as appropriate.

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04 billing. The attending provider must be an active AHCCCS registered provider.

Reimbursement of Inpatient Hospital 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. 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: 111 Patient status: 20

AHCCCS will reimburse six days because the patient status indicates expired.

Example 3:

Dates of service: 03/25 through 03/31 Accommodation days billed: 6

Bill type: 112 Patient status: 30

AHCCCS will reimburse six days. AHCCCS will pay the last accommodation day billed when the patient status is 30 (still a patient – first interim billing).

Example 4:

Dates of service: 03/05 through 03/10 Accommodation days billed: 2

Bill type: 111 Patient status: 01

AHCCCS will reimburse two days. 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.

When a patient is admitted and discharged on the same day, AHCCCS will reimburse the claim as follows:

1. Same day admit/transfer:
   If the transferring hospital is an IHS/638 facility the reimbursement will be at the outpatient All Inclusive Rate (AIR).

   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.

2. Same day admit/discharge:
   The IHS/638 facility will be reimbursed at the outpatient All Inclusive Rate (AIR)
   If the hospital bills as an inpatient admission and the AHCCCS system would qualify the claim as Maternity or Nursery tier, reimbursement will be at the inpatient All Inclusive Rate (AIR).

3. Same day admit/patient expires:
   The IHS/638 facility will be reimbursed at the inpatient All Inclusive Rate (AIR).

AHCCCS reimburses inpatient claims from IHS and 638 tribal facilities as follows:

Federally published All Inclusive Rate as established by the federal Office of Management and Budget (OMB)

When Medicare is the primary payer and has made payment on the claim AHCCCS will reimburse the Medicare coinsurance and/or deductible when appropriate. Please refer to Chapter 7, Medicare/Other Insurance Liability, of the IHS/Tribal Provider Billing Manual for further information.

Outpatient Facility Services

AHCCCS covers preventive, diagnostic, rehabilitative, and palliative services or items ordinarily provided 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 services for the emergency room, observation, or other outpatient charges must be billed on the inpatient claim.

Billing and Reimbursement of Outpatient Services for Title XIX (Medicaid)

IHS/638 tribal **hospital outpatient surgery claims** for **Title XIX (Medicaid)** members are billed on the 1500 claim form (837P for electronic claims).

Use the appropriate surgical CPT code(s).

- The AHCCCS Claims System will price the procedure at the appropriate AHCCCS ASC Fee Schedule amount accordingly.
- The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (See Chapter 8, Individual Practitioner Services). These claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Outpatient Pharmacy

IHS/638 facility Pharmacy outpatient services for **Title XIX (Medicaid)** members are billed on a UB-04 claim form (837I for electronic claims) using the appropriate pharmacy clinic revenue code 0519.

Effective with date of service 01/01/2016 the facility's NPI must be billed as the attending provider on the UB-04, as AHCCCS does not register pharmacists.

Effective with date of service 07/01/2016 all pharmacy claims billed on a UB-04 with revenue code 0519 must be billed with the National Drug Code (NDC) for each medication and vaccine. For detailed billing information refer to Chapter 5 Claim Form Requirements and the NDC resource documents available on the AHCCCS website at:
https://www.azahcccs.gov/AmericanIndians/Providers

The outpatient IHS/638 all-inclusive rate is billable for a pharmacy clinic consult visit when the pharmacist, or an intern under the supervision of a pharmacist, counsels the patient at the point of picking up the medication(s).

Each clinic pharmacy consultation visit billed to AHCCCS must be supported by pharmacy records including, but not limited to, the patient's dated signature and their prescription profile to support the date of consultation at the pharmacy.

The Initial Pharmacy Consultation service includes the cost of medication. Reimbursement for pharmacy consultation services is only available on a day when medication is dispensed. Refills at the facility for prescribed medications after the initial Pharmacy Consultation are reimbursable as a pharmacy encounter under this same methodology when the pharmacist, or an intern under the supervision of a pharmacist, counsels the member at the point of medication pick up at the pharmacy.

For members eligible for Medicare Part D coverage, the pharmacy service cannot be billed to AHCCCS for any medications covered by the Part D plan, including Part D copays. (refer to Chapter 7 Medicare for further details and the AHCCCS Pharmacy web page https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCSDualFormulary.pdf for the AHCCCS Drug List [ADL] for Duals)

Adult (age 21 and older) seasonal flu and pneumococcal vaccines administered by the facility's pharmacist are also considered a pharmacy outpatient service when administered by a pharmacist who is licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this policy and state law ARS §32-1974.

AHCCCS allows one outpatient pharmacy clinic encounter per member, per date of service regardless of the number of pharmacy services during the encounter. (Note: the number of clinic visits per member, per date of service is limited to 5, one of which can be the outpatient pharmacy clinic visit.)

Date of service for a pharmacy outpatient clinic visit is defined as:

- the date of the face-to-face encounter for the medication counseling as supported by the member's dated signature;
- the date the pharmacist administered the adult vaccine(s);
- the date of the face-to-face encounter for anti-coagulant therapy management

The date of service must be supported in the pharmacy records by the member's dated signature at the time of the consultation in the pharmacy.

The AHCCCS Claims System will reimburse the service at the outpatient all inclusive rate (AIR) as established annually by the federal Office of Management and Budget (OMB). A pharmacy outpatient clinic visit is eligible for reimbursement at the AIR so long as an AHCCCS covered service has been provided during the visit and all other criteria is met.

Effective with date of service 04/01/2017 the All Inclusive Rate (AIR) shall be reimbursed for federally reimbursable drugs rather than pharmacy clinic consult services.

IHS/638 facility Pharmacy outpatient services for Title XIX (Medicaid) members are required to be billed using revenue code 0519, the National Drug Code (NDC) of the medication and the facility's NPI billed as the attending provider on the UB-04 claim form (837I for electronic claims)

1. The Indian Health Services and 638 Tribal facility pharmacies shall bill AHCCCS the AIR using the date of service, also known as the fill date. AHCCCS allows one outpatient pharmacy clinic encounter per member, per date of service regardless of the number of pharmacy services during the encounter. (Note: the number of clinic visits per member, per date of service is limited to 5, one of which can be the outpatient pharmacy clinic visit.)

2. The AIR shall be reimbursed for claims submitted with a valid/covered NDC code on Line 1, when a claim is submitted for multiple drugs on the same date of service/fill date. Note: Anticoagulants do not have an NDC, therefore must be submitted with a valid corresponding diagnosis code for that NDC.

3. The AIR shall be reimbursed for only one pharmacy visit per date of service, when claims are submitted on separate claims forms for drugs billed on the same date of service/fill date.

4. Three-month supplies of medication dispensed to the member shall be billed and reimbursed as one AIR for the first federally reimbursable drug whether submitted as individual claims or three separate claims on the same date of service/ fill date.

5. The pharmacy must provide verification, upon request, that the member received the prescribed drug within 10 days of the date of service/fill date, as evidenced by, at a minimum, acknowledging receipt of the prescribed drug when the drug is dispensed to the member or the member's representative at the pharmacy or other methodology if the drug(s) are mailed to the member.

6. If prescribed drugs are "returned to stock" and the facility has been reimbursed the AIR, the facility shall submit a void to AHCCCS for the AIR when the member did not receive the service.

7. When a non-IHS/638 pharmacy is used to provide mail order or centralized pharmacy services, the Mail Order or Centralized Pharmacy must be an AHCCCS registered provider and must comply with all regulations as stated in the Provider Participation Agreement (PPA).

8. Seasonal flu and pneumococcal vaccines for ages 18 and older, administered by the facility's pharmacist are also considered a pharmacy outpatient service when administered by a pharmacist who has obtained the Immunizer Certificate from the American Pharmacists Association or the Arizona State Board of Pharmacy.

9. Refer to AMPM Policy 310-V Prescription Medication/Pharmacy Services for program guidelines, limitations and exclusions.

10. The AIR shall not be reimbursed when:
    a. More than one federally reimbursable drug claim per day is submitted.
    b. The pharmacy is out-of-stock of a medication. The AIR shall only be billed and reimbursed when the member is dispensed the initial available quantity. The pharmacy shall not bill a second AIR when the remaining quantity of the prescription is dispensed.
    c. The member receives a maintenance medication for an ongoing or chronic condition and the quantity dispensed is less than a 30-day supply unless:
        i. The medication is new to the members drug regimen; or

ii. The previous drug dosage has changed in the frequency ordered or the dosage strength of the medication; or
iii. The member's medication is lost or stolen as documented in the member's pharmacy profile.

d. The prescribing clinician has ordered a 30-day supply of medication to be dispensed in smaller quantities. Only one AIR rate may be billed to AHCCCS.
e. Controlled substance prescriptions dispensed to a member are written by a prescribing clinician with an invalid DEA number.
f. Prescription drugs dispensed to a member were written by a prescribing clinician whose license has expired or is prescribing outside the restricted limitations of their license.

Prescription Drug Coverage Limitations

IHS and Tribal 638 pharmacists and pharmacies are not required to be licensed in the State of Arizona. However, all pharmacists and pharmacies providing prescription medications, to AHCCCS members and Non-Title XIX SMI members, must adhere to all Arizona State Board of Pharmacy and Federal rules and regulations.

AHCCCS covers the following for AHCCCS members and non-Title XIX SMI members who are eligible to receive Medicare:

1. An Over-the-Counter (OTC) medication that is not covered as part of the Medicare Part D prescription drug program and is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and more cost effective than the covered prescription medication.
2. A drug that is excluded from coverage under Medicare Part D by CMS and the drug is medically necessary and federally reimbursable.

   Refer to the AHCCCS Pharmacy webpage for the AHCCCS Duals Formulary at https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCSDualFormulary.pdf

AHCCCS Pharmacy Benefit Exclusions

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless prescribed to treat a condition other than a sexual or erectile dysfunction and the Food and Drug Administration (FDA) has approved the medication for the specific condition.
2. Medications that are personally dispensed by a physician, dentist or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the FDA.
4. Outpatient medications for individuals under the Federal Emergency Services Program (FESP).
5. Medical marijuana. Refer to AMPM Policy 3120-M Medical Marijuana.

6. Drugs eligible for coverage under Medicare Part D for AHCCCS members eligible for Medicare whether or not the member obtains Medicare Part D coverage.
7. Pharmacies are prohibited from auto-filling prescription medications.
8. Repackaged medications are not federally reimbursable.

Other Outpatient Hospital and Clinic Services

All **other hospital** and **clinic outpatient services** for **Title XIX (Medicaid)** members are billed on a UB-04 claim form (837I for electronic claims) using the appropriate clinic revenue code (0510 for medical; 0512 for dental; 0516 for ER).

Effective with date of service 01/01/2016 the attending provider's NPI must be billed on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.

An outpatient clinic service (revenue code 0510, 0512, 0516) is eligible for reimbursement at the All Inclusive Rate (AIR) so long as an AHCCCS covered service has been provided during the visit and all other criteria are met.

Effective with date of service 01/01/2016, the IHS/Tribal facility has the option to breakout Emergency Department services by billing with revenue code 0516 and must include the ED attending provider's NPI. Billing the ED services with revenue code 0516 (rather than using the clinic code 0510) will allow for more accurate data reporting to help inform care coordination efforts for the members. There will be no edits placed to deny for incorrect place of service for revenue code 0516.

Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).

Enter the outpatient all inclusive rate (AIR) rate in the Total Charges field.

The AHCCCS Claims System will reimburse the service at the outpatient all inclusive rate (AIR) as established annually by the federal Office of Management and Budget (OMB).

The federal OMB **all inclusive rate (AIR)** encompasses all services performed and/or ordered during the clinic visit including labs, x-ray and imaging. The technical component (-TC) cannot be billed separately. (A "Stand Alone Visit" is a visit (encounter) that occurs in conjunction with a clinic visit, either before or after that clinic visit, but on a separate day. As a matter of policy AHCCCS does not reimburse Stand Alone Visits for lab services.)

A clinic visit is inclusive of all services provided in conjunction with the visit and includes any laboratory service that may be performed on the same day, before, or after the clinic visit. The AIR that is paid for the clinic visit (encounter) includes the laboratory services done on the same day or any other day.

A lab test that is ordered during a clinic visit but is done on another day is not considered an "Orphan Visit" and cannot be billed separately. For example: during a billable clinic visit a lab test is ordered for that day's assessment. For whatever reason, the lab work is not done the same day as the clinic visit. Documentation should reflect one single visit for the clinic and ordered lab work and therefore one billable All Inclusive Rate (AIR) encounter.

An "Orphan Visit" is a planned laboratory visit based on the provider's care plan, i.e. a new medication and a laboratory assessment is required after treatment initiation. Since this Orphan Visit is a planned laboratory visit, the patient is checked in, a visit is created and the labs are performed. Documentation must reflect this is an Orphan Visit and must be supported in the provider's care plan. The Orphan Visit can be billed separately as an outpatient claim, reimbursable at the AIR and is counted as one of the allowable visits per day.

AHCCCS does reimburse for Stand Alone Visits for radiology and medical imaging professional services. AHCCCS registered radiologists may bill for their interpretation services on a CMS 1500 claim form with HCPCS/CPT codes and modifier -26.

Billing and Reimbursement of Outpatient Services for Title XXI (KidsCare)

Claims for KidsCare must be submitted to the member's ***enrolled health plan***. If the KidsCare member is enrolled in a managed care plan, submit the claim to that plan. If the KidsCare member is enrolled as FFS or AIHP, then submit the claim to AHCCCS.

IHS/638 tribal **hospital outpatient surgery claims** for **Title XXI (KidsCare)** members are billed on the 1500 claim form (837P for electronic claims) with appropriate CPT/HCPCS codes. Claims are reimbursed at the AHCCCS ASC Fee Schedule amount accordingly.

The surgeon and anesthesiologist may bill for services on the CMS 1500 claim form. (837P for electronic claims). (Refer to Chapter 8, Individual Practitioner Services). These claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee schedule.

All **other *hospital* outpatient services** for **Title XXI (KidsCare)** members are billed on the UB-04 claim form (837I for electronic claims) with appropriate revenue codes. **Effective with date of service 01/01/2016** the attending provider's NPI must be billed on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.

Claims are reimbursed at the Outpatient Fee Schedule (OPFS) rate.

All **other *clinic* outpatient services** for **Title XXI (KidsCare)** members are billed by the individual practitioner (physician, nurse practitioner, etc.) on the CMS 1500 with HCPCS/CPT codes. Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Outpatient **dental services** for **Title XXI (KidsCare)** members are billed by the individual practitioner dentist on the ADA 2012 claim form with CDT-4 codes. Claims are reimbursed at the lesser of billed charges or the AHCCCS capped fee.

Billing for 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:

- Use of a bed
- Periodic monitoring by the 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

Observation stays must be provided in a designated "observation area" of the hospital unless such an area does not exist.

IHS and 638 tribal hospitals must bill for observation services for **Title XIX (Medicaid)** members on the UB-04 claim form (837I for electronic claims) following the instructions for other outpatient services above. AHCCCS will reimburse the observation services at the outpatient AIR rate.

IHS and 638 tribal hospitals must bill for observation services for **Title XXI (KidsCare)** members on the UB-04 claim form and must bill with 762 revenue code (Treatment/ Observation Room - Observation Room).

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04. The attending provider must be an active AHCCCS registered provider.

AHCCCS defines a "unit" of observation service as each hour or portion of an hour that a member is in observation status.

For example:

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 762

Units to bill: 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.
The inpatient claim is priced at the inpatient All Inclusive Rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the inpatient AIR payment.

Group Billing

IHS and 638 tribal 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 or clinic group biller ID.

See Chapter 3, Provider Records and Registration, for information on registering as a group biller, or the AHCCCS website for Provider Registration at:

https://www.azahcccs.gov/PlansProviders/NewProviders/registration.html

Revision/Update History

Date	Description of changes **All page numbers correspond to the individual chapter page numbers.	Page(s)
	References added in lieu of listing all services: "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.	1
2/28/19	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 section updated.	
	Health Care Acquired Conditions and Other Provider-Preventable	

Conditions section updated.	1
Reference to AMPM added to Outpatient Facility Services section in lieu of listing all covered services.	2
Reference to 25 inpatient day limit removed from observation services section.	5
	11

1/23/2018	Formatting Phone number removed	All 1
04/01/2017	Inserted changes to Outpatient Pharmacy section effective 04/01/2017	10-13
07/26/2016	Added clarification for where to submit KidsCare claims	12
06/30/2016	Added web link to NDC references and resources for billing information	9
05/23/2016	Added clarification: pharmacy clinic visit attending provider must be facility's NPI, not the pharmacist's as initially advised Added NDC required beginning with date of service 07/01/2016 Updated web address for AHCCCS Duals Drug list Added clarification: pharmacist must be licensed and certified in AZ for adult immunizations to administer without a prescription order on file Clarification language added re: AIR eligible reimbursement for covered service Updated web address for Group Billing information	9 9 10 10 10 14
12/21/2015	"Attending Provider" language added as UB-04 billing requirement effective with date of service or date of discharge 01/01/2016 attending provider NPI required	6, 9, 11, multiple

	Added new section header for Title XIX; Language clarified "eligible for Part D"; Clarified pharmacy encounter visit limit Removed language for adult seasonal flu/pneumo vaccines re: physician order must be on file Added optional breakout billing for ED services effective with service date 01/01/2016 Language clarified for pharmacy encounter "date of service". Added new section header for KidsCare; Corrected the KidsCare outpatient hospital reimbursement language New document layout/formatting	9 9 9 10 10 11 11 11 all
8/14/2014	Added clarification for adult seasonal flu and pneumococcal vaccines administered by the pharmacist, physician order must be on file	9
1/24/2014	Added "perfusion services" to list of covered inpatient ancillary services to align with Medicare payment policy	1

CHAPTER 10 ~ PHARMACY SERVICES

Chapter 10 ~ Pharmacy Services

REVISION DATES: 10/1/2018; 3/22/2018; 2/16/2018; 12/29/2017; 10/13/2015; 05/31/2012

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 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.azahccc.gov under the American Indian Section. Under 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 Pharmacy Benefit 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
11. Intrauterine Devices

Pharmacy 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 FFS network pharmacy and KidsCare prescription claims must be submitted electronically at the point-of-sale to the AHCCCS FFS PBM, OptumRx.

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 PBM 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 and/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. Please refer to the AHCCCS Medical Policy Manual (AMPM) Policy 320-K, Tobacco Cessation Product Policy for additional 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. 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.

All Inclusive Rate (AIR) Claims Billing Specifications for Title XIX AHCCCS Members

IHS/638 pharmacies dispensing and billing prescription claims at the All Inclusive Rate (AIR) for Title XIX members shall submit prescription claims to the AHCCCS Administration on the UB-04 claim form (or 837I for electronic claims) or shall submit via the AHCCCS website. The claim form shall:

- Use revenue code 519 (Other Clinic).
- Enter the outpatient All Inclusive Rate (AIR) on the first service line of the claim (0519).
  Use bill type 131 (Hospital outpatient, admit through discharge) or 711 (Clinic, rural health, admit through discharge).
- Include the AIR in the Total Charges field (Field 47), on the 0001 line.

The AHCCCS Claims System will reimburse the pharmacy claim at the outpatient AIR rate.

All Inclusive Rate Claims Billing for Title XIX Dual Eligible Members

The All Inclusive Rate may be billed for Dual Eligibles, members that are enrolled in AHCCCS under Title XIX and also eligible for Medicare, for prescription claims when:

a. The medication is listed on the AHCCCS FFS Dual Eligible Drug List; and
b. The medication is excluded from coverage under Medicare Part D by CMS and the drug is medically necessary and federally and state reimbursable.

The AIR may be billed for Dual Eligibles for Medicare Part B drugs when the claim is submitted from IHS/638 Pharmacy requesting reimbursement as the secondary payer.

a. The Medicare Part B EOMB must be submitted with the claim that is submitted to the AHCCCS Administration for reimbursement.

The AIR shall not be reimbursed for:

a. Medications eligible for coverage under Medicare Part D.
b. Part B covered drugs, devices and syringes when they are not billed as a secondary claim for payer reimbursement.
c. Medicare Part D or Medicare Part B drugs, devices, and syringes when the member is eligible for Medicare and the member has opted out of Medicare Part D and/or Medicare Part B enrollment.

Claims for Title XXI KidsCare Members

Pharmacy claims for Title XXI (KidsCare) Members must be submitted to OptumRx, the FFS PBM, as described in this chapter.

KidsCare claims are not eligible for reimbursement at the All Inclusive Rate.

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 refer to the AMPM 310-V, Prescription Medications-Pharmacy Services, Section C.

Medication Prescribing 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 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
1/1/2018	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 Updating of phone numbers and links	7 9 9-10 10 All All
10/13/2015	New formatting; New PBM vendor effective 10/01/2015 New Exhibit 10-1 OptumRX Prior Authorization Form	All & Exh 10-1

12/31/2012	Section title alpha corrections	All
10/01/2012	New PBM vendor – MedImpact effective 10/01/2012	All

Exhibit 10-1 ~ 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:

Revised: 09/29/2015 Effective: 10/01/2015

CHAPTER 11 ~ TRANSPORTATION

Chapter 11 ~ Transportation

REVISION DATES: 10/1/2018; 07/01/2018; 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. Covered transportation services include:

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.
4. 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.
5. 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.

Note: IHS/638 transportation providers are not regulated by the Department of Health Services (ADHS) and do not operate under an ADHS-granted Certificate of Necessity (CON).

6. 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.
7. 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.
8. Air ambulance services are covered under the following conditions:
    - If initiated at the request of:
        1. An emergency response unit,
        2. A law enforcement official,
        3. A clinic or hospital medical staff member, or
        4. 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 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. 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.

NON-EMERGENCY AMBULANCE TRANSPORTATION SERVICES

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 11-3 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:

1. 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.)

2. 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 11-1. Detailed instructions for completing the Daily Trip Report can be found in Exhibit 11-2.

Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Report found in Exhibit 11-1 will be denied.

- Please note that different versions of the Daily Trip Report may ***not*** be used or submitted. The attachment in Exhibit 11-1 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 IHS/Tribal 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 11-1 for the AHCCCS Daily Trip Report for NEMT.

Refer to Exhibit 11-2 for instructions on how to fill out the AHCCCS Daily Trip Report for NEMT.

Refer to Exhibit 11-3 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.	2-3
	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:* 1. *An emergency response unit,* 2. *A law enforcement official,* 3. *A clinic or hospital medical staff member, or* 4. *A physician or practitioner.*	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*	3
	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:*	4

	• *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	11-12 11--12
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)	2 2 6 6 7 7 7-8 8 8

	Billing section updated Wait Time Billing Section Added TN Modifier Section Added 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 11-1 Updated version of the Trip Report Instructions added as Exhibit 11-2	11-12 13 13 13-14 14 14-16 18-19 All All Exhibit 11-1 Exhibit 11-2
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 6-714
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 11-1 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 11-2 ~ 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 11-3 ~ Tribal Contact List

IHS Chapter 11 Transportation Services Exhibit 11-3
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	**Yavapai Prescott Tribe**

P.O. Box 9000 Window Rock, AZ 86515 (928) 871-6352	530 E. Merritt Prescott, AZ 86301 (928) 445-8790

CHAPTER 12 ~ BEHAVIORAL HEALTH SERVICES

Chapter 12 ~ Behavioral Health Services

REVISION DATE: 12/7/2018; 7/31/2018; 2/16/2018; 1/17/2018; 12/29/2017; 10/01/2016; 10/01/2015

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: http://www.azahcccs.gov/

This policy applies to Indian Health Services (IHS) or Tribal owned and/or operated facilities (638), for the purpose of benefit coordination and determining financial responsibility for AHCCCS covered behavioral health services provided to Fee-For-Service members.

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 either the American Indian Health Program (AIHP); 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.
- For members receiving all services from Tribal ALTCS, including acute services and behavioral health services, the enrolled health plan is Tribal ALTCS.

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 after study 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. The claim requires an admitting and principal diagnosis. Claims come to the AHCCCS Administration and are reimbursed at the AIR.

Professional Claims

The Inpatient AIR does not include professional fees.

1. Payment responsibility for professional services associated with an inpatient stay is determined by the principal diagnosis on the professional claim.

   For members enrolled with a TRBHA or RBHA, the AHCCCS Fee-For-Service Administration or RBHA is responsible for payment of behavioral health professional services, such as psychiatric consults.

   Case management is billable as a behavioral health service professional claim, and must be billed on a 1500 claim form.

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 for an emergency department facility claim is reimbursed at the AIR. These claims would come to the AHCCCS Administration.

Professional Fees

The Inpatient AIR does not include professional fees.

1. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim.

For members enrolled with a TRBHA or RBHA, the AHCCCS Fee-For-Service Administration or RBHA is responsible for payment of behavioral health professional services, such as psychiatric consults.

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.

IHS/Tribally Owned or Operated 638 Facilities

1. AHCCCS Fee-For-Service (FFS) is responsible for payment of claims for physical and behavioral health services provided by an IHS or tribally owned and/or operated 638 facility to Title XIX members, whether enrolled in an AHCCCS Complete Care (ACC) health plan or FFS.
2. If the member is a RBHA enrolled member, with a behavioral health diagnosis, the RBHA will be responsible for payment of claims for (physical and behavioral) health services that are provided by an IHS or tribally owned and/or operated 638 facility to Title XIX members.
3. KidsCare members enrolled with an ACC health plan should have claims sent to the ACC health plan.
4. KidsCare members enrolled with a RBHA should have claims sent to the RBHA.

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.

MCO ALTCS and Tribal ALTCS Members

ALTCS Elderly and Physically Disabled (EPD) Enrolled Members are not assigned to a RBHA or TRBHA for behavioral health services. ALTCS EPD plans are integrated service plans that reimburse for both physical and behavioral health services.

MCO ALTCS EPD Enrolled Members
Payment for an emergency department facility claim and inpatient services for ALTCS EPD members enrolled in managed care is the responsibility of the enrolled entity.

- The ALTCS contractor should be notified within 24 hours of admission.

Tribal ALTCS EPD Enrolled Members
Payment for an emergency department facility claim and/or inpatient services for Tribal ALTCS EPD members is the responsibility of the AHCCCS administration.

- A tribal case manager should be notified within 24 hours of admission.

Additional Information

For information further regarding payment responsibility for transportation, outpatient and physician services, and therapies associated with behavioral health, or for additional information on inpatient and ER 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.

Claims for emergency services rendered at an IHS facility will go to the AHCCCS Administration for payment. Claims for emergency services rendered at an IHS facility for a KidsCare member enrolled with an AHCCCS Complete Care health plan will go the ACC health plan.

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 once 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 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.

Arizona tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state court ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Services are no longer the county/tribe'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 specific information regarding payment structures for American Indians behavioral health care, please see Tribal Court Procedures for Involuntary Commitment, available on the AHCCCS website at:

https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCommitment/

Since many tribes do not have treatment facilities on reservation to provide court-ordered treatment, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the tribal court order must be "recognized" or transferred to the jurisdiction of the state. This is done via A.R.S. 12-136, and once complete the tribal court order is enforceable off reservation. Treatment facilities, including the Arizona State Hospital, must then provide treatment, as identified by the tribe and recognized by the state.

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 at the All Inclusive Rate (AIR). 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/clinic services are billed on a UB-04 and reimbursed at the AIR, subject to the daily visit limit.

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.

- Note: Non-AHCCCS registered behavioral health professionals, like BHTs, may bill for outpatient behavioral health services using revenue code 0510 for reimbursement at the AIR. However, the claim must be submitted using the facility NPI as the attending provider.

  For example, a BHT may provide a behavioral health service at a behavioral health outpatient clinic (provider type 77). In this event the claim would be submitted with the behavioral health clinic listed as the attending provider on the UB-04 form.

For BCBA and BHT criteria refer to:

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA1.pdf

Professional services not included as a part of the AIR 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.

For Title XXI (KidsCare) members:

- When physician services are provided, except when BCBA, BHPP, or BHT professional services are provided, the physician's NPI number must be listed on the claim as the billing provider.
- When BCBA, BHPP, or BHT professional services are provided, the clinic NPI must be listed on the claim as the billing provider.

Refer to the IHS/638 BH billing guide at:

https://www.azahcccs.gov/PlansProviders/Downloads/GM/CoveredServiceGuide/AppendixA2.pdf

Services are reimbursed at the Office of Management and Budget's **All Inclusive Rate (AIR).**

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 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 10, Pharmacy, of the IHS/Tribal Provider Billing Manual

Tribal Court Procedures for Involuntary Commitment:
https://www.azahcccs.gov/AmericanIndians/TribalCourtProceduresForInvoluntaryCommitment/

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)
12/7/2018	The entire chapter was restructured and formatting updated.	1-20
	Important Notice regarding the Covered Behavioral Health Service (CBHSG) added.	1
	List of covered behavioral health services updated.	1-2
	New section added called 'Members Enrolled in an Integrated Health Plan for Physical and Behavioral Health Services.'	2-3
	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)	4-5

	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 Payer responsibility section updated to read as 'Payment Responsibility for Members Enrolled with Different Entities for their Physical and Behavioral Health Services.' The information regarding who the payer is for inpatient facility and professional claims, ER facility and professional 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.	5-9 9 9 9 9-10 10-12 12-14 16 17
7/31/2018	Link updated on page 8 to link to the AHCCCS Behavioral Health Allowable Procedure Code Matrix	9

2/16/2018	Billing the AIR for BH services conducted by a non-AHCCCS registered behavioral health professional, like a BHT, clarification added.	10
1/17/18	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
12/29/17	Definitions updated Emergency Services section updated Billing for Professional Services section updated Medication Assisted Treatment for Opioid Use Disorder added Billing for Methadone Administration section updated General Requirements Regarding Payment for Physical and Behavioral Health section updated. Inpatient Facility Payment Responsibility section updated Emergency Department Payment Responsibility section updated 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	2-7 7-8 9-10 10 11 11-13 12 12-13 13 14-15 15-16 15-16 All
7/1/2016	Behavioral Health changes effective service date 07/01/2016 and later BH Billing Matrix	9 – 17 Exh 12-1
10/01/2015	New format ICD-9 replaced by ICD	All 7

CHAPTER 13 ~ HOME HEALTH CARE SERVICES

Chapter 13 ~ 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:

1. It must relate to the primary reason the member requires home health services.

2. It must occur no more than 90 days prior to or 30 days following the start of services.

3. It must be performed 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.

4. A non-physician practitioner who performs the face-to-face encounter must communicate the 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 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.

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 to the initiation of services only.

Face-to-face encounter requirements do apply to rehabilitative therapies 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.

Face-to-face encounter requirements **do** apply to medical equipment, appliances and supplies if provided under the home health benefit. Please see Fee-For-Service Provider Billing Manual Chapter 13 or AMPM Policy 310-P Medical Equipment, Medical Appliances and Medical Supplies for further information regarding the face-to-face requirement.

BILLING FOR SERVICES

Prior authorization from the AHCCCS Administration is required for home health services rendered by tribal providers to acute fee-for-service IHS members. However, no authorization is required for home health services rendered by Indian Health Service (IHS).

Home health services must be billed 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.

For dates of service on and after January 1, 2004, 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	1
	Clarification added to General Information section (changed from “medically necessary supplies” to “Medical equipment, appliances and supplies; and/or”)	1
	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. “	2
	“Member” changed to “Member”	All
	References section added.	5
10/1/2017	Face-To-Face Requirements Formatting	1-2 All

CHAPTER 14 ~ ALTCS

Chapter 14 ~ ALTCS

REVISION DATES: 5/04/2018; 10/01/2017; 10/05/2016; 05/31/2012

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 Web site at www.azahcccs.gov.

Covered Services

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 14-2). 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 EPD members) are enrolled with a program contractor in their county of residence. American Indian EPD 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 EPD 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.

EPD 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 Systems 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 14-1 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 Chapter 15, Nursing Facility Services, for a detailed description of nursing facility services as well as the 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.)

Covered HCBS services include:

1. Assisted living facility
   ALTCS covers services, except room and board, for EPD 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 EPD 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 13, 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.

8. Personal care services provide assistance to members who need help doing essential activities of daily living (i.e., eating, bathing, dressing).

10. 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.

<u>Occupational Therapy</u>

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 PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.

Outpatient occupational therapy services are covered for EPSDT and 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 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 PCP/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.

In accordance with AHCCCS Administrative Rules A.A. C. R9-22-215 and R9-28-202 outpatient PT services are covered for adult members, 21 years of age and older (Acute and ALTCS) as follows:

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

The service limits are:

- 15 PT visits per contract year (10-1 thru 9/30) for habilitation (to attain or acquire a particular skill for function never learned or acquired and maintain that function once acquired); and
- 15 PT visits per contract year for rehabilitation (to restore a particular skill or function the individual previously had but lost due to injury or disease and maintain that function once restored).

When the member is Dual Eligible (also known as Medicare Primary, non QMB Dual) AHCCCS is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to the PT service limits. In the event that the PT service limit is reached prior to the Medicare maximum dollar amount, AHCCCS will pay the Medicare cost sharing up to the service limit per contract year.

1. As part of their Medicare benefit, members may opt to receive services up to Medicare maximum dollar amount; **however** the Medicare cost sharing for any visits beyond the service limit allowed by AHCCCS are the member's responsibility.
2. In the event that the member exhausts the Medicare dollar maximum amount prior to utilizing the PT service limit, AHCCCS will continue to cover the additional visits up to the service limit maximum.

When the member is QMB Dual AHCCCS is responsible for Medicare cost sharing up to Medicare maximum dollar amount.

1. In the event that the PT service limit is reached prior to the Medicare maximum dollar amount, AHCCCS will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

2. In the event that member exhausts the Medicare maximum dollar amount prior to utilizing the PT service limit allowed, AHCCCS will continue to cover the additional visits up to the service limit maximum.

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 - Any outpatient place of service. (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).

Dual Eligible (Non-QMB Dual) - An individual who is Medicare and Medicaid eligible with income above 100% FPL. The individual does not qualify for the federal QMB program.

QMB Dual -An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL. The individual does qualify for the federal QMB program.

Physical therapy prescribed only as a maintenance regimen is excluded.

Authorized 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.

<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 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 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.

No outpatient rehabilitation services are covered for FESP members.

Therapy Services Prior authorization requirements:

AHCCCS covers occupational, physical, respiratory, and speech therapy services, that are ordered by a Primary Care Physician (PCP), prior authorized by the Tribal ALTCS Case Managers and provided by or under the direct supervision of a licensed therapist.

Members residing in their own home, an HCB approved alternative residential setting or an institutional setting may receive physical, occupational, and speech therapies through a

licensed Medicare-certified Home Health Agency (HHA) or by a qualified licensed physical, occupational or speech therapist in independent practice, as applicable.

Services require a Primary Care Provider (PCP) or attending physician's order and must be included in the member's individualized care plan. The care plan must be reviewed at least every 62 days (bimonthly) by the member's PCP or attending physician.

For acute care the following written documentation must be received by the ALTCS Case Manager prior to the issuance of a PA number:

1. Nature, date, extent of injury/illness and initial therapy evaluation.
2. Treatment plan, including specific services/modalities of each therapy, and
3. 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 ALTC Case Manager 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 match criteria 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:

- 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 performing services in an IHS or 638 clinic facility will be billed on the UB-04 with revenue code 0512 and the AIR amount by the IHS or 638 facility. Dental treatment record must be submitted with the claim.

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.

Revisions

Date	Revision(s)	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 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 'member' was changed to 'member.'	3 All
10/01/2017	Dental Occupational Therapy	10-13 5-6

	Format Changes	All
10/06/2016	New format Update Physical Therapy visit limit to conform to AMPM ALTCS Dental Services added, effective 10/01/2016	All 8 11
12/18/2013	Reformatting Updated ALTCS office listing	All Exh 14-2

CHAPTER 15 ~ NURSING FACILITY SERVICES

Chapter 15 ~ Nursing Facility Services

Revision Dates: 2/2/2018; 9/1/2010

GENERAL INFORMATION

NOTE: 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)/638 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.

- 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 the 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, 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
- Walkers (all non-customized)
- Water mattresses
- 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.

- 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.

AUTHORIZATION FOR SERVICES

The AHCCCS Administration does not authorize any services rendered by Indian Health Service (IHS)/638 facilities. For nursing facility services rendered by tribal providers to acute fee-for-service American Indian Health Program members, PA from AHCCCS is required unless the member becomes retroactively eligible for AHCCCS.

Providers may phone or fax the AHCCCS PA Unit to request authorization. To obtain PA by telephone, providers must call between 9:00 a.m. and 11:30 a.m. and 12:00p.m.-4:00p.m. Monday – Friday:

> (602) 417-4400 (Phoenix area) Providers in area codes 602, 480, and 623 **must** use this number.
>
> 1-800-433-0425 (within Arizona) This number is blocked for callers in area codes 602, 480, and 623.
>
> 1-800-523-0231 (outside Arizona)

The AHCCCS PA Unit's fax number is (602) 256-6591.

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.

BILLING FOR SERVICES

Nursing facilities cannot submit claims that overlap months.

AHCCCS only pays for the date of admission up to, but not including, the date of discharge, unless the patient expires.

Nursing facilities must bill for room and board services on the UB-04 claim form. The table on Page 15-5 summarizes the allowable revenue codes and bill types, effective with dates of service on and after March 01, 2009.

Revenue Codes		Allowable Bill Types
190	Subacute General	86X, 650-668
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

When Medicare is the primary payer, AHCCCS will pay the full Medicare coinsurance amount minus any other third party payment. 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 7, Medicare/Other Insurance Liability, for detailed information on billing nursing facility claims with Medicare.

REVISION HISTORY

Date	Description of Change(s)	Page(s)
2/2/2018	Updated respite care hour limits Formatting	3 All

CHAPTER 16 ~ CLAIMS PROCESSING

Chapter 16 ~ Claims Processing

REVISION DATES: 10/1/2018; 1/16/2018

General Information

All claims submitted to AHCCCS by Indian Health Service (IHS) and Tribal 638 providers 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 "March 10, 2004" should be recorded as 03/10/2004 (MM/DD/YYYY format) and the claim is received with 2004/03/10, 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. These data elements, as applicable, are required on all claims.

After editing for completeness and correctness of the data submitted, the system edits to ensure that data fields are valid and logical. The most important of these edits enssure 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(s) it was delivered; and
- Diagnosis and procedure codes were valid for the date(s) of service.

Another set of edits ensures that the claim complies with AHCCCS policy requirements. These edits ensure that:

- 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(s) 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 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 IHS/Tribal Provider Billing Manual. For additional information on the remit, please refer to Chapter 18, Understanding the Remittance Advice, of the IHS/Tribal 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 Member Age & Gender
- L023.2 -Diagnosis Code #1 – Invalid for Member Age
- L023.3 -Diagnosis Code #1 – Invalid for Member Gender

If one or more edits failed 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 it will pend internally until the Medical Review department 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.

- The claim may be denied. Please see Chapter 17, Correcting Claim Errors, for further information.
    - If the data required for adjudication of a claim is complete, but the service does not meet AHCCCS policy requirements, the claim will be denied.

      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
- All errors in the data provided are 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 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. For IHS facilities and providers, if your claim is replaced without the CRN, the claim will be treated as a first-time submission and may not pass the 12-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 incorrectly identified as a duplicate of an existing claim and denied.

ALL INCLUSIVE RATE (AIR) INFORMATION

Claims requesting the AIR for reimbursement must be submitted on a UB-04 form.

If multiple AIRs are submitted on one (1) claim, even if each AIR is for a different date of service, all AIRs will still deny. Only one (1) AIR per claim can be submitted.

Claims will be edited based on the allowance of 5 All Inclusive Rates (AIR) per member, per day. The system is set up to **automatically deny** any AIR claim submissions in excess of 5 per member, per day.

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, deductible, or co-pay, minus any 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.

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 rate, 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	

   The AIR rate for IHS/638 tribal facility outpatient services is considered to be a capped fee.

5. If there is no provider-specific rate for the service, no capped fee on file, and the service does not require manual pricing, 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, claims billed on a CMS 1500 claim form (837P for electronic claims) are reimbursed at the current AHCCCS by-report percentage of covered billed charges. Claims billed on a UB-04 claim form (837I for electronic claims) are reimbursed at the current AHCCCS by-report percentage of covered billed charges.

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

REVISION 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:	1-2
	"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."*	2-3
	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.*	3
	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*	4

	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."* 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	5 All that are not system edit definitions. 5
1/16/2018	AIR Updates AIR allowance updated from 3 to 5 per member, per day. Formatting	1 3 All

CHAPTER 17 ~ CORRECTING CLAIM ERRORS

Chapter 17 ~ Correcting Claim 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 Claim 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.

L099 Recipient Eligibility/Enrollment (CMS 1500) and
H216 Recipient Eligibility/Enrollment (UB-04 claims)

These edits relate to the member's eligibility for the services billed on the CMS 1500 (L099) or the UB-04 (H216) claim forms.

L099.1 Recipient Not Elig/Enrl For Entire DOS; Invalid Eligibility

H216.1 Recipient Not Elig/Enrl For Entire DOS; Invalid Eligibility

A claim has been received for a member who was not AHCCCS eligible on the date(s) of service.

Verify the member's AHCCCS ID number on the Remittance Advice and on the claim that you submitted. If the AHCCCS ID is correct, verify the member's dates of eligibility.

Bill only for services rendered on the dates the member was AHCCCS eligible. The member may have been enrolled in the American Indian Health Program (AIHP) for dates of service billed on the claim. However, enrollment in the American Indian Health Program does not guarantee AHCCCS payment.

The services may need to be split, billing only for the dates the member was AHCCCS eligible. For example, assume that services were from March 28 through April 5. The patient's AHCCCS eligibility began April 1. Only bill AHCCCS for services provided April 1 – 5. If the entire date span is billed (March 28 – April 5), the claim will fail edit L099.1.

Verify the member's AHCCCS ID number and eligibility standing with the AHCCCS Division of Member Services (DMS). See Chapter 2, Eligibility.

H002 Recipient ID Test

H002.3 Recipient ID; Field Is Not On File

The member ID number on the claim is not a valid ID number in the AHCCCS system.

Verify the member's AHCCCS ID number using AHCCCS Online.

Enter the correct member AHCCCS ID on your claim and refile the claim.

L077 Service Provider Status Test (CMS 1500 claims) and
H200 Service Provider Status Test (UB-04claims)

This edit relates to the service provider's ability to bill for the service indicated on a CMS 1500 claim (L077) or on a UB-04 claim (H200)

L077.1 Service Provider Status Not Active; Not Authorized to Bill for Service

H200.1 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.)

L078 Billing Provider Status Test (CMS 1500 claims)

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.

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.

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.

L076 Timeliness Test (CMS 1500 claims) and the H199 Timeliness Test (UB-04 claims)

L076.4 Claim - Received Past 6 Month Limit

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.

L076.2 Claim Received - Past 12 Month Limit, Deny

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 your claim.

NOTE: REFER TO THE SECTION ON "RESUBMISSIONS, REPLACEMENTS, AND VOIDS" IN CHAPTER 4, GENERAL BILLING RULES, FOR THE AHCCCS REQUIRED FIELDS. 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.

L081 Duplicate Check

L081.2 Duplicate Check Failed; Duplicate Claim

A claim for the same provider, same member, and same date of service has already been billed and paid.

L067 Medicare Crossovers (CMS 1500 claims)

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. Medicare will automatically cross the claim over to AHCCCS for payment of coinsurance and deductible.

Please refer to Chapter 7, Medicare/Other Insurance Liability for information on Medicare and other insurance.

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.

L032 Recipient Age/Gender Test For Procedure

L032.1 Procedure Code Is Invalid For Recipient Age and Gender

L032.2 Procedure Code Is Invalid For Recipient Age

L032.3 Procedure Code Is Invalid For Recipient Gender

For all of the edits, determine if the correct procedure code was billed for the member. If the procedure code is incorrect, enter the correct code and resubmit the claim. If the procedure code is correct, contact Claims Customer Service and request a review of the age and/or gender limits for the procedure 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 CMS 1500 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.

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 UB-04 claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

L019 Diagnosis Code #1 Test

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 code is a valid ICD diagnosis code and entered correctly on the CMS 1500 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 code was used for the member. If the diagnosis code is incorrect, enter the correct diagnosis code and resubmit the claim following the instructions in Chapter 4. If the diagnosis is correct, contact Claims Customer Service and request a review of the age and/or gender limits for the diagnosis code.

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	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 **master account holder**. For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration." Checking Online Claim Submission and Prior Authorization Submission were both added to the "Other services available at AHCCCS Online" bullet pointed list. 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: • L099 • H216 • H002 • L077 • H200 • L078 • H211 • L016 • L076 • H199 • L081 • L067 • L001 • L032 • L060	1 1 1 1-7

	• H094 • L019 • L023 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	 4 7 Throughout (except edits) All
10/01/2015	New format "ICD-9" replaced with "ICD	All

CHAPTER 18 ~ UNDERSTANDING THE REMITTANCE ADVICE

Chapter 18 ~ Understanding the Remittance Advice

REVISION DATES: 2/28/2019; 12/8/18; 12/30/2015; 04/26/2013; 05/31/2012

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 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. (See Chapter 19, 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 18-1) 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 18-2) reports check 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.
    - Providers receive separate checks for each Pay For Category
- 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 18-3) 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                                  PAGE:
PROGRAM ID:                                    NON-FACILITY REMITTANCE ADVICE                                            RUN:
                                               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       ALLOWED AMOUNT (*)
 A########    Patient Account #            MM/DD/YYYY                                      1.00                        -----------
                                                                                                                        40.00       NET PAID AMOUNT

 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 18-4) 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                                  PAGE:
PROGRAM ID:                                    NON-FACILITY REMITTANCE ADVICE                                             RUN:
                                                          DENIED CLAIMS

BILLING PROVIDER:                                  NPI:
SERVICE PROVIDER:                                  NPI:

      TAX ID:
      FORM TYPE:  FORM 1500

                                                                                  SERVICE CD/      DATES OF
AHCCCS ID  RECIPIENT  NAME                    PATIENT ACCOUNT NBR   CRN           MODIFIER         SERVICE          BILLED AMOUNT    BILLED UNITS
-------------------------------------------------------------------------------------------------------------------------------------------------
A########  A########  Last Name, First Name  T########CLAIM        ##############  97110            MM/DD/CCYY       30.00                1.00
                                                                                  GP
 REASON CDS: H001.7  L013.1
-------------------------------------------------------------------------------------------------------------------------------------------------
A########  A########  Last Name, First Name  T########CLAIM        ##############  97110            MM/DD/CCYY       225.00               3.00
                                                                                  GP
 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 18-5) 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                                  PAGE:
PROGRAM ID:                                    NON-FACILITY REMITTANCE ADVICE                                             RUN:
                                             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   ALLOWED AMOUNT (*)
                                                                                        2.00                            57.20-  PREVIOUSLY PAID
                                                                                                                     ----------
                                                                                                                          0.00   NET PAID AMOUNT
 PRICE EXPL: *AHA
-------------------------------------------------------------------------------------------------------------------------------------------------
```

NON-FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims (Exhibit 18-6) 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                                  PAGE:
PROGRAM ID:                                    NON-FACILITY REMITTANCE ADVICE                                             RUN:
                                             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
-------------------------------------------------------------------------------------------------------------------------------------------
#######     Last Name, First Name         CRN Number     00400         MM/DD/YYYY    2000.00             4.00          0.00   ALLOWED AMOUNT (*)
#######     Account Number                MM/DD/YYYY     AA                                4.00                      200.00-  PREVIOUSLY PAID
                                                                                                                   -----------
                                                                                                                     200.00-  NET PAID AMOUNT
 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 18-7) 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	BILLED UNITS
A########	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	2.00
A########	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	2.00
A########	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	1.00
A########	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	2.00
A########	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	1.00

NUMBER OF CLAIMS: 15
TOTAL BILLED AMOUNT: 300.00

NON-FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* (Exhibit 18-8) 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 18-9) 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      ALLOWED AMOUNT (*)
A########      Account Number                MM/DD/YYYY       MM/DD/YYYY        3.00                                300.00-      DISCOUNT
                                                                                                                  -----------
                                                                                                                    9,700.00      NET PAID AMOUNT
 PRICE EXPL: *AHA          (Q5 - 1%)
```

FACILITY PAID CLAIMS/OUTPATIENT

The *Paid Claims* section for outpatient facility claims (Exhibit 18-10) 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        ALLOWED AMOUNT (*)
A########     Account Number                MM/DD/YYYY       MM/DD/YYYY      5.00                                 2.50-        DISCOUNT
                                                                                                              ---------
                                                                                                              447.50        NET PAID AMOUNT
-------------------------------------------------------------------------------------------------------------------------------
```

FACILITY DENIED CLAIMS

The *Denied Claims* section for facility claims (Exhibit 18-11) 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                    PAGE:
PROGRAM ID:                                      FACILITY REMITTANCE ADVICE                                 RUN:
                                                        DENIED CLAIMS

BILLING PROVIDER:  Provider ID #      Billing Provider Name      NPI:
SERVICE PROVIDER:  Provider ID #      Service Provider Name      NPI:

      TAX ID:
      FORM TYPE:  INPATIENT

AHCCCS ID   RECIPIENT   NAME                          PATIENT ACCOUNT NBR   CRN            DATES OF SERVICE          BILLED AMOUNT   BILLED UNITS
-------------------------------------------------------------------------------------------------------------------------------------------------
 A########  A########   Last Name, First Name         #########             ############   MM/DD/CCYY  MM/DD/CCYY   $4,000.00          4.00
 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 18-12) 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 facility claims (Exhibit 18-13) 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                                  PAGE:
PROGRAM ID:                                  FACILITY REMITTANCE ADVICE - MDOC FEE FOR SERVICE                            RUN:
                                              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-      ALLOWED AMOUNT (*)
A########     Account Number                MM/DD/YYYY          MM/DD/YYYY            1.00                              500.00       DISCOUNT
                                                                                                                    -----------
                                                                                                                      9500.00-       NET PAID AMOUNT

 PRICE EXPL: *AHA          (Q5 - 1%)
 REASON CDS: EV100 --LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE01, LINE01, LINE01, LINE01, LINE01, LINE
 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 18-14) 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 the section.
- TOTAL BILLED AMOUNT for all claims in the section.

REPORT ID:
PROGRAM ID:

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
FACILITY REMITTANCE ADVICE
CLAIMS IN PROCESS

PAGE:
RUN:

BILLING PROVIDER: NPI:
SERVICE PROVIDER: NPI:

TAX ID:
FORM TYPE: INPATIENT

AHCCCS ID	RECIPIENT	NAME	PATIENT ACCOUNT NBR	CRN	DATES OF SERVICE		BILLED AMOUNT	BILLED UNITS
A########	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	30,000.00	3.00
A########	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	78,900.00	7.00
COMMENTS:	OUTLIER REQUESTED, NOT QUALIFIED							
A########	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	50,000.00	2.00

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 18-8).

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	Page(s)
2/28/2019	General Information Section – Clarifications added and link to the 835 Claim Remittance Advice Companion Document updated.	1
	Link added for 835 AHCCCS Companion Documents	1
	FAQs added regarding the Electronic Remittance Advice	
	• Who may request ERA setup?	1
	• How can a provider request ERA setup?	2
	• What information does AHCCCS require to set up the Electronic Transaction Process?	2
	Clarification added to the paper remittance advice section reading as, “There will be only one payment issued for any combination of invoices paid.”	3
	Remittance Sections list added	3
	Contact information (to request a duplicate paper remittance advice) for the Division of Business and Finance added.	3
	Address Page section updated	4
	Financial Summary section updated	4-5
	Non-Facility Paid Claims section updated	5-6
	Non-Facility Denied Claims section updated	6-7

	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 added and 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	7-8 8-9 9-10 10-11 11-12 12-13 13-14 14-15 15-16 16-17
12/8/18	References Section Added Formatting	10 All

Exhibit 18-1

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: 04/16/2004

BILLING PROVIDER:   654321  01

    INVOICE DATE:   04/16/2004
    PAYMENT DATE:   04/20/2004
```

Address page shows billing provider's name and Pay-To mailing address

```
          PROVIDER NAME
          STREET ADDRESS OR P.O. BOX
          ANYTOWN                  AZ
                        99999

** PLEASE CALL CLAIMS CUSTOMER SERVICE FOR QUESTIONS OR CLARIFICATION ABOUT THE CONTENTS OF THIS PACKAGE **
** CLAIMS CUSTOMER SERVICE MAY BE REACHED AT (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0331 (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.
```

Exhibit 18-2

SAMPLE REMITTANCE ADVICE – FINANCIAL SUMMARY

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 2
PROGRAM ID: FI04L400                       REMITTANCE ADVICE - FINANCIAL SUMMARY                       RUN: 04/16/2004
001549                                          INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   PROVIDER NAME

      TAX ID:       999999999
PAYMENT DATE:       04/20/2004
```

PAY FOR CATEGORY	CHECK NUMBER	INVOICE DATE	INVOICE NUMBER	TYPE	GROSS AMOUNT	DISCOUNT	NET AMOUNT
ACUTE FEE-FOR-SERVICE	48746	04/16/2004	A0400000000001		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, the 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 18-3

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:  04/16/2004
001549                                           PAID CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC                                   INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                                   CHECK NUMBER:    48746
                                                                                 PAYMENT DATE:    04/20/2004

        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              04100000100801   99223          03/09/2004       150.00       1.00    29.00   ALLOWED AMOUNT (*)
A12007007      007                      04/15/2004                                         1.00                --------
                                                                                                                 29.00   NET PAID AMOUNT
PRICE EXPL:    SUB   *MCC
-------------------------------------------------------------------------------------------------------------------------------
A12007007      BOND, JAMES              04099000103701   99233          03/03/2004       400.00       5.00    72.00   ALLOWED AMOUNT (*)
A12007007      007                      04/15/2004                      03/14/2004         5.00                --------
                                                                                                                 72.00   NET PAID AMOUNT
PRICE EXPL:    SUB   *MCC
-------------------------------------------------------------------------------------------------------------------------------
A61743893      HOLMES, SHERLOCK         04100000100801   99233          03/09/2004       300.00       3.00   240.00   ALLOWED AMOUNT (*)
A61743893      12714-350493             04/15/2004                      03/11/2004         3.00                --------
                                                                                                                240.00   NET PAID AMOUNT
 PRICE EXPL:   MAX   *AHA
-------------------------------------------------------------------------------------------------------------------------------
A21742813      KURIYAKIN, ILYA          04100000100801   90828          03/24/2004       800.00       5.00   680.00   ALLOWED AMOUNT (*)
A21742813      12224-489133             04/15/2004                      03/28/2004         5.00                270.00-  OTHER INSURANCE
                                                                                                                --------
                                                                                                                410.00   NET PAID AMOUNT
 PRICE EXPL:   SUB   MAC    *AHA
-------------------------------------------------------------------------------------------------------------------------------
A21742813      PEELE, EMMA              04100000100801   99233          03/24/2004       290.00       3.00   146.00   ALLOWED AMOUNT (*)
A21742813      12714-350493             04/15/2004                      03/26/2004         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, 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 18-4

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: 04/16/2004
                                                          DENIED CLAIMS

BILLING PROVIDER:   654321  01   HOLLIDAY, 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              04100000103301   90828          03/22/2004       160.00          1.00
 REASON CDS:   H077.2
-------------------------------------------------------------------------------------------------------------------------------------
A12003210   A12003210   CLANCY, IRB       96-007L               04100000100801   99245          03/17/2004        96.00          1.00
 REASON CDS:   H094.1    L017.1    L019.1
-------------------------------------------------------------------------------------------------------------------------------------
A21110770   A21110770   EARP, WYATT       XYX96089              04100000030170   99233          03/03/2004       255.00          3.00
 REASON CDS:   L017.1    03/04/98
-------------------------------------------------------------------------------------------------------------------------------------
A12345678   A12345678   JANE, CALAMITY    ABC96037              04100000100801   99223          03/12/2004       150.00          1.00
 REASON CDS:   L019.1
-------------------------------------------------------------------------------------------------------------------------------------
A12345678   A12345678   JANE, CALAMITY    ABC96037              04100000100802   99233          03/13/2004        85.00          1.00
 REASON CDS:   L019.1
-------------------------------------------------------------------------------------------------------------------------------------
A12007007   A12007007   BOND, JAMES       XYX96033              04100000100901   99233          03/15/2004        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 18-5

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: 04/16/2004
001549                                  ADJUSTED CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC                          INVOICE NUMBER:  A0300000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                          CHECK NUMBER:    48746
                                                                        PAYMENT DATE:    04/20/2004

       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        04100000100801  99233         03/09/2004        300.00        3.00     222.00  ALLOWED AMOUNT(*)
A61743893      12714-350493            04/14/2004                    03/11/2004          3.00                   148.00- PREVIOUSLY PAID
                                                                                                              --------
                                                                                                                 74.00  NET PAID AMOUNT
 PRICE EXPL:   MAC   *AHA
-------------------------------------------------------------------------------------------------------------------------------
A21742813      KURIYAKIN, ILYA         04099000100801  90828         03/24/2004        800.00        5.00     680.00  ALLOWED AMOUNT(*)
A21742813      12224-489133            04/14/2004                    03/28/2004          5.00                   544.00- PREVIOUSLY PAID
                                                                                                              --------
                                                                                                                136.00  NET PAID AMOUNT
 PRICE EXPL:   SUB   MAC   *AHA
-------------------------------------------------------------------------------------------------------------------------------
A21742813      PEELE, EMMA             04110000100801  99233         03/24/2004        290.00        3.00     146.00  ALLOWED AMOUNT(*)
A21742813      12714-350493            04/14/2004                    03/26/2004          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 18-6

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: 04/16/2004
001549                                   VOIDED CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC                          INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                          CHECK NUMBER:    48746
                                                                        PAYMENT DATE:    04/20/2004

       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             04100000100801   99223        03/09/2004        150.00        1.00     29.00-  ALLOWED AMOUNT(*)
A12007007      007                     04/14/2004                                                     1.00   --------
                                                                                                             29.00-  NET PAID AMOUNT
PRICE EXPL:SUB   *MCC
-------------------------------------------------------------------------------------------------------------------------------
A12007007      BOND, JAMES             04100000103701   99233        03/03/2004        400.00        5.00     72.00-  ALLOWED AMOUNT(*)
A12007007      007                     04/14/2004                    03/07/2004          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 18-7

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: 04/16/2004
                                                   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	04100000103301	90828	03/22/2004	160.00	1.00
A12003210	A12003210	CLANCY, IKE	96-007L	04100000100801	99245	03/17/2004	96.00	1.00
A21110770	A21110770	EARP, WYATT	XYX96089	04100000301701	99233	03/03/2004	255.00	3.00
A12345678	A12345678	JANE, CALAMITY	ABC96037	04099000100801	99223	03/12/2004	150.00	1.00
A12345678	A12345678	JANE, CALAMITY	ABC96037	04100000100803	99233	03/13/2004	85.00	1.00
A12007007	A12007007	BOND, JAMES	XYX96033	04101000100801	99233	03/15/2004	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 18-8

SAMPLE REMITTANCE ADVICE – PROCESSING NOTES

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE: 15
PROGRAM ID: FI04L400                       REMITTANCE ADVICE - PROCESSING NOTES                        RUN: 04/16/2004

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC

       TAX ID:     999999999
       FORM TYPE:  FORM 1500

NOTE      TYPE    DESCRIPTION
----      ----    ------------------------------------------------------------------------------------------------------------

              ** PLEASE CALL CLAIMS CUSTOMER SERVICE FOR FURTHER EXPLANATION OF ANY DESCRIPTION **

              ** CLAIMS CUSTOMER SERVICE MAY BE REACHED AT (602) 417-7670 OR 1-800-794-6862 (IN-STATE) OR 1-800-523-0331 (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 31 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 18-9

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: 04/16/2004
001549                                  PAID CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                    INVOICE NUMBER:  A0300000000001
SERVICE PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                    CHECK NUMBER:    48746
                                                                            PAYMENT DATE:    04/20/2004

      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                 041000001001   03/20/2004      1,507.00        1.00       1,507.00  ALLOWED AMOUNT  (*)
A12345678     O011617768-1                  04/14/2004     03/21/2004          1.00                   ---------
                                                                                                      1,507.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                041000003003   03/25/2004      3,014.00        2.00       3,014.00  ALLOWED AMOUNT  (*)
A87654321     J4176037943-1                 04/14/2004     03/27/2004          2.00                   ---------
                                                                                                      3,014.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------
A18273645     EARP, WYATT                   040990003003   03/19/2004      4,521.00        3.00       4,521.00  ALLOWED AMOUNT  (*)
A18273645     E0116543257-2                 04/14/2004     03/22/2004          3.00                   ---------
                                                                                                      4,521.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------
A11223344     YOUNGER, COLE                 041010040004   03/21/2004      1,507.00        1.00       1,507.00  ALLOWED AMOUNT  (*)
A11223344     Y0327188796-1                 04/14/2004     03/22/2004          1.00                   ---------
                                                                                                      1,507.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------
A43218765     CRAWFORD, KATY                040950005005   03/23/2004      6,080.00        8.00       6,080.00  ALLOWED AMOUNT  (*)
A43218765     C5522613008-1                 04/14/2004     03/31/2004          8.00                   ---------
                                                                                                      6,080.00  NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------
A18273645     JAMES, JESSE                  041020006006   03/28/2004      1,520.00        2.00       1,520.00  ALLOWED AMOUNT  (*)
A18273645     J7158700699-1                 04/14/2004     03/30/2004          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 18-10

SAMPLE REMITTANCE ADVICE – PAID FACILITY OUTPATIENT CLAIMS

```
REPORT ID:  FI04W400                          ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                          PAGE:  4
PROGRAM ID: FI04L400                             FACILITY REMITTANCE ADVICE - ACUTE                                 RUN:  04/16/2004
001549                                         PAID CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                          INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                          CHECK NUMBER:    48746
                                                                                  PAYMENT DATE:    04/20/2004

      TAX ID:      999999999
    FORM TYPE:  OUTPATIENT

AHCCCS ID     NAME                          CRN          DATES OF      BILLED AMOUNT   ALLOWED
RECIPIENT     PATIENT ACCOUNT NUMBER        STATUS DATE  SERVICE        BILLED UNITS     UNITS
-----------------------------------------------------------------------------------------------------------------------
A12345678     OAKLEY, ANNIE                 040950003003 03/20/2004         652.00                   255.52  ALLOWED AMOUNT  (*)
A12345678     O011617768-1                  04/14/2004   03/20/2004                                 --------
                                                                                                     255.52  NET PAID AMOUNT
 PRICE EXPL:  (SCO - .3919)  *AHA
-----------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                040950008008 03/25/2004         450.00                   176.36  ALLOWED AMOUNT  (*)
A87654321     J4176037943-1                 04/14/2004   03/25/2004                                 --------
                                                                                                     176.36  NET PAID AMOUNT
PRICE EXPL:   (SCO - .3919)  *AHA
-----------------------------------------------------------------------------------------------------------------------
A18273645     EARP, WYATT                   040950007007 03/19/2004         750.00                   293.93  ALLOWED AMOUNT  (*)
A18273645     E0116543257-2                 04/14/2004   03/19/2004                                 --------
                                                                                                     293.93  NET PAID AMOUNT
PRICE EXPL:   (SCO - .3919)  *AHA
-----------------------------------------------------------------------------------------------------------------------
A11223344     YOUNGER, COLE                 040950009009 03/21/2004         980.00                   384.06  ALLOWED AMOUNT  (*)
A11223344     Y0327188796-1                 04/14/2004   03/21/2004                                 --------
                                                                                                     384.06  NET PAID AMOUNT
PRICE EXPL:   (SCO - .3919)  *AHA
-----------------------------------------------------------------------------------------------------------------------
```

- **Last page of Paid Claims section lists totals for inpatient and outpatient claims**

```
NUMBER OF CLAIMS:            10
TOTAL BILLED AMOUNT:  23,714.67
TOTAL REMIT AMOUNT:   23,714.27
```

Exhibit 18-11

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: 04/16/2004
001549                                                DENIED CLAIMS

BILLING PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY
SERVICE PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY

        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	041000050001	03/24/2004	03/26/2004	3,014.00	2.00
REASON CDS: H154.3								
A17650082	A17650082	HAWTHORNE, NATHANIEL	148C123	041000010113	03/29/2004	03/30/2004	1,507.00	1.00
REASON CDS: H140.3 H141.3 H142.3								
A17050080	A17050080	HEMINGWAY, ERNEST	168B456	041000010312	03/01/2004	03/03/2004	1,507.00	1.00
REASON CDS: L037.1								
A17030074	A17030074	IRVING, WASHINGTON	148D789	041010010312	03/23/2004	03/26/2004	4,521.00	3.00
REASON CDS: L037.1								
525465421	525465421	STEIN, GERTRUDE	150L654	040990777763	03/04/2004	03/06/2004	3,014.00	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:  13,563.00
```

Exhibit 18-12

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: 04/16/2004
001549                                        ADJUSTED CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                          INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                          CHECK NUMBER:    48746
                                                                                  PAYMENT DATE:    04/20/2004

        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                   041000001001  03/20/2004      4,521.00        3.00        4,521.00   ALLOWED AMOUNT (*)
A12345678     0011617768-1                    04/14/2004    03/23/2004          3.00                    1,507.00-  PREVIOUSLY PAID
                                                                                                        -----------
                                                                                                        3,014.00   NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                  041000002001  03/26/2004      4,521.00        2.00        3,014.00   ALLOWED AMOUNT (*)
A87654321     J4176037943-1                   04/14/2004    03/29/2004          3.00                    4,521.00-  PREVIOUSLY PAID
                                                                                                        -----------
                                                                                                        1,507.00-  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:     9,042.00
TOTAL REMIT AMOUNT:      1,507.00
```

Exhibit 18-13

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: 04/16/2004
001549                                        VOIDED CLAIMS - INVOICE DATE: 04/16/2004

BILLING PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                          INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY                          CHECK NUMBER:    48746
                                                                                  PAYMENT DATE:    04/20/2004

        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                   041000001001  03/20/2004       1,507.00        1.00       1,507.00-  ALLOWED AMOUNT (*)
A12345678     O011617768-1                    04/14/2004    03/21/2004           1.00                   ---------
                                                                                                        1,507.00- NET PAID AMOUNT
 PRICE EXPL:  PDM  *AHA
-------------------------------------------------------------------------------------------------------------------------
A87654321     JANE, CALAMITY                  041000003003  03/25/2004       3,014.00        2.00       3,014.00-  ALLOWED AMOUNT (*)
A87654321     J4176037943-1                   04/14/2004    03/27/2004           2.00                   ---------
                                                                                                        3,014.00- 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:     4,521.00
TOTAL RECOUPED AMOUNT:   4,521.00
```

Exhibit 18-14

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: 04/16/2004
001549                                                     CLAIMS IN PROCESS

BILLING PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY
SERVICE PROVIDER:   654321  01   IHS/638 TRIBAL FACILITY

        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	041000050001	03/24/2004	03/26/2004	3,014.00	2.00
A17650082	A17650082	GEHRIG, LOUIS	148C123	041000010113	03/29/2004	03/30/2004	1,507.00	1.00
A17050080	A17050080	RUTH, GEORGE HERMAN	168B456	041000010312	03/01/2004	03/03/2004	1,507.00	1.00
A17030074	A17030074	WILSON, HACK	148D789	041000010319	03/23/2004	03/26/2004	4,521.00	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 19 ~ CLAIM DISPUTES

Chapter 19 ~ Claim Disputes

REVISION DATES: 10/1/2018; 12/30/2015; 04/26/2013; 05/31/2012

General Information

Indian Health Service (IHS) and tribal 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 the 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 the 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.

For a retro-eligibility claim, the provider must institute any claim dispute within 12 months from the date of the eligibility posting.

If action 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 with OALS. 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 grievance/clean claim deadline 05/05/2014

Special 60-day claim dispute deadline

Because the denial of the resubmitted 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 Services701 E. Jefferson Street, 3rd Floor
Phoenix, AZ 85034

Providers also may submit a claim dispute via fax at (602) 253-9115.

Providers registered with AHCCCS Online also may submit a claim dispute via the AHCCCS Online Provider Portal as of August 16th, 2018. There are no changes to the claim dispute requirements when submitting online.

The claim dispute must state in detail the factual and legal basis of the claims 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 will send 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's 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 the Office of Administrative Legal Services 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, you 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 providers through the claim dispute process.

- If a provider files a claim dispute for 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 <u>specificity.</u>

The request must state why the claim dispute is being filed and why the provider believes 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 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 grievance 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	*The below updates do not represent a change in processes currently occurring.	
	On-line" changed to "online" to correct the AHCCCS Online provider portal name.	1
	Clarifying language was added to the Claim Dispute Process chapter.	2-3
	Providers registered with AHCCCS Online also may submit a claim dispute via the AHCCCS Online Provider Portal as of August 16th, 2018. There are no changes to the claim dispute requirements when submitting online.	3 3
	Clarifying language was added to the Approving a Claim Dispute section.	4
	The Hearing Process section was updated	4
	Updated the address for the Office of Administrative Hearings	5
	The Claim Dispute Submission Suggestions section had clarifying language added (changed from 'date' to 'The date of the call made to AHCCCS')	All
	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	7
	Dispute Avoidance Chapter updated with clarifying language	All
	Formatting	All

	Changes “member” to “member” throughout.	
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

CHAPTER 20 ~ 638 FQHC

Chapter 20 ~ 638 FQHC

Chapter Creation: 3/2/2018
Revision Dates: 10/1/2018; 5/23/2018

GENERAL INFORMATION

This billing manual chapter provides information about the 638 FQHC provider type, what facilities are eligible to make the change to become a 638 FQHC, and billing and claims information.

For any additional questions not answered in the contents of this chapter please email the Fee-for-Service Provider Training email inbox at ProviderTrainingFFS@azahcccs.gov.

What Providers are Eligible to Elect to Become a 638 FQHC?

Tribal 638 Clinics that are provider type 05 or 77 are eligible to elect to become a 638 FQHC. IHS Clinics are not eligible to become a 638 FQHC.

> Note: To elect to become a 638 FQHC, a Tribal 638 Clinic does **not** need to meet the requirements for receipt of grant funds under section 330 of the Public Health Service Act and does **not** need to meet the requirements for designation as a "look alike" FQHC by the Health Resources and Services Administration (HRSA).
>
> The **only** requirement the Tribal 638 Clinic must meet, in order to be recognized as an FQHC by Medicaid, is to be operated by a Tribe or Tribal organization under P.L. 93-638.
>
> The facility does **not** need to enroll in Medicare as an FQHC in order to change its designation to a 638 FQHC. A facility will be recognized as an FQHC by Medicaid if it is operated by a Tribe or Tribal organization in accordance with P.L 93-638.

4 WALLS

4 Walls Definition

The "4 Walls" of a 638 Clinic refer to the physical building the clinic operates within. The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that "clinic services" do not include any services delivered outside of the "four walls" of the clinic, except if services are provided to a homeless individual.

Due to this interpretation, even if a Tribal 638 Clinic has a written care coordination agreement in place with a non-Tribal provider, if the service takes place outside of the clinic's physical building then the clinic is unable to be reimbursed at the facility rate for clinic services. The reimbursement is instead based on the non-Tribal provider and service(s) rendered.

638 FQHC Exemption

FQHC facilities are exempt from the "4 Walls" requirement. An FQHC may bill the facility rate for services rendered to its patients outside of its "4 Walls" by a non-Tribal provider.

If an FQHC has a care coordination agreement with a non-Tribal provider, such as a neurologist, and the service is provided offsite (outside of the FQHC's building), the FQHC may still bill the facility rate for the service. However, the FQHC would need to bill for the service, **not** the offsite provider.

A Tribal 638 Clinic that elects to become a 638 FQHC will have the same exemption from the limitations of the "4 Walls" requirement that current FQHCs receive. A 638 FQHC will be able to bill for reimbursement at **the facility rate, also called the Alternative Payment Methodology (APM)**. Services provided in the member's home or at a facility acting as the member's home, such as an assisted living or skilled nursing facility, would also be eligible for reimbursement at the APM facility rate.

DOCUMENTATION REQUIREMENTS FOR ELECTING 638 FQHC STATUS

For information pertaining on how a Tribal 638 Clinic can elect to become a Tribal 638 FQHC, including all applicable provider registration requirements, please refer to Chapter 3, Provider Records and Registration, in the IHS/Tribal Provider Billing Manual.

REIMBURSEMENT AND VISIT LIMITS

638 FQHCs will receive reimbursement for authorized categories of service at an **Alternative Payment Methodology (APM)** rate, which is equivalent to the AIR (the OMB outpatient rate for all FQHC services). Authorized services are currently reimbursed at the AIR. For additional information on the APM please refer to the State Plan Amendment (SPA) surrounding 638 FQHCs, which is available on the AHCCCS website.

The published APM rate may be paid for up to five (5) encounters/visits per member, per day, per distinct visit.

> Note: The system is set up to automatically deny any claims submitted for reimbursement at the APM rate in excess of 5 per member, per day.

The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

> **Note:** Pharmacy and Non-Emergency Medical Transportation (NEMT) Services are **not** FQHC services. These services should continue to be billed as a part of the provider's **clinic** ID. These services should not be billed under the 638 FQHC provider type.

Pharmacy Services

Pharmacy services will **not** be billed under the new 638 FQHC provider type, and will continue to be billed for under the provider's previous designation (05). The reimbursement methodology for pharmacy services will *not change* and shall continue to be reimbursed at the **All Inclusive Rate (AIR).**

- Note: Only 1 AIR per member, per day, per pharmacy may be reimbursed. The AIR limits for pharmacy will not change.

Non-Emergency Medical Transportation (NEMT) Services

NEMT services will **not** be billed under the new 638 FQHC provider type, and will continue to be billed for under the provider's previous designation (05 or 77). The reimbursement methodology for NEMT services will *not change* and shall continue to be reimbursed at the **capped FFS fee schedule.** NEMT will not be reimbursed at the APM rate.

Case Management Services for Medical and Behavioral Health

Medical and behavioral health case management services, to be billed with T1016, will be billed under the C5 provider type. The reimbursement methodology for case management will be at the **capped FFS fee schedule.** Case management will not be reimbursed at the APM rate as it is not an FQHC service.

A 638 FQHC that is also an American Indian Medical Home (AIMH) will not be eligible for reimbursement of T1016. AIMHs receive a **Per Member Per Month (PMPM) rate** for case management services.

Group Therapy

Group therapy and/or any other services provided to a group do 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 and/or any other service provided to a group from being a PPS-eligible service.

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.

CLAIM SUBMISSION REQUIREMENTS

The preferred method of claims submission is via the 837 electronic claims process.

Claims may also be submitted via the AHCCCS Online provider portal, available on the AHCCCS website at:
https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

The final method of claims submission is via a paper claim form.

For information on submitting claims on the CMS 1500, UB-04, and ADA 2012 claim forms, please refer to Chapter 10 Addendum, FQHC/RHC; Chapter 5, Billing on the CMS 1500 Claim Form; Chapter 6, Billing on the UB-04 Claim Form; and Chapter 7, Billing on the ADA 2012 Claim Form of the Fee-For-Service Provider Billing Manual.

638 FQHC Clinic Visits

Claims for 638 FQHC services reimbursed at the APM rate shall be submitted on the **CMS 1500 claim form**. These services will be billed under the provider's new provider type (C5).

- Clinic Visit/Encounter - The APM should be entered on the first service line of the claim and HCPC code T1015 (FQHC visit/encounter, all inclusive) should be used.
- HCPC Codes & Charges - Claims must include all HCPC codes (including E&M codes) describing the services rendered as a part of the visit. These individual services will be billed with a $0.00 charge in the $ Charges column (Column F) of the CMS 1500 claim form.
- Modifiers - Multiple visits on the same day that are distinct and separate visits must be identified by billing the T1015 HCPC code with **modifier 25**. Modifier 25 indicates a same day, subsequent visit that is a distinct and separate visit. The modifier will be entered under the Modifier column in section D, Procedures, Services, or Supplies on the CMS 1500 claim form.
- APM - Include the APM in the Total Charges field (Field 28).

Pharmacy

Claims for pharmacy services shall be reimbursed at the AIR and submitted on the **UB-04 claim form**. These services will be billed under the provider's previous provider type (05). The UB-04 claim form must include the NDC codes for **all prescriptions filled that day**. However, only one (1) AIR shall be reimbursed.

- The outpatient AIR should be entered on the first service line of the claim and revenue code 0519 (Other Clinic) should be used.
- Include the AIR in the Total Charges field (Field 47), on the 0001 line.

Claims should be submitted with the facility's NPI as the attending provider, since AHCCCS does not register pharmacists.

Case Management Services for Medical and Behavioral Health

Claims for case management (behavioral health or medical), to be billed with T1016, will be reimbursed at the capped FFS fee schedule. Case management claims should be submitted on a CMS 1500 claim form.

- Note: A 638 FQHC that is also an American Indian Medical Home (AIMH) will not be eligible for reimbursement of T1016.

Professional Services

Claims for professional services shall be submitted on the **CMS 1500 claim form**. These services will be billed for under the individual practitioner's provider type. These services will be reimbursed at the capped FFS fee schedule.

Non-Emergency Medical Transportation (NEMT)

Claims for Non-Emergency Medical Transportation (NEMT) services shall be submitted on the **CMS 1500 claim form**. These services will be billed under the provider's previous provider type (05 or 77). These services will be reimbursed at the capped FFS fee schedule.

Dental Services

Claims submitted for dental services shall be submitted on the **ADA 2012 form**. These services will be billed under the 638 FQHC provider type (C5) and reimbursed at the APM.

Group Therapy

A Tribal 638 Clinic that elects to become a 638 FQHC can bill for group therapy services under their clinic provider type (05 or 77). The claim should be submitted on the CMS-1500 claim form and it will be reimbursed at the capped FFS fee schedule.

References

For additional guidance on the CMS interpretation of the "4 walls" please refer to the State Health Official letter from February 26, 2016 titled *Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives,* which can be found at https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf.

For additional information on the 638 FQHC provider type please refer to the FAQ released in January of 2017 at https://www.medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf.

For information on submitting claims on the CMS 1500, UB-04, and ADA 2102 claim forms, please refer to Chapter 5, Billing on the CMS 1500 Claim Form; Chapter 6, Billing on the

UB-04 Claim Form; and Chapter 7, Billing on the ADA 2012 Claim Form of the Fee-For-Service Provider Billing Manual.

For information on submitting FQHC claims on the CMS 1500 Claim Form, please refer to Chapter 10 Addendum, FQHC/RHC, in the Fee-For-Service Provider Billing Manual.

For general billing requirements, please refer to Chapter 4, General Billing Rules, and Chapter 5, Claim Form Requirements, of the IHS/Tribal Provider Billing Manual.

For information on initial provider registration requirements and documentation requirements for electing to become a 638 FQHC, please refer to Chapter 3, Provider Records and Registration, of the IHS/Tribal Provider Billing Manual.

For the definition of what qualifies as an FQHC visit please refer to the Chapter 10 Addendum, FQHC/RHC, of the Fee-For-Service Provider Billing Manual.

Revision History

Date	Description of changes	Page(s)
10/1/2018	A section on billing for group therapy was added	6
5/23/18	Group therapy section added BHT services section added Telehealth/telemedicine services sections added Reference added to direct the reader to the definition of a FQHC visit.	4 4 4 6
3/2/18	Initial Chapter Creation What Providers are Eligible to Elect to Become a 638 FQHC 4 Walls Documentation Requirements for Electing to Become a 638 FQHC Reimbursement & Visit Limits Pharmacy Reimbursement and limits NEMT Reimbursement Case Management Services for Medical and Behavioral Health Reimbursement General Claim Submission Requirements section added 638 FQHC Clinic Billing section added Pharmacy Billing section added Case Management Services for Medical and Behavioral Health Billing section added Professional Services Billing section added NEMT Billing section added Dental Billing section added References added Revision History	All 1 1-2 2 2-3 3 3 3 4 4 4-5 5 5 5 5 6 7