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AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PROVIDER NOTIFICATION

DATE: August 2, 2010

TO: All Interested Stakeholders

FROM: Marc Leib, M.D., J.D.
Chief Medical Officer

SUBJECT: AHCCCS Benefit Changes Effective October 1, 2010

In response to significant fiscal challenges facing the State and continuing growth in the Medicaid population, AHCCCS will implement several changes to the adult benefit package.

POPULATION

The changes to the benefit package will impact **all** adults 21 years of age and older, unless otherwise specified. This population includes both Acute Care AHCCCS members as well as members in the Arizona Long Term Care System (ALTCS). At this time, these changes also apply to American Indians regardless of whether they receive services through managed care or fee for service. AHCCCS will provide notice if there are any changes.

For AHCCCS eligible individuals with incomes at or below 100 % of the federal poverty level (FPL) who are also Medicare eligible as a Qualified Medicare Beneficiary (also known as QMB Dual Members), AHCCCS will continue to pay the applicable cost sharing (deductibles, co-pays, and coinsurance) for Medicare covered services that are no longer covered by AHCCCS. For AHCCCS members with incomes greater than 100% FPL who are also Medicare eligible (known as non-QMB Dual Members), AHCCCS will not pay cost sharing for Medicare covered services that are no longer covered by AHCCCS. Managed care members and providers are encouraged to contact the member's Health Plan/ Program Contractor to determine the circumstances under which Medicare cost sharing applies.

AHCCCS eligible members who are under the age of 21 years old will continue to receive the full benefit package available under the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program.

EFFECTIVE DATE OF BENEFIT CHANGES

AHCCCS is actively working with the Centers for Medicare and Medicaid Services (CMS) regarding the implementation of the legislatively mandated benefit changes as well as other changes to services authorized by ARS §36-2907. The benefit changes will be effective October 1, 2010. Please refer to the Attachments A and B for details.

NON-COVERED SERVICES & MEMBER BILLING

Although the Agency cannot provide you with legal advice, please be aware that AHCCCS rule R9-22-702 permits AHCCCS registered providers to bill AHCCCS members under very limited situations. The specific factual circumstances underlying each particular case are important in making such a determination, and providers are encouraged to consult with an attorney or legal advisor in making these decisions. However, State Law ARS §36-2903.01 L. prohibits providers from billing members, their representatives, or their financially responsible relatives for services that were reimbursed OR SHOULD BE reimbursed by the AHCCCS Program.

Administrative regulation R9-22-702 sets forth certain exceptions when AHCCCS members may be billed. Subsection D of this rule describes situations where providers may bill AHCCCS members after certain prerequisites are satisfied, including but not limited to advance written agreement by the member to pay the provider for a service which otherwise would not be covered or authorized by the health plan. Note that this provision does NOT permit a provider to bill a member for a service which *could* have been reimbursed by a health plan had the provider complied with plan requirements (such as obtaining prior authorization or timely filing a claim) but because the provider failed to do so, the provider was not paid. An example of this scenario is when a health plan would have reimbursed the provider for physical therapy but the provider neglected to timely file the claim with the health plan; in this example, the provider cannot bill the member because the denial of payment by the plan was due to the provider's failure to comply with the claim filing deadlines.

Because the specific facts in each case must be taken into consideration before determining whether billing a member is permissible, it may be helpful to discuss this matter with an attorney. For additional general information, you may also contact the AHCCCS Office of Inspector General at AHCCCSFraud@azahcccs.gov.

Additional information about the benefit changes can be found at http://www.azahcccs.gov/reporting/legislation/2010/BenefitChanges.aspx. Questions regarding the benefit changes can be e-mailed to LegislativeBenefitChange@azahcccs.gov.

Attachment A

AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)

BENEFIT TYPE	BENEFIT CHANGE	CODES NO LONGER BILLABLE *
Insulin Pumps	AHCCCS will eliminate coverage of Insulin pumps. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	E0784
Percussive Vests	AHCCCS will eliminate coverage of percussive vests. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	E0483
Bone-Anchored Hearing Aids	AHCCCS will eliminate coverage of Bone-Anchored Hearing AID (BAHA). Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8690, L8692
Cochlear Implants	AHCCCS will eliminate coverage of cochlear implants. Supplies, equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L8614
Prosthetics	AHCCCS is limiting this benefit change to apply only to the elimination of microprocessor controlled lower limbs and microprocessor controlled joints for lower limbs.	L5856, L5857, L5858 and L5973
Orthotics	AHCCCS will eliminate coverage of orthotics. Orthotics are described as devices prescribed by a physician or other licensed professionals of the healing arts to support a weak or deformed portion of the body. AHCCCS considers orthotics to generally be items in codes L0001-L4999 with some exceptions. (There are some supplies which are also listed in this range of orthotic codes. Those supplies will **not** be eliminated.) Equipment maintenance and repair of component parts will remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided at the time prior authorization is sought.	L0001 - L4999, Refer to **Attachment A-1** for exceptions-
Emergency Dental	Emergency adult dental services are eliminated. However, in accordance with federal law and the State Plan, AHCCCS will cover medical and surgical services furnished by a dentist only to the extent that such services	Refer to **Attachment A-2**

* Codes no longer billable for dates of service on or after 10/1/2010 unless otherwise noted

AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)

BENEFIT TYPE	BENEFIT CHANGE	CODES NO LONGER BILLABLE *
Service	may be performed under State law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician. For members 21 years of age and older, the services must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw. The covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Certain pre-transplant services (e.g. dental cleanings, fillings, restorations, extractions) and prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head are also covered.	for list of dental covered codes
Services by Podiatrist	Foot and Ankle Services provided by a podiatrist are no longer covered. Those services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.	Not Applicable
Well Exams	Well visits are no longer covered. Well exams means physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. However, pap smears, mammograms, and colonoscopies will still continue to be covered.	**CPT codes:** 99385 - 99387, 99395 - 99397 and S5190 **OR** professional claim (regardless of procedure code) with primary dx of V72.31 V70.0 V70.9
Transplants	E**ffective 10/1/2010, the following non-experimental transplants will not be covered (excluded from coverage) for persons age 21 years and older.** **Exception:** members who are in the "prep and transplant" phase or one of the post-transplant care phases for one of these transplants prior to 10/1/2010 will remain covered for the transplant and subsequent care. (This means that prior to October 1, the tissue has been harvested, the organ has been procured, or the transplant surgery has been performed **Transplants not covered** • Pancreas after kidney transplants • Lung transplants • Allogeneic unrelated hematopoietic cell (bone marrow) transplants • Liver transplants for members with a diagnosis of Hepatitis C • Heart transplants for non-ischemic cardiomyopathies	Specific transplant case types are eliminated.

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AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)

BENEFIT TYPE	BENEFIT CHANGE	CODES NO LONGER BILLABLE *
	• Any other transplants not listed as covered. "Non-ischemic cardiomyopathy" is defined as a condition in which the underlying cardiac abnormality has not resulted in irreversible permanent damage to the heart muscle. Members with "non-ischemic cardiomyopathy" have sufficient cardiac function to circulate adequate volumes of blood and oxygen to the heart muscle and other body organs. "Ischemic cardiomyopathy" is defined as an underlying cardiac abnormality that causes insufficient blood flow to the heart, resulting in permanent damage to the heart muscle. There are several causes of ischemic cardiomyopathy, including; 1) atherosclerotic coronary artery disease, which results in narrow blood vessels in the heart; 2) ventricular hypertrophy that impedes blood flow due to compression of arteries within the heart muscle; 3) heart failure with an ejection fraction that is not sufficient to provide adequate blood and oxygen to the heart muscle. The term "ischemic cardiomyopathy" when used in the context of this benefit restriction does not imply that the underlying cause of the cardiac abnormality is restricted to ischemia; rather, it is used to denote that the underlying cardiac abnormality results in ischemia with permanent, irreversible damage to the heart muscle. **Effective 10/1/2010**, **transplants which are covered** for persons age 21 years and older are limited to only: Heart, Liver, Kidney (cadaveric and live donor), Simultaneous Pancreas/Kidney (SPK), Autologous and Allogeneic Related Hematopoietic Cell Transplants, Cornea, and Bone. In order to be covered, the transplant must be medically necessary, not experimental, and not for the purpose of research.	
Physical Therapy	Outpatient physical therapy visits are limited to 15 visits per contract year (10/1--9/30). Outpatient physical therapy refers to any occurrence of codes 97001-97546; All provider types except for 13 (Occupational Therapist) 22 – (Nursing Home); All places of service excluding 31 (Nursing Home) 32 (Nursing facility), and 33 (Custodial Care Facility); Count each unique date of service as a visit; Form Type to include OP Hospital or 1500. **Refer to Attachment B for more detail regarding Medicaid only members, QMB duals, and Medicare Primary (non QMB duals)**	Not Applicable

* Codes no longer billable for dates of service on or after 10/1/2010 unless otherwise noted

Attachment A

AHCCCS BENEFIT CHANGE IMPLEMENTATION 10/1/2010
(Limited to Adult (Acute and ALTCS) Members 21 Years of Age and Older)

BENEFIT TYPE	BENEFIT CHANGE	CODES NO LONGER BILLABLE *
Bariatric Surgery	Bariatric surgery will not be eliminated. However, specific criteria for coverage for bariatric surgery will be developed and added to the AHCCCS Medical Policy Manual.	Not Applicable
DME	Per discussions with CMS, AHCCCS will not make changes to the current DME policy (DME does not include orthotics or prosthetics)	Not Applicable
Transport-ation	If approved by CMS, changes to non-emergency medical transportation will be implemented sometime after October 1, 2010. If implemented, there will be no impact to children, or members in the Arizona Long Term Care System, or members who live outside of Maricopa and Pima Counties.	Not Applicable

* Codes no longer billable for dates of service on or after 10/1/2010 unless otherwise noted

ORTHOTICS EXCEPTIONS

CODE	DESCRIPTION
L0859	Addition to Halo procedure, magnetic resonance image compatible systems rings and pins, any material.
L0861	Addition to halo procedure, replacement liner/interface material
L0980	Peroneal straps, pair
L0982	Stocking supporter grips, set of four (4)
L0984	Protective body sock, each
L2810	Addition to lower extremity orthosis, knee control, condylar pad
L2840	Addition to lower extremity orthosis, tibial length sock, fracture or equal, each
L2850	Addition to lower extremity orthosis, femoral length sock, fracture or equal, each
L4000	Replace girdle for spinal orthosis (ctlso or so)
L4002	Replacement strap, any orthosis, includes all components, any length, any type
L4010	Replace trilateral socket brim
L4020	Replace quadrilateral socket brim, molded to patient model
L4030	Replace quadrilateral socket brim, custom fitted
L4060	Replace high roll cuff
L4070	Replace proximal and distal upright for kafo
L4080	Replace metal bands kafo, proximal thigh
L4090	Replace metal bands kafo-afo, calf or distal thigh
L4100	Replace leather cuff kafo, proximal thigh
L4110	Replace leather cuff kafo-afo, calf or distal thigh
L4130	Replace pretibial shell
L4205	Repair of orthotic device, labor component, per 15 minutes
L4210	Repair of orthotic device, repair or replace minor parts
L4392	Replacement, soft interface material, static afo
L4394	Replace soft interface material, foot drop splint

DENTAL HCPC CODES INFORMATION
(Limited To Adult Members 21 Years Of Age And Older)

Note:

- Reimbursement of dental codes are limited to members under age 21 except for the limited set of codes indicated by "X" below for medically necessary services.
- Adult pre-transplant recipients may receive additional dental treatment in preparation for a transplant. The additional codes available for pre-transplant recipients are indicated by "T" below.

Code	Codes indicated by an "X", remain reimbursable for members 21 years of age and older	Additional codes limited to transplant preparation for adults are indicted by "T"	Description (may be truncated)
D0120		T	Periodic oral evaluation - established patient
D0140	X		Limited oral evaluation - problem focused
D0150		T	Comprehensive oral evaluation - new or established patient
D0160		T	Detailed and extensive oral evaluation - problem focused, by report
D0180		T	Comprehensive periodontal evaluation - new or established patient
D0210		T	Intraoral-complete series (including bitewings)
D0220	X		Intraoral-periapical-first film
D0230	X		Intraoral-periapical-each additional film
D0240	X		Intraoral-0cclusal film
D0250	X		Extraoral-first film
D0260	X		Extraoral-each additional film
D0270		T	Bitewing-single film
D0272		T	Bitewings-two films
D0273		T	Bitewings - three films
D0274		T	Bitewings-four films
D0277		T	Vertical bitewings - 7 to 8 films
D0290	X		Posterior-anterior or lateral skull and facial bone survey film

D0320	X		Temporomandibular joint arthrogram, including injection
D0321	X		Other temporomandibular joint films, by report
D0330	X		Panoramic film
D0502		T	Other oral pathology procedures, by report
D0999		T	Unspecified diagnostic procedure, by report
D1110		T	Prophylaxis-adult
D1204		T	Topical application of fluoride - adult
D2140		T	Amalgam-one surface, primary or permanent
D2150		T	Amalgam-two surfaces, primary or permanent
D2160		T	Amalgam-three surfaces, primary or permanent
D2161		T	Amalgam-four or more surfaces, primary or permanent
D2330		T	Resin-one surface, anterior
D2331		T	Resin-two surfaces, anterior
D2332		T	Resin-three surfaces, anterior
D2335		T	Resin-four or more surfaces or involving incisal angle (anterior)
D2390		T	Resin-based composite crown, anterior
D2391		T	Resin-based composite - one surface, posterior
D2392		T	Resin-based composite - two surfaces, posterior
D2393		T	Resin-based composite - three surfaces, posterior
D2394		T	Resin-based composite - four or more surfaces, posterior
D2799		T	Provisional crown
D2910		T	Recement inlay, onlay or partial coverage restoration
D2915		T	Recement cast or prefabricated post and core
D2920		T	Recement crown
D2931		T	Prefabricated stainless steel crown-permanent tooth
D2932		T	Prefabricated resin crown
D2940		T	Sedative filling
D2950		T	Core build-up, including any pins
D2951		T	Pin retention-per tooth, in addition to restoration
D2952		T	Post and core in addition to crown, indirectly fabricated
D2954		T	Prefabricated post and core in addition to crown
D2999		T	Unspecified restorative procedure, by report
D3221		T	Pulpal debridement, primary and permanent teeth

D3310		T	Endodontic therapy, anterior tooth (excluding final restoration)
D3346		T	Retreatment of previous root canal therapy-anterior
D3410		T	Apicoectomy/periradicular surgery-anterior
D3430		T	Retrograde filling-per root
D3999		T	Unspecified endodontic procedure, by report
D4210		T	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded or
D4211		T	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded
D4240		T	Gingival flap procedure, including root planing - four or more contiguous teeth
D4241		T	Gingival flap procedure, including root planing - one to three contiguous teeth
D4260		T	Osseous surgery (including flap entry and closure) - four or more contiguous
D4261		T	Osseous surgery (including flap entry and closure) - one to three contiguous
D4341		T	Periodontal scaling and root planing - four or more teeth per quadrant
D4342		T	Periodontal scaling and root planing - one to three teeth, per quadrant
D4355		T	Full mouth debridement to enable comprehensive evaluation and diagnosis
D4910		T	Periodontal maintenance
D4920		T	Unscheduled dressing change (by someone other than treating dentist)
D4999		T	Unspecified periodontal procedure, by report
D6930		T	Recement bridge
D7140		T	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210		T	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap
D7220		T	Removal of impacted tooth-soft tissue
D7230		T	Removal of impacted tooth-partially bony
D7240		T	Removal of impacted tooth-completely bony
D7241		T	Removal of impacted tooth-completely bony, with unusual surgical complications

D7250		T	Surgical removal of residual tooth roots (cutting procedure)
D7260	X		Oral antral fistula closure
D7261	X		Primary closure of a sinus perforation
D7285	X		Biopsy of oral tissue - hard (bone, tooth)
D7286	X		Biopsy of oral tissue - soft
D7292	X		Surgical placement: temporary anchorage device [screw retained plate] requiring
D7293	X		Surgical placement: temporary anchorage device requiring surgical flap
D7294	X		Surgical placement: temporary anchorage device without surgical flap
D7410	X		Excision of benign lesion up to 1.25 cm
D7411	X		Excision of benign lesion greater than 1.25 cm
D7412	X		Excision of benign lesion, complicated
D7413	X		Excision of malignant lesion up to 1.25 cm
D7414	X		Excision of malignant lesion greater than 1.25 cm
D7415	X		Excision of malignant lesion, complicated
D7440	X		Excision of malignant tumor-lesion diameter up to 1.25 cm
D7441	X		Excision of malignant tumor-lesion diameter greater than 1.25 cm
D7450	X		Removal of benign odontogenic cyst or tumor-lesion diameter up t0 1.25 cm
D7451	X		Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm
D7460	X		Removal of benign nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm
D7461	X		Removal of benign nonodontogenic cyst or tumor-lesion diameter greater than
D7465	X		Destruction of lesion(s) by physical or chemical methods, by report
D7490	X		Radical resection of maxilla or mandible
D7510	X		Incision and drainage of abscess-intraoral soft tissue
D7511	X		Incision and drainage of abscess - intraoral soft tissue - complicated
D7520	X		Incision and drainage of abscess-extraoral soft tissue
D7521	X		Incision and drainage of abscess - extraoral soft tissue - complicated

D7530	X		Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	X		Removal of reaction-producing foreign bodies-musculoskeletal system
D7550	X		Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	X		Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	X		Maxilla-open reduction (teeth immobilized if present)
D7620	X		Maxilla-closed reduction (teeth immobilized if present)
D7630	X		Mandible-open reduction (teeth immobilized if present)
D7640	X		Mandible-closed reduction (teeth immobilized if present)
D7650	X		Malar and/or zygomatic arch-open reduction
D7660	X		Malar and/or zygomatic arch-closed reduction
D7670	X		Alveolus - closed reduction, may include stabilization of teeth
D7671	X		Alveolus - open reduction, may include stabilization of teeth
D7680	X		Facial bones-complicated reduction with fixation and multiple surgical
D7710	X		Maxilla-open reduction
D7720	X		Maxilla-closed reduction
D7730	X		Mandible-open reduction
D7740	X		Mandible-closed reduction
D7750	X		Malar and/or zygomatic arch-open reduction
D7760	X		Malar and/or zygomatic arch-closed reduction
D7770	X		Alveolus - open reduction stabilization of teeth
D7771	X		Alveolus, closed reduction stabilization of teeth
D7780	X		Facial bones-complicated reduction with fixation and multiple surgical
D7810	X		Open reduction of dislocation
D7820	X		Closed reduction of dislocation
D7830	X		Manipulation under anesthesia
D7840	X		Condylectomy
D7850	X		Surgical discectomy; with/without implant
D7852	X		Disc repair
D7854	X		Synovectomy
D7856	X		Myotomy

D7858	X		Joint reconstruction
D7860	X		Arthrotomy
D7865	X		Arthroplasty
D7870	X		Arthrocentesis
D7871	X		Non-arthroscopic lysis and lavage
D7872	X		Arthroscopy-diagnosis, with or without biopsy
D7873	X		Arthroscopy-surgical: lavage and lysis of adhesions
D7874	X		Arthroscopy-surgical: disc repositioning and stabilization
D7875	X		Arthroscopy-surgical: synovectomy
D7876	X		Arthroscopy-surgical: discectomy
D7877	X		Arthroscopy-surgical: debridement
D7880	X		Occlusal orthotic appliance
D7899	X		Unspecified tmd therapy, by report
D7910	X		Suture of recent small wounds up to 5 cm
D7911	X		Complicated suture-up to 5 cm
D7912	X		Complicated suture-greater than 5 cm
D7920	X		Skin graft (identify defect covered, location, and type of graft)
D7940	X		Osteoplasty-for orthognathic deformities
D7941	X		Osteotomy - mandibular rami
D7943	X		Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	X		Osteotomy-segmented or subapical
D7945	X		Osteotomy-body of mandible
D7946	X		Lefort i (maxilla-total)
D7947	X		Lefort i (maxilla-segmented)
D7948	X		Lefort ii or lefort iii (osteoplasty of facial bones for midface hypoplasia or
D7949	X		Lefort ii or lefort iii-with bone graft
D7950	X		Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla -
D7951	X		Sinus augmentation with bone or bone substitutes
D7953	X		Bone replacement graft for ridge preservation - per site
D7955	X		Repair of maxillofacial soft and/or hard tissue defect
D7970		T	Excision of hyperplastic tissue-per arch

D7971		T	Excision of pericoronal gingiva
D7972		T	Surgical reduction of fibrous tuberosity
D7980	X		Sialolithotomy
D7981	X		Excision of salivary gland, by report
D7982	X		Sialodochoplasty
D7983	X		Closure of salivary fistula
D7990	X		Emergency tracheotomy
D7991	X		Coronoidectomy
D7995	X		Synthetic graft-mandible or facial bones, by report
D7996	X		Implant-mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	X		Appliance removal (not by dentist who placed appliance), includes removal of
D7998	X		Intraoral placement of a fixation device not in conjunction with a fracture
D7999	X		Unspecified oral surgery procedure, by report
D9220	X		Deep sedation/general anesthesia-first 30 minutes
D9221	X		Deep sedation/general anesthesia-each additional 15 minutes
D9230	X		Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	X		Intravenous conscious sedation/analgesia - first 30 minutes
D9242	X		Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	X		Non-intravenous conscious sedation
D9310		T	Consultation - diagnostic service provided by dentist or physician other than
D9410	X		House/extended care facility call
D9420	X		Hospital call
D9610		T	Therapeutic parenteral drug, single administration
D9930		T	Treatment of complications (postsurgical) - unusual circumstances, by report
D9951		T	Occlusal adjustment-limited

Attachment B

APPLICATION OF PHYSICAL THERAPY 15 VISIT OUTPATIENT LIMIT
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER

CONDITION	CONTRACTOR IMPLEMENTATION (Fiscal Implications)
Member is Medicaid only and is not Medicare eligible. (Also known as non dual)	Contractor is responsible for the visit up to 15 PT visits per contract year.
Member is Dual Eligible (Also known as Medicare Primary, non QMB dual)	Contractor is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to 15 PT visits. • In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor 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 members' responsibility. • In the event that the member exhausts the 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 Contractor.
Member is QMB Dual	Contractor is responsible for Medicare cost sharing up to Medicare maximum dollar amount. • In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached. • In the event that member exhausts the 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 Contractor.

Definitions:

Visit - a visit equals PT services received in one day. The 15 visit limit applies regardless that the member has the same contractor or changes contractors during the contract year.

Setting - Any out patient 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 QMB.

QMB Dual -An individual who is Medicare and Medicaid eligible with income not exceeding 100%FPL.