





IHS/638 Providers Quarterly Billing Forum

First Quarter 2023

Tuesday, February 14, 2023

Time: 2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

IHS/638 2023 First Quarter Billing Forum

- Quarterly Tribal Consultation Events
- Pending IHS/638 Providers All Inclusive Rate (AIR) Updates for 2023
- Public Health Emergency PHE)
- American Indian Medical Home (AIMH)
- Serious Mental Illness (SMI)
- Participating Provider Reporting Requirements
- IHS/638 Dental Limits Update
- NEMT Pickup/Drop Off
- Title XXI Billing KidsCare Claims
- Billing Third Party Liability Claims
- Billing Medicare Secondary Claims
- School Based Claiming
- Ambulatory Surgery Center
- NEMT Transports for COVID-19




Upcoming
Quarterly Tribal Consultation Events

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Upcoming Quarterly Tribal Consultation Events

Quarterly Tribal Consultation Session	May 11, 2023 (Thursday)	1:00 p.m. - 5:00 p.m. (Arizona Time)
Quarterly Tribal Consultation Session	August 10, 2023 (Thursday)	1:00 p.m. – 5:00 p.m. (Arizona Time)
Quarterly Tribal Consultation Session	November 09, 2023 (Thursday)	1:00 p.m. - 5:00 p.m. (Arizona Time)

Please check AHCCCS Tribal Consultation web page for meeting information.




2023 All-Inclusive Rate

2023 All Inclusive Rate (AIR)

The Federal Register has not published the 2023 All Inclusive Rates (AIRs). Once notification is received, AHCCCS will send an email alert notifying IHS/638 Tribal providers of the new AIR rates.

Additional communications will be sent regarding the Claim Recycle process.




Public Health Emergency (PHE) Extension

Public Health Emergency (PHE) Extension

At the present time, the federal government plans to extend the PHE through May 11, 2023. The Biden administration has indicated it will continue to provide a 60-day notice period before any end to the PHE.

To view additional information, refer to the Preparing for the End of COVID-19: Return to Normal Renewals web page.




American Indian Medical Home (AIMH)

What is an American Indian Medical Home

American Indian Medical Homes help address health disparities that exist between American Indians and other populations in Arizona by offering services and supports which improve access to critically needed care. Learn more about DFSM's efforts on the AIMH web page.

AIHM Provider Requirements

- Be an IHS or Tribal 638 facility,
- Enter into an AIMH Intergovernmental Agreement (IGA),
- Primary Care Medical Home (PCMH) accreditation,
- Provide 24-hour telephonic access to the care team,
- Dependent on selected Tier Level,
  - Provide diabetes education, or
  - Participate bi-directionally in the State Health Information Exchange (HIE).

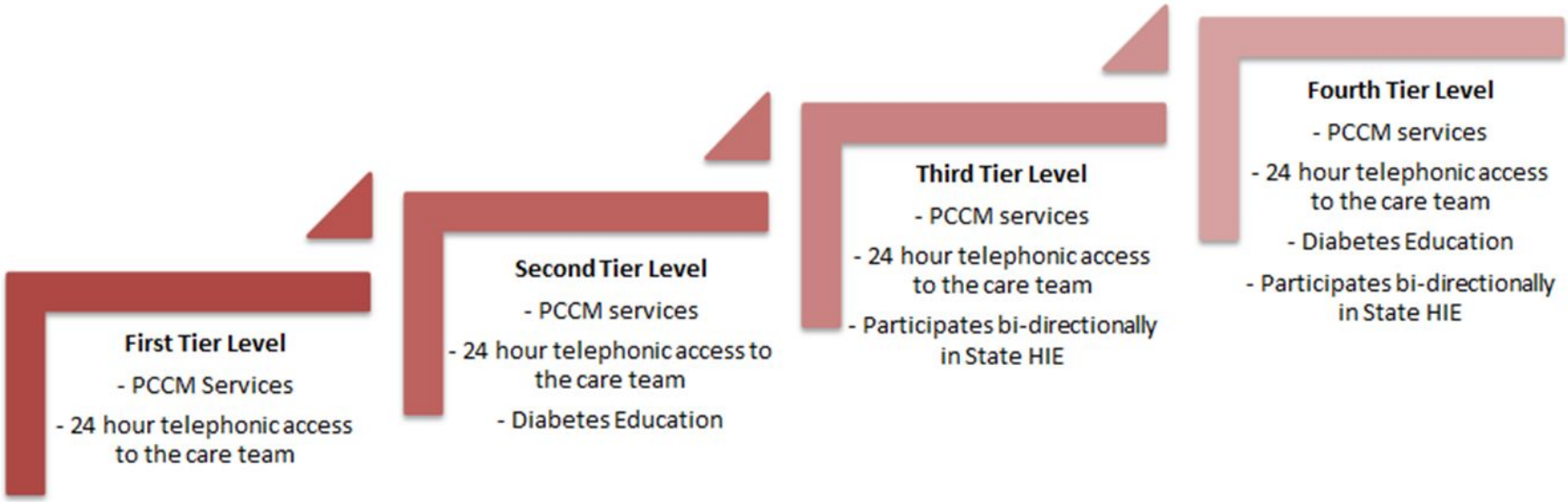
AIMH Reimbursement Rates

- Facilities who choose to become an AIMH will receive a Prospective Per Member Per Month (PMPM) rate for services provided by their medical home.
- Payments are dependent upon the AIMH tier level selected.
- Tier levels (4) include annual rate increases.

IHS/638 Provider Types that can choose to become a American Indian Medical Home Provider

Provider Type	Description
02	Hospital
05	Clinic
29	Community Rural Health Center
C2	Federally Qualified Health Center
C5	638 Federally Qualified Health Clinic (FQHC)
IC	Integrated Clinic

American Indian Medical Home Tiers



AIMH Reimbursement Rates 2023

AIMH 4.6% Rate Increase Calculation 10- Year Forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Level 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
Level 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
Level 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
Level 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Chinle Comprehensive Healthcare	4	**14,552**
Fort Yuma Health Care	1	**11**
Parker Indian Health Center	1	**917**
Phoenix Indian Medical Center	2	**5,562**
San Carlos Apache Healthcare	4	**5,539**
Tuba City Regional Healthcare Corporation	4	**2,618**
Whiteriver Indian Hospital	2	**6,799**
Winslow Indian Health Care	4	**4114**




AIHP Member Transition
Serious Mental Illness (SMI)
Effective 10/01/2022

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RHBA Member Transitions

Individuals with an SMI designation currently enrolled with the American Indian Health Program (AIHP) for physical health services and receiving behavioral health services from a Regional Behavioral Health Authority (RBHA) will have:

- Behavioral Health services ***transition*** to AIHP effective 10/1/2022, and
- Physical health services ***continue*** with AIHP.

TRBHA Member Transitions

Individuals with an SMI designation currently enrolled with an AHCCCS Complete Care (ACC) plan for physical health services and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA) will have:

- Physical health services ***transition*** to AIHP effective 10/1/2022, and
- Behavioral health services ***continue*** with TRBHA.




Participating Provider Reporting Requirements

Participating Provider Reporting Requirements

Effective for dates of service on and after January 1, 2023, the following provider types must report the actual professional practitioner (provider) participating in/performing services associated with clinic visits.

- Provider Types:
  - Integrated Care Clinic (PT IC),
  - Behavioral Health Outpatient Clinic (PT 77) and,
  - Clinic (PT 05)

Participating Provider Reporting Requirements

- Providers must follow the requirements outlined in Exhibit 8-2 in the AHCCCS IHS/Tribal Provider Billing Manual for the participating provider reporting requirements and billing instructions for proper claims submissions.
- Effective July 1, 2023, any claim filed without the participating provider information will be systematically denied.
- https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/Exhibit8-2ParticipatingProvider.pdf




IHS/638 Dental Limit Updates

Dental Limit Eliminated for AI/AN Receiving Services at IHS/638 Tribal Facilities

Effective 10/14/2022:

- The $1000 dental services limits for AI/AN members over 21 years of age, and AI/AN ALTCS members, receiving services for Medically necessary diagnostic, therapeutic, and preventative dental services at IHS/638 facilities are eliminated.
- This expenditure authority applies only when dental services are provided to American Indian/Alaskan Native (AI/AN) beneficiaries who receive services from participating IHS facilities and/or participating Tribal 638 facilities.

Dental Services Performed Outside IHS/638 Facilities

AHCCCS covered dental services performed outside of the IHS/638 Tribal facilities remain limited to the $1000 Emergency Dental Benefit for members 21 years of age and over, and additional $1000 for members enrolled in ALTCS.




Non-Emergency Medical Transport (NEMT) Reporting Pick-up and Drop-off Information

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Reporting Pickup/Drop Off Information

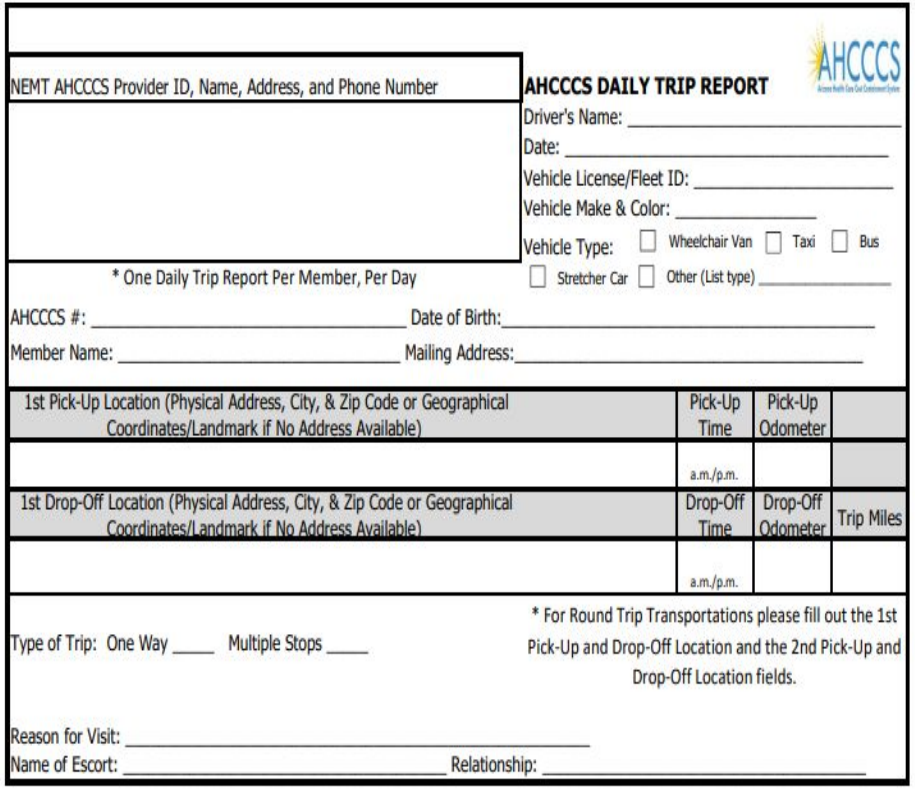
- Reminder effective for dates of services 11/01/2022 and after, the pickup and drop off information must be reported on the claim submission.
- This change applies to paper submissions on the CMS 1500 claim form, electronic EDI (837P) transaction and the AHCCCS Online Provider Portal.

Reporting Pickup/Drop Off Information

- The pickup and drop off information can be entered in the ***Additional Claim Information*** field (Box 19) and please note spacing is limited.
- NEMT claim submissions providers must continue to include a copy of the AHCCCS Daily Trip Report with each claim.

Reporting Pickup/Drop Off Information

- The pickup and drop off information can be entered in the *Additional Claim Information* field (Box 19) on the CMS 1500 (professional) claim format and spacing in this field is limited.
- NEMT claim submissions providers must continue to include a copy of the AHCCCS Daily Trip Report with each claim.



NEMT AHCCCS Provider ID, Name, Address, and Phone Number

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) _____

* One Daily Trip Report Per Member, Per Day

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 ____

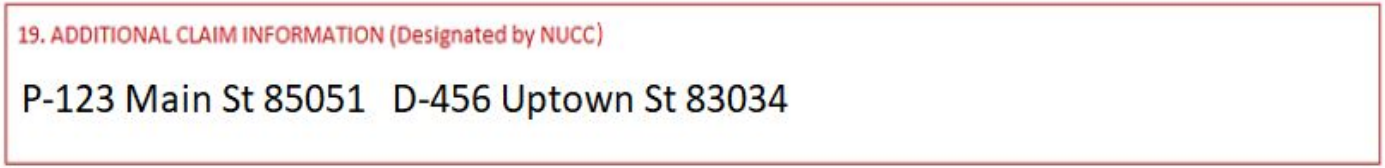
* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.

Reason for Visit: _____

Name of Escort: _____ Relationship: _____

Claim Submission Tips (cont.)

- As spacing may be limited in the additional claim information field, we suggest to abbreviate an address to allow more characters, i.e., St, Rd, Ave, Ln, Blvd.
- If a house or street assignment is not available for the pickup, providers can enter the GPS coordinates for the pickup information.
- Do not enter the city and state. The Zip code is ***required*** and is used to identify the city and state
- Example:



NEMT Pick Up/Drop Off Address Updates (cont.)

If the pick-up and drop off information is missing or incomplete this will result in an automatic denial of the claim.

Below are the most common denial reason codes that may appear on the remittance advice if the pick-up and drop off information is missing and or incomplete on the claim form.

Denial Reason Code	Description
L214.3	Incomplete address and Zip Code
L214.4	No Address Listed




Title XXI (KidsCare)
Billing Reminders

Submitting Title XXI KidsCare Claims

If the member is enrolled in an ACC Plan	Submit the claim to the ACC plan.
If the member is enrolled in AHCCCS FFS or AIHP	Submit the claim to AHCCCS DFSM.

Title XXI KidsCare Billing Reminders

- KidsCare Members: Services provided to Title XXI (KidsCare) members are not reimbursable at the All Inclusive Rate (AIR)

Billing example: A claim is submitted for a member enrolled in the KidsCare program. The claim is submitted on the UB-04 claim form.

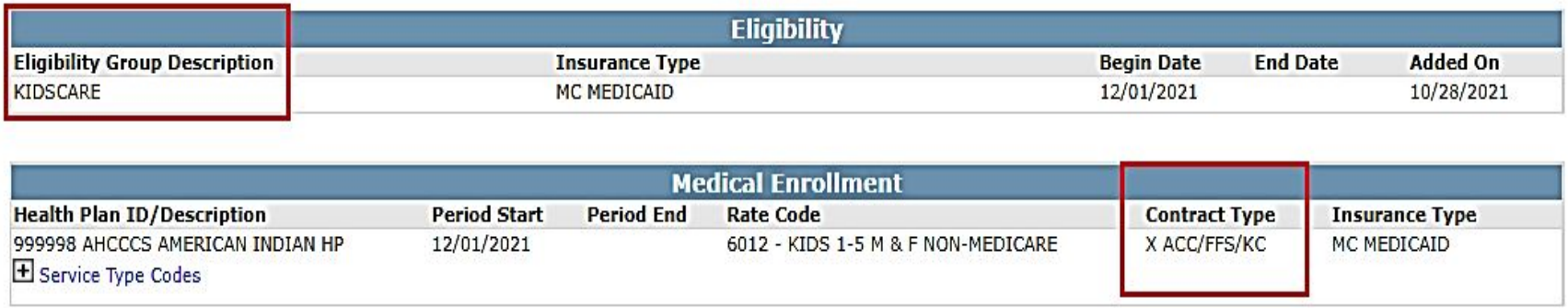
- The claim will deny with the remark code

  AD102 - "IHS/638 KidsCare must bill on the CMS 1500, Dental (ADA) or Point of Sale for (pharmacy service) to AHCCCS".

Verifying KidsCare Enrollment

Providers can verify eligibility and enrollment for any member enrolled with AHCCCS Medicaid using the AHCCCS Online Provider Portal.

Select the member verification tab, under the field title **Eligibility Group Description** you will see KidsCare. Under the field title **Contract Type** you will see ACC/FFS/KC (KidsCare).



Eligibility

Eligibility Group Description	Insurance Type	Begin Date	End Date	Added On
KIDSCARE	MC MEDICAID	12/01/2021		10/28/2021

Medical Enrollment

Health Plan ID/Description	Period Start	Period End	Rate Code	Contract Type	Insurance Type
999998 AHCCCS AMERICAN INDIAN HP	12/01/2021		6012 - KIDS 1-5 M & F NON-MEDICARE	X ACC/FFS/KC	MC MEDICAID
⊞ Service Type Codes					




Billing Third Party Liability Claims

Third Party Liability (TPL) Secondary Claims

- When submitting a secondary claim, providers must include the primary payer's *Explanation of Benefits* which details how the claim was processed and or denied by the payer.
- Reconsideration:
  - Providers must follow the primary payer's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the primary payer's appeal decision for consideration of reimbursement of the claim.




Billing Medicare Secondary Claims

Parts of Medicare Coverages

Medicare Part A covers inpatient care in hospitals, skilled nursing facility, home health, hospice care and more.

Medicare Part B covers physician services, durable medical equipment X-rays, labs, etc.

Medicare Part C is also referred to as a Medicare Advantage plan, which combines Medicare parts A, B, and may also include Medicare Part D drug coverage.

Medicare Part D provides prescription drug coverage.

Reminders: Billing Medicare Secondary Claims

- Medicare secondary claims refers to any claims for which AHCCCS is the secondary payer after Medicare and any other third party payer.
- AHCCCS will consider Medicare secondary claims even if the claim includes procedures that were not covered by Medicare.
- A copy of the Medicare Explanation of Benefits is required with each claim submission.
- All services billed to AHCCCS are subject to Medicaid policy and are subject to review.

Medicare Claims Process

- Medicare pays first for members enrolled in Medicare Parts *A,B,C or D* coverage.
- Medicaid pays after all first and third party payers.
- Medicare direct crossover claims are considered based on the information presented on the claim (copay, coinsurance, deductible).
- Replacement Claims:
  - Attachments required with the initial claim submission are required for replacement claim submissions.
  - Claim corrections can be done via the Online Portal.

Submitting Medicare Secondary Claims

- When submitting a secondary claim, please include the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* information identifying why Medicare denied the claim, this may be due to exhausted benefits, medical necessity or eligibility, or another reason that may apply.
- Reconsiderations:
  - Providers must follow Medicare's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the Medicare appeal decision for consideration of reimbursement of the claim.




Ambulatory Surgery Center Billing

Ambulatory Surgery Center

As a reminder, the training team has created a training course designed specifically for IHS/638 providers that cover billing ASC services on the CMS 1500 claim format.

The link to this training guide is ***IHS/638 Tribal Facility Billing Guide Ambulatory Surgery Center (ASC)***.




NEMT Transports for Covid-19 Vaccine Administration

Covid-19 Vaccine Billing Information

(updated 1/19/23) **Question: Are AHCCCS members able to use Veyo or other Medicaid-funded transportation to get to their vaccine appointment?**

Answer: Non-emergency medical transportation (NEMT) is a covered Medicaid service, available to any AHCCCS member who is unable to provide their own transportation, or find alternative transportation, to a covered Medicaid service appointment. Traditional NEMT (when a member is dropped off for a service and then picked up to return home) will be used for AHCCCS members who need transportation to COVID-19 vaccinations where two trips, a drop-off and pick-up, are appropriate.

Please refer to the **COVID-19 FAQ** webpage for more information.




DFSM Provider Education and Training Unit

DFSM Provider Education and Training

Our goal is to help providers understand billing policy and successful claim submission for the FFS program.

The provider training team offers eLearning and video training presentations on specific topics which are in a self-paced format that allows providers to access trainings. We encourage the attendance of billing staff and agencies, practitioners and others to attend.

DFSM Provider Education and Training

The provider training schedules are posted quarterly on the DFSM Provider Education Web page and registration is required to attend.

- DFSM Provider Training includes at any time and provide important information about how to use the AHCCCS Online Provider portal and the Transaction Insight Portal, recorded webinars and job aids for FFS providers.
- Courses can be attended remotely from any location via Zoom. To register for a session, click on the "Zoom Registration Link".
- For additional training videos, providers can visit the AHCCCS Medicaid YouTube Channel.

DFSM Provider Education and Training Updates

Upcoming IHS/638 Tribal Provider Billing Forums:

- To be announced.

Provider Training Requests and Questions email: **Providertrainingffs@azahcccs.gov**

Call Center Services

If you have questions regarding claims that cannot be resolved on the online portal, please outreach the Call Center unit at:

- (602) 417-7670 – Select Option 4
- Use the AHCCCS Online Provider Portal to view claims.
- AHCCCS Online Provider Portal

Provider Assistance

Call from 602, 623, or 480 area codes: 602-417-7670 and select option 5

Call from 928 or 520 area codes: 1-800-794-6862

Call from any other area code: 1-800-523-0231

Provider Assistance Call Center Hours: Mon.-Fri., 8 a.m. - 5 p.m.

Email: APEPtrainingquestions@azahcccs.gov

New Providers: AZ-APEP.gov/UserRegistration

Existing Providers: AZAPEPLogin.com

FFS Prior Authorizations

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
  - https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/
- DFSM Prior Authorization Web Page:
  - https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231

IHS 638 Provider Billing and Policy Resources

AHCCCS FFS Provider Billing Manual:

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

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual

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

Questions?

Thank You.