





IHS 638 Quarterly Billing Forum

Fourth Quarter 2022

Wednesday, November 9, 2022

Time: 2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

IHS/638 Quarterly Billing Forum Agenda

- Upcoming Tribal Consultation
- IHS/638 Dental Limit Updates
- Participating Provider Extension
- Public Health Emergency Extension
- American Indian Medical Homes (AIMH)
- Ambulatory Surgical Center (ASC) Overview
- Non-Emergency Medical Transportation (NEMT) Address Information Updates
- Title XXI (KidsCare) Billing Reminders
- Vaccine Reminders
- AHCCCS Complete Care / RHBAs
- Serious Mental Illness Integration
- Reminders Medicare and Third-Party Liability Billing

Upcoming Announcements

Upcoming Events

February 09, 2023 at 1 p.m.

Please check AHCCCS Tribal Consultation web page for meeting information.

IHS/638 Dental Limit Updates

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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 on ALTCS.

Participating Provider Reporting Requirements Deadline Extended

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Provider Participation Modifier Deadline Extended

- AHCCCS has extended the deadline for providers to begin reporting the individual practitioner who rendered services on professional and dental service claims until January 1, 2023.

- This requirement impacts all claims for AHCCCS providers registered as:
  - Integrated Clinics (Provider Type IC),
  - Behavioral Health Outpatient Clinics (Provider Type 77), and
  - Clinics (Provider Type 05).

Provider Participation Modifier Deadline Extended

- For additional guidance refer to the AHCCCS Fee-For-Service Provider Billing Manual for billing instructions for proper claims submissions.
- FFS Provider Billing Manual, Exhibit 10-1, Participating Provider Information

Public Health Emergency (PHE) Extension

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Public Health Emergency (PHE) Extension

Health and Human Services Secretary Xavier Becerra has formally extended the Public Health Emergency (PHE) to January 11, 2023. The Biden administration has indicated it will 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 Homes (AIMH)

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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.

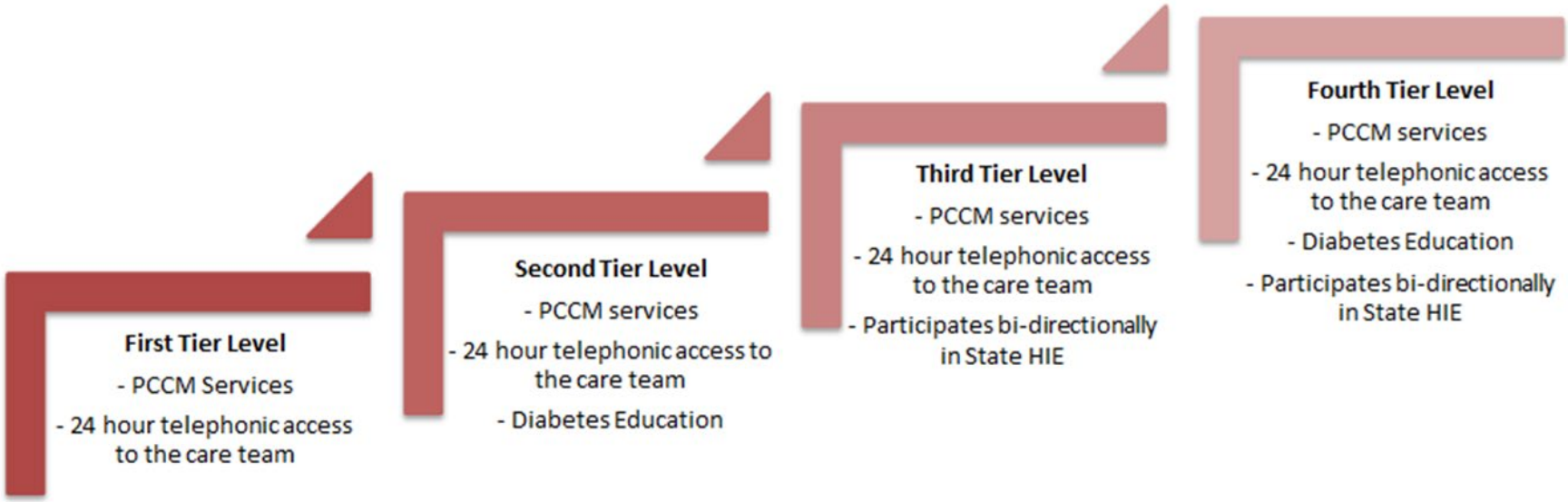
AIHM Provider Requirements

- 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).

AIHM Medical Provider Types

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 2022

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

AIMH	Tier Level	Members
Chinle Comprehensive Healthcare	4	**14,283**
Fort Yuma Health Care	1	**11**
Parker Indian Health Center	1	**849**
Phoenix Indian Medical Center	2	**5,547**

Current AIMHs and Members

AIMH	Tier Level	Members
San Carlos Apache Healthcare	4	**5,229**
Tuba City Regional Healthcare Corporation	4	**2,628**
Whiteriver Indian Hospital	2	**6,668**
Winslow Indian Health Care	4	**4,092**

Ambulatory Surgery Center (ASC) Overview

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Ambulatory Surgery Center

The following slides will give a general overview of the Ambulatory Surgery Center (ASC). Additional ASC information is provided in the ***IHS/638 Tribal Facility Billing Guide Ambulatory Surgery Center (ASC)*** presentation.

Ambulatory Surgery Center

- An Ambulatory Surgical Center (ASC) is a certified, free-standing facility that operates exclusively for the purpose of furnishing outpatient surgical services that are on the approved ASC list.
- Ambulatory surgical centers can be identified as:
  - A hospital-based entity, or
- A freestanding outpatient surgical center that operates exclusively for the purpose of furnishing outpatient surgical procedures *that does not require a hospital stay*.

Medicare ASC Guidelines

- All IHS/638 Tribal ASCs must be approved by CMS.
- Medicare approves all surgical procedure codes that can be performed in an ASC setting. AHCCCS follows Medicare's guidelines.
- Surgical procedures that are *excluded* from the Medicare ASC list will not be considered.
- Inpatient designated procedure codes are not allowed to be performed at an ASC and are not payable by AHCCCS.

Prior Authorization Is Not Required For Services Performed in an IHS/638 Tribal Facility

- Surgical procedures performed at an IHS/638 tribal facility will not require a prior authorization but may require the submission of a consent form(*i.e., voluntary sterilization*) based on the procedure rendered.
- Note: A procedure performed at a non-IHS/638 facility including an ASC, the standard DFSM PA requirements may apply. Providers should review the current PA Requirements list for guidance.

https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/ProcedurePARequirements4-2021.xlsx

Services Included in the ASC Fee Schedule

The ASC Capped Fee Schedule payment covers all services provided in the ASC including but not limited to:

- Nursing and technician services,
- Medical supplies,
- Surgical dressings,
- Splints & casts,
- Blood,
- Materials for anesthesia, and/or
- Equipment and use of the facility.

AHCCCS follows guidelines set forth by the CMS and standard coding rules established by the American Medical Association (AMA).

ASC Reimbursement

The AHCCCS ASC fee schedule will assign a rate to each allowable CPT code(s). This structure is similar to the Medicare ASC structure, but rates will be AHCCCS specific.

The AHCCCS ASC fee schedule may have fees established as $0.00 for CPT codes that are allowable in the ASC setting but are included in the fees associated with the *surgical procedures.*

ASC Reimbursement (cont.)

- Unlike other AHCCCS fee schedules, if the fee for the procedure is $0.00 for the claim date of service, the allowed amount should be $0.00 (zero pay).
- Providers can view the current and historical rates on the FFS Rates webpage.
- The appearance on this website of a code and rate is not an indication of coverage, nor a guarantee of payment.
- AHCCCS ASC FFS RATES AND CODES

Billing ASC Facility Charges

Category	Billing Information
Claim Form Type	CMS 1500/837-P (EDI)
Place of Service Codes	24 (ASC)
Surgical CPT Procedure Code(s)	10000-69999
Modifier SG required) on all ASC **facility claims only.**	• The SG modifier must be entered on each line of service billed. • Use other modifiers in conjunction with the SG modifier if applicable based on national coding standards.
Reimbursement	The facility services are reimbursement based on the CPT codes billed.

Billing Professional Services Performed In A ASC Setting

- Form Type - CMS 1500 / 837-P (EDI)
- The professional services are billed separately by each practitioner that has performed a AHCCCS covered service during the surgical encounter.
- All providers, including out-of-state providers, must register to be reimbursed for *covered services* provided to AHCCCS members.
- Place of Service – 24 (ASC)
- Surgical CPT procedure Code(s) range 10000 - 69999
- Modifiers *(if applicable)*

NOTE: The rules applicable to multiple and bilateral procedures also apply to the professional/surgeon services.

Billing Capped FFS Rate for Anesthesia Services for Medical Procedures

- Anesthesia services must be provided by an AHCCCS registered provider type (anesthesiologist or certified registered nurse anesthetist (CRNA).
- Form Type: CMS 1500 / 837P (EDI)
- Place of Service – 24 (ASC)

Billing Capped FFS Rate for Anesthesia Services for Medical Procedures (cont.)

- Anesthesia time begins when the provider of services physically prepares the patient for induction of anesthesia in the operating room (or equivalent) and ends when the provider of services is no longer in constant attendance.
- Anesthesia CPT procedure Code(s) range (00100 - 01999)
- Anesthesia time is reported on the claim submission in actual minutes. If units are billed this will result in an incorrect payment.
- Paper submissions, the begin and end time of the anesthesia administration must be entered on the claim form for i.e., (9:30am – 10:45am = 75 minutes).

Provider Remittance Advice Notices

When PT 43 (ASC) is billing services under a distinct NPI that is not affiliated with the hospital.	When a PT 43 (ASC) and hospital are billing using the same NPI number.
Individual remittance advice for ASC services.	All payments will be identified on the same remittance advice.
Easier posting of payments.	Payment denials are combined on one remittance notice.
Claim denials will be identified on a separate remittance advice.	Claim denials for AIR and ASC services will be included on the same remittance advice.
Facilities have more control scheduling same day surgeries.	

Non-Emergency Medical Transport (NEMT)
Pick-up and Drop-off Address Updates

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NEMT Pick Up/Drop Off Address Updates

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 Provider Portal.** The pickup and drop off information can be entered in the ***Additional Claim Information*** field (Box 19) and please note spacing is limited.

Note: NEMT claim submissions providers must continue to include a copy of the AHCCCS Daily Trip Report with each claim.

NEMT Pick Up/Drop Off Address Updates

Tips:

- As spacing may be limited in the additional claim information field, we suggest using abbreviations when possible, 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 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

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Title XXI KidsCare Billing Reminders

KidsCare members that are enrolled in an ACC plan, IHS/638 providers must submit the claim to the ACC plan.

KidsCare members that are enrolled in Fee-for-Service or AIHP, the claims are submitted to AHCCCS.

Billing example: A claim is submitted for a KidsCare member and is billed 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".

How to Verify 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					

Vaccine Billing Reminders

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Covid-19 Vaccine Billing Information

(updated 7/11/22) **Question: Can my child receive a COVID-19 vaccine at a pharmacy?**

Answer: Children three years of age and older can receive a COVID-19 vaccine at a pharmacy. Children under three years of age can only receive a COVID-19 vaccine at a PCP's or pediatrician's office.

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

AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) Contractors

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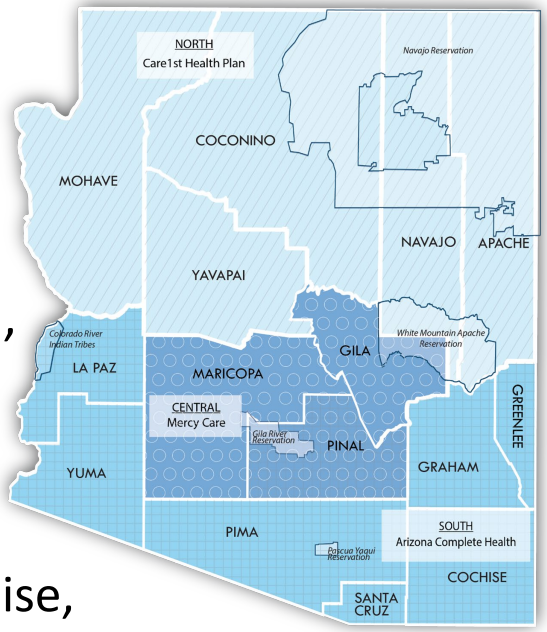
AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) Contractors

- ACC-RBHA Contractors responsible for:
  - Integrated physical and behavioral health services for Title XIX/XXI eligible individuals with Serious Mental Illness (SMI)
  - Administration of Non-Title XIX/XXI funded services including, but not limited to:
    - Crisis services, grant funded services, and Court Ordered Evaluations (COE)
- ACC-RBHA Awards made 11/15/2021
- Transition occurring 10/1/2022

ACC-RBHA Geographical Service Areas (GSA)

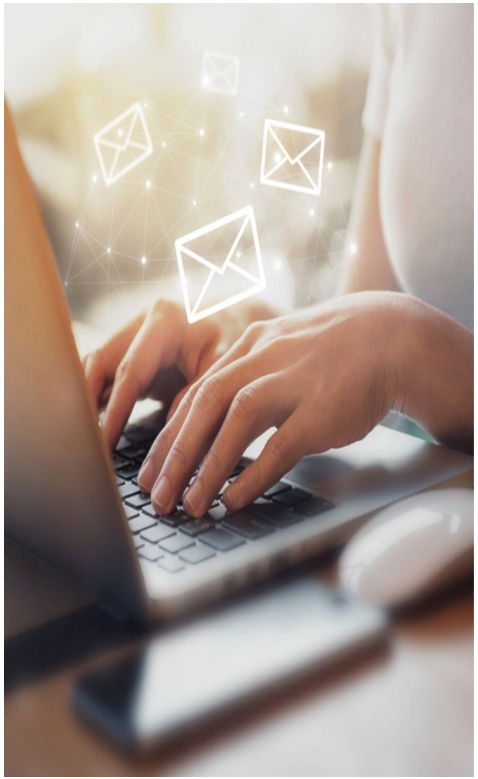
- Aligning GSAs to match ACC and EPD GSAs:
  - Gila moving from North to Central
  - Pinal moving from South to Central
- ACC-RBHAs and awarded GSAs
  - Care1st - North GSA: Mohave, Coconino, Yavapai, Navajo, Apache
  - Mercy Care - Central GSA: Maricopa, Gila, Pinal
  - Arizona Complete Health-Complete Care Plan - South GSA: La Paz, Yuma, Pima, Santa Cruz, Cochise, Graham, Greenlee



Transitions for Members

- Central GSA – ACC-RBHA will be Mercy Care effective 10/1/2022.
  - Members in Maricopa County will ***continue*** to receive services from Mercy Care.
  - Members in Gila County will ***transition*** from Health Choice to Mercy Care.
  - Members in Pinal County will ***transition*** from Arizona Complete Health-Complete Care Plan to Mercy Care.

Member Transitions (cont.)



- AHCCCS will send out enrollment notices to all members transitioning to a new health plan.
- Member notices will be sent out by AHCCCS at least 30 days prior to the 10/1/2022 transition date.
- AHCCCS will work with all involved health plans to transition important member information.




American Indian Health Program
Member Transition
Serious Mental Illness (SMI) Effective 10/01/2022

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Reminder: 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.

This transition will impact roughly 300 members.*

*Enrollment as of December 2021

Member Transitions (cont.)

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.

This transition will impact roughly 100 members.*

*Enrollment as of December 2021




Reminders:
Billing Medicare Secondary Claims

Reminders: Billing Medicare Secondary Claims

What is a secondary claim?

- Secondary claims refer to any claims for which Medicaid is the secondary payer, including third party insurance as well as Medicare crossover claims.
- If the claim was denied by Medicare due to billing issues, the provider should submit a corrected claim to Medicare.

Medicare Secondary Claims

- 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.

Medicare Secondary Claims

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







Reminders:
Billing Third Party Liability Secondary Claims

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Third Party Liability (TPL) Secondary Claims

- When submitting a secondary claim, providers must include the primary payers *Explanation of Benefits* which details how the claim was processed and or denied by the payer.
- Appealing a Claim Denial:
  - Providers must follow the primary payers appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The primary insurer explanation of benefit is required.


DFSM Provider Education and Training Unit

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DFSM Provider Education and Training

Our goal is to help providers understand billing policy and successful claim submission.

The provider training team offers eLearning and video training presentations on specified topics which is 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**

Claims Customer Service Assistance

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

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

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.