



# Tribal 638 Federally Qualified Health Center (FQHC)

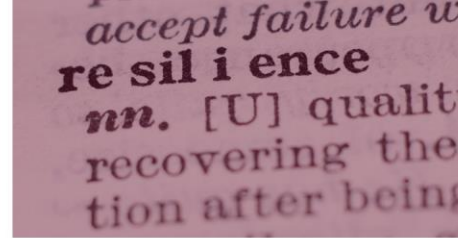
May 2021

# About this Course

Please note that these materials are designed for Fee-for-Service programs, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), and Tribal Arizona Long Term Care Services (ALTCS).

This training presentation will cover policy and billing information for 638 FQHCs.

If you have any questions about this presentation please email the [providertrainingffs@azahcccs.gov](mailto:providertrainingffs@azahcccs.gov)



# What is a 638 FQHC?

# What is a 638 FQHC?

Effective April 1, 2018, AHCCCS established a new provider type that allowed Tribal 638 Clinics to elect to be recognized as a 638 Federally Qualified Health Center (FQHC).

The new 638 FQHC provider type designation is **C5**.

**NOTE:** Under section 1905(l)(2)(B) of the Social Security Act, outpatient health programs or facilities operated by a Tribe or Tribal organization under the Indian Self-Determination Act (Public Law 93-638) are by definition FQHCs.

Tribal facilities may enroll in state Medicaid programs as FQHCs, but they are not required to do so.

For additional information, please see [State Health Official \(SHO\) Letter #16-002](#).

# 638 FQHC Requirements

## Who can become a 638 FQHC ?

Any Tribal 638 Clinic that is currently registered as provider type 05 (Clinic) or 77 (BH Outpatient Clinic).

- Please note that IHS Clinics are not eligible to become a 638 FQHC.

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 Public Law (P.L.) 93-638.

# 638 FQHC Requirements

## Who can become a 638 FQHC? (Continued...)

- The facility **does not** need to enroll in Medicare as an FQHC in order to change its designation to a 638 FQHC.
- 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).
- ***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.***



# How Can a Provider Elect to Become a 638 FQHC?

# Documentation Requirements for Electing to Become a 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 Unit. The written notification must include:

## Documentation Requirements

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

A signature from one of the authorized signers on record for the provider, within the provider's current provider profile.



# How to Elect to Become a 638 FQHC?

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.

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



## 638 FQHC and Provider Types

## 638 FQHC and 05/77 Provider Types

When it comes to changing to a 638 FQHC status and billing for services, providers that previously provided either Pharmacy Services or NEMT Services will have to retain their previous provider type designation (05 or 77) *in addition* to their new provider type of 638 FQHC (C5).

# 638 FQHC and 05/77 Provider Types

This means that some 638 FQHCs will have *two* provider types in the AHCCCS Claims System:

- The C5 (638 FQHC) Provider Type; and
- Their previous Provider Type of 05 (Clinic) or 77 (Behavioral Health Outpatient Clinic).

Depending upon what service is being billed, the provider may need to use either their C5 or their 05/77 Provider Type when submitting claims.

Additional information on this topic is found in the billing section of this presentation.



# The “Four Walls”

638 FQHCs

# The “Four Walls” of the Clinic

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.

# The “Four Walls” of the Clinic

Due to this interpretation, 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.

This applies 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 four walls, the clinic cannot receive the facility rate.

# Tribal 638 FQHCs and the “Four Walls”

The “4 Walls” requirement does not apply to FQHCs.

An FQHC may bill the facility rate for services rendered to its patients outside of its “Four Walls”, even when services are rendered by a non-Tribal provider, so long as the below requirements are met.

- If an FQHC has a Care Coordination Agreement (CCA) 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.



# Tribal 638 FQHCs and the “Four Walls”

A Tribal 638 Clinic that elects to become a 638 FQHC will not be subject to the limitations of the “Four Walls” requirement.

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.



# 638 FQHC Reimbursement and Visit Limits

# 638 FQHC Reimbursement

Tribal 638 FQHCs are reimbursed via the Alternative Payment Methodology (APM), for authorized categories of service.

The APM is the equivalent of the AIR (the OMB outpatient rate for all FQHC services).

100% Federal Medical Assistance Percentage (FMAP) will apply for American Indians/Alaskan Natives (AI/AN) treated outside the “Four Walls” of the FQHC.

# 638 FQHC Visit Limits

Up to 5 encounters/visits may be billed at the APM per member, per day, for separate and distinct visits.

- **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.



# FQHC Definitions

# FQHC/RHC Visit

## What is Considered an FQHC/RHC Visit?

- A face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service.
- FQHC/LA/RHC services do not require a prior authorization.

# FQHC Multiple Visits on the Same Day

## Multiple Visits

- Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.
- In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether or not on the same day or at the same location, is considered to be part of the visit and is not reimbursed separately.

# “Incident To” Services

## What Services are Considered “Incident To”?

Services “incident to” a visit means:

- a) Services and supplies that are an integral, though incidental, part of the physician’s or practitioner's professional service.
  - Examples include medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant; or
- b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services.
  - Examples include x-ray; medication; laboratory test.

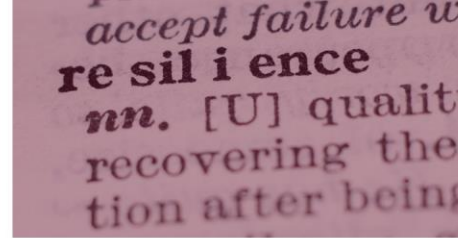


# Face to Face Encounter

## What is an Encounter?

A face to face encounter between a patient and a health professional

- Physician,
- Clinical Psychologist, Clinical Social Worker
- Dentist or oral surgeon, Dental hygienist (when services are billed under the dentist's license number),
- Physician Assistant,
- Nurse practitioner, Nurse Midwife
- Home health and Visiting nurse, (to the homebound in an area where the Centers for Medicare & Medicaid Services (CMS) has certified that there exists a shortage of home health agencies)
- Registered dietician (pursuant to a referral by a physician and as defined in section 1861 subsection (r)(1) of the Social Security Act),



# FQHC Services vs. Non-FQHC Services

# What is NOT a 638 FQHC Service?

## What are NOT Considered to be 638 FQHC Services?

- Pharmacy Services
- Non-Emergency Medical Transportation (NEMT) Services
- Case Management for Medical & Behavioral Health Services
- Group Therapy

# What is NOT a 638 FQHC Service?

## Billing under the 05/77 Provider Type

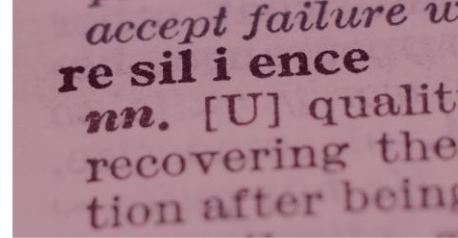
Pharmacy, NEMT, and Group Therapy should continue to be billed as a part of the provider's clinic ID/provider type (05/77).

- These three services *cannot* be billed under the 638 FQHC Provider Type.

# What is NOT a 638 FQHC Service?

## Billing under the 638 FQHC (C5) Provider Type

Case Management Services for Medical & Behavioral Health (when appropriate) should be billed under the 638 FQHC Provider Type (C5).



# Billing and Reimbursement

## FQHC Services vs. Non-FQHC Services

# Billing and Reimbursement Overview

Service	Billing	Payment
FQHC Services	Will be billed under the 638 FQHC provider type (C5).	Reimbursed at the APM which is equivalent to the OMB AIR.
Dental	Will be billed under the 638 FQHC provider type (C5)	Reimbursed at the APM which is equivalent to the OMB AIR.
Pharmacy	Will continue to be billed for under the provider type (05), using the non-638 FQHC facility id#	All Inclusive Rate (AIR) (Only 1 AIR per member, per day, per pharmacy may be reimbursed)
NEMT	Will continue to be billed for under the provider types (05 or 77) using the non-638 FQHC facility id#	Capped FFS Fee Schedule

# Billing and Reimbursement Overview

Service	Billing	Payment
Group Therapy	Will continue to use the CMS 1500 Claim Form under the provider type (05/77)	Capped FFS Fee Schedule
Case Management	Will continue to use the CMS 1500 Claim Form under the 638 FQHC provider type (C5), with code T1016.	Capped FFS Fee Schedule
Professional Services	Individual Practitioner's Provider Type	Capped FFS Fee Schedule



# 638 FQHC Services

## 638 FQHC Services

For qualifying 638 FQHC services, billing occurs as follows:

- **Claim Form Type:** CMS 1500
- **Reimbursement Rate:** APM
  - The APM should be entered in as the charges on the first line of the claim form.
  - Include the APM in the Total Charges field (Field 28).
- **Provider Type:** C5
  - FQHC clinic visits must be billed under the new provider type C5 and corresponding NPI number

# 638 FQHC Services

## 638 FQHC Services

For qualifying 638 FQHC services, billing occurs as follows:

- **HCPCP Code(s):** T1015 (FQHC visit/encounter, all inclusive) should be entered on the first line of the claim.

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.

# 638 FQHC Services

## 638 FQHC Services

For qualifying 638 FQHC services, billing occurs as follows:

- **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.

# Dental Services

## Dental Services

- **Claim Form Type:** ADA 2012 Claim Form
- **Reimbursement Rate:** APM
- **Provider Type:** C5
  - FQHC dental visits must be billed under the new provider type C5 and corresponding NPI number

# Pharmacy Services

## 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 also not change. Pharmacy services 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.

# Pharmacy Services

## Pharmacy Services

- **Claim Form Type:** UB-04 Claim Form
- **Codes:** Revenue code 0519 (Other Clinic)
  - The UB-04 Claim Form must include the NDC codes for **all prescriptions filled that day**. However, please note that only 1 AIR will be reimbursed.
- **Reimbursement Rate:** AIR
  - The outpatient AIR should be entered on the first service line of the claim.
  - Include the AIR in the Total Charges field (Field 47), on the 0001 line.

# Pharmacy Services

## Pharmacy Services

- **Provider Type:** 05
- **Attending Provider:** Claims should be submitted with the facility's NPI as the attending provider, since AHCCCS does not register pharmacists.

**Note:** All Fee-For-Service prescription claims must be submitted electronically at the point-of-sale to the AHCCCS contracted Pharmacy Benefit Manager, OptumRx.

- OptumRx Customer Service Help Desk at (855) 577-6310.

# Non-Emergency Medical Transportation (NEMT)

## Non-Emergency Medical Transportation (NEMT) Services

NEMT services ***will not be billed*** under the new 638 FQHC provider type.

NEMT services must continue to be billed under the provider's previous designation (05 Clinic or 77 Behavioral Health Outpatient clinic).

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.



# Non-Emergency Medical Transportation (NEMT)

## Non-Emergency Medical Transportation (NEMT) Services

- **Claim Form Type:** CMS 1500 Claim Form
- **Code:** CPT/HCPCS
  - Providers are expected to follow all national coding standards.
- **Reimbursement Rate:** Capped FFS Fee Schedule
- **Provider Type:** 05/77

# Group Therapy

## 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.

# Group Therapy

## Group Therapy

- **Claim Form Type:** CMS 1500 Claim Form
- **Code:** CPT/HCPCS
  - Providers are expected to follow all national coding standards.
- **Reimbursement Rate:** Capped FFS Fee Schedule
- **Provider Type:** 05/77

# Case Management Services

## Case Management Services

Effective with dates of service on and after 10/01/2015, AHCCCS *will not recognize case management* as a PPS-eligible service.

To the extent that case management services are reimbursable, they will be reimbursed according to the Capped FFS Fee Schedule.

# Case Management Services

## Case Management Services

Case Management is not an FQHC service.

- **Claim Form Type:** CMS 1500 Claim Form
- **Code:** T1016
- **Reimbursement Rate:** Capped FFS Fee Schedule
  - Case management will not be reimbursed at the Alternative Payment Methodology (APM) rate as it is not an FQHC service.
- **Provider Type:** C5

# Case Management Services

## Case Management Services – FQHC and American Indian Medical Homes (AIMH)

- 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.

# Professional Services

## Professional Services

- **Claim Form Type:** CMS 1500 Claim Form
- **Code:** CPT/HCPCS
- **Reimbursement Rate:** Capped FFS Fee Schedule
- **Provider Type:** Individual Practitioner's Provider Type



# FQHC and Telehealth and Telemedicine Services



# FQHC and Telehealth Services

## 638 FQHCs – Telehealth Services

- Telehealth and telemedicine may qualify as an FQHC/RHC visit if it meets the requirements specified in AMPM 320-I, Telehealth and Telemedicine.
- FQHC's and RHC's can bill for Telemedicine services and should submit claims with HCPCS code T1015, plus any additional appropriate CPT/HCPCS codes to reflect the services provided
- Telemedicine services should be billed with the GT modifier appended to the HCPCS code T1015 in addition to any other applicable modifiers.

# FQHC and Telehealth Services

Modifier	Description
GT	Telehealth via interactive audio and video telecommunication system (Synchronous)
GQ	Transmission of recorded health history through a secure electronic communications system (Asynchronous; Store & Forward)
UD	Telephonic

**Distant site:** FQHCs providing services for a recipient from a distant site may bill the appropriate PPS / APM rate for the Telehealth service with the appropriate modifier.

**Originating site:** FQHCs providing services for a recipient from a distant site may bill the appropriate PPS / APM rate for the Telehealth service with the appropriate modifier.



# 638 FQHCs and Behavioral Health Technicians (BHTs)

# 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. FQHC Reimbursement for Behavioral Health Technician (BHT) provided services.

A 638 FQHC can bill for reimbursement at the APM for allowable services provided by a BHT, only when those services qualify as services incident to the services of an FQHC practitioner consistent with federal requirements as stated above, and it counts as an FQHC service. This does not include Case Management Services.

For additional information on BHT please review the following document:

- <https://www.azahcccs.gov/PlansProviders/Downloads/FQHC-RHC/CaseManagementBHT.pdf>



# FQHC/RHC Billing Examples

# FQHC Billing Format Example #1 Field 19 "One participating/performing provider"

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 1122334455 Brown, John (In this example the provider is a registerable provider)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY E11.42 A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ K. _____ J. _____ I. _____										22. RESUBMISSION CODE		ORIGINAL REF. NO.									
24. A. From Date of Service To MM DD YY MM DD YY										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT-ICPCS MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. FQHC Family Plan	I. R. QUAL	J. RENDERING PROVIDER ID, #
1	03	01	2021	03	01	2021	50			T1015			A	519	00	1		NPI	1234567890		
2	03	01	2021	03	01	2021	50			99213			A	0	00	1		NPI	1234567890		
3	03	01	2021	03	01	2021	50			85025			A	0	00	1		NPI	1234567890		
4																		NPI			
5																		NPI			
6																		NPI			
25. FEDERAL TAX ID, NUMBER XXXXXXXXXX					SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. 1234567XXX			27. ACCEPT ASSIGNMENT? (For cont. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 519 00		29. AMOUNT PAID \$		30. Rsvd for NUCC Use					
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.					32. SERVICE FACILITY LOCATION INFORMATION					33. BILLING PROVIDER INFO & PH # ( )											
SIGNED					DATE					a. NPI		b. 1234567890		c.		d.					

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

# FQHC Billing Format Example #1

## Field 19 “Non- registerable provider”

<b>19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)</b> 9999999999 AHCCCS, Mary (In this example the provider is a Non-registerable provider)										<b>20. OUTSIDE LAB?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO				<b>\$ CHARGES</b>				
<b>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY</b> (Range A-L to service line below (24E)) ICD Ind.										<b>22. RESUBMISSION CODE</b>				<b>ORIGINAL REF. NO.</b>				
A. E11.42 B. C. D. E. F. G. H. K. J. L.										<b>23. PRIOR AUTHORIZATION NUMBER</b>								
<b>24. A. Dates of Services</b>										<b>F. \$ CHARGES</b>		<b>G. DAYS OR UNITS</b>	<b>H. EPIC/17/18/19/20/21/22/23/24/25/26/27/28/29/30/31/32/33/34/35/36/37/38/39/40/41/42/43/44/45/46/47/48/49/50/51/52/53/54/55/56/57/58/59/60/61/62/63/64/65/66/67/68/69/70/71/72/73/74/75/76/77/78/79/80/81/82/83/84/85/86/87/88/89/90/91/92/93/94/95/96/97/98/99/00</b>	<b>I. ID. QUAL.</b>	<b>J. RENDERING PROVIDER ID. #</b>			
<b>MM</b>	<b>DD</b>	<b>YY</b>	<b>MM</b>	<b>To</b>	<b>DD</b>	<b>YY</b>	<b>B. PLACE OF SERVICE</b>	<b>C. EMG</b>	<b>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</b>		<b>E. DIAGNOSIS POINTER</b>							
1	03	01	2021	03	01	2021	50		T1015		A	519	00	1	NPI	1234567890		
2	03	01	2021	03	01	2021	50		99213		A	0	00	1	NPI	1234567890		
3	03	01	2021	03	01	2021	50		85025		A	0	00	1	NPI	1234567890		
4															NPI			
5															NPI			
6															NPI			
<b>25. FEDERAL TAX ID. NUMBER</b> XXXXXXXXXX						<b>SSN EIN</b> <input type="checkbox"/> <input checked="" type="checkbox"/>		<b>26. PATIENT'S ACCOUNT NO.</b> 1234567XXX			<b>27. ACCEPT ASSIGNMENT?</b> (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>28. TOTAL CHARGE</b> \$ 519 00		<b>29. AMOUNT PAID</b> \$		<b>30. Rsvd for NUCC Use</b>	
<b>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</b> (I certify that the statements on the reverse apply to this bill and are made a part thereof.)								<b>32. SERVICE FACILITY LOCATION INFORMATION</b>				<b>33. BILLING PROVIDER INFO &amp; PH #</b> ( )						
SIGNED _____ DATE _____								a. NPI		b. 1234567890		c.		d.				

PHYSICIAN OR SUPPLIER INFORMATION

 NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

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# DFSM Provider Education and Training Unit



# DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

# Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at [FFSRates@azahcccs.gov](mailto:FFSRates@azahcccs.gov)
- Coding - Questions on AHCCCS Coding should be directed to the coding team at [CodingPolicyQuestions@azahcccs.gov](mailto:CodingPolicyQuestions@azahcccs.gov)
  - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at [ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)

# Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or [ISDCustomerSupport@azahcccs.gov](mailto:ISDCustomerSupport@azahcccs.gov)

# Claims Questions?

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

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

**NOTE:** Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

# Prior Authorization Questions?

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
- FESP Dialysis: 602-417-7548

**NOTE:** Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.

# Policy Information

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?

Please outreach the DFSM Provider Training Team at  
[providertrainingffs@azahcccs.gov](mailto:providertrainingffs@azahcccs.gov)



Thank You.