



WELCOME

IHS/638 Quarterly Forum

January 17, 2018

2:00 – 3:30 PM

Gold Room



Introductions





Outpatient Pharmacy – Future use of the Pharmacy Benefit Manager (PBM) - Update



PBM Request for Proposal

- AHCCCS contract with our current Pharmacy Benefit Manager (PBM), Optum, will expire 9/30/18.
- Because of competing priorities on 10/1/18 we have opted to move extend the contract to 03/31/19.
- AHCCCS will publish a Request for Proposal this month to identify the PBM that will be effective for 4/01/19.

Pharmacy Claims

- Currently only **non-IHS/638** pharmacies go through the PBM with the exception of all Title 21 claims.
- It is the intent of the new contact that will be effective 4/01/2019, the IHS and Tribally operated 638 facilities will submit claims via the PBM.
- Claims are submitted electronically using a point-of-sale process.
- IHS/638 pharmacies will still receive the All Inclusive Rate.

Billing Pharmacy Claims Title XIX

- The All Inclusive Rate (AIR) will continue to be reimbursed for federally reimbursable drugs.
- The AIR shall be reimbursed for only one pharmacy visit per date of service, per member, per facility.
- Each prescription claim is submitted on separate claim form for drugs billed on the same date of service/fill date.
- Allows for a separate reimbursement methodology for specialty drugs dispensed at IHS/638 facilities

Billing Pharmacy Claims Title XXI

- Claims for Title XXI (KidsCare) recipients will continue to be submitted to OptumRx as described in Chapter 10 of the IHS/Tribal Provider Billing Manual until 04/01/19 when the new PBM is effective.
- The current contract with OptumRx will be extended to 3/31/19.

<https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap10Pharmacy.pdf>

Questions?





2018 All Inclusive Rate Update



New 2018 All Inclusive Rates

The Federal Register published the new 2018 All Inclusive Rates on January 5, 2018. These new rates are retro-active back to January 1, 2018.

2018 Inpatient rate is \$3,229.00, increased from \$2,933.00

2018 Outpatient rate is now \$427.00, increased from \$391.00

The new rates were uploaded into the PMMIS system on January 8, 2018. Only those claims submitted **January 1 through January 12, 2018** will be re-cycled.

It will be the provider's responsibility to submit any adjusted claims with the correct rate if a claim is submitted with the 2017 AIR after January 12, 2018.

Questions?





DFSM Provider Trainings



NEMT Workshop

- DFSM Provider Training held a two hour interactive workshop on Non-Emergency Medical Transportation (NEMT) on *December 14th 2017*.
- During the workshop, we covered:
 - Submitting a prior authorization
 - Completing the Daily Trip Report
 - Submitting the Daily Trip Report
 - Submitting a claim for the NEMT service
 - NEMT Policies
- We received wonderful feedback from our participants!

NEMT Follow Up

- DFSM Provider Training will be offering a webinar follow-up to the questions asked during the NEMT workshop.
- We are looking at enhancing the workbook by making updates to reflect the feedback received.
- We highly suggest subscribing to Constant Contact at [Constant Contact Subscription](#) in order to stay current with updates and notifications.

Daily Trip Report

All NEMT providers must be utilizing the most updated Daily Trip Report posted on the AHCCCS Webpage.

1. Begin at the AHCCCS Website: <https://www.azahcccs.gov/>
2. On the toolbar, select PLANS/PROVIDERS




The screenshot shows the AHCCCS website interface. At the top left is the AHCCCS logo with the tagline 'Arizona Health Care Cost Containment System'. To the right is a search bar labeled 'Google Custom Search'. Below the logo and search bar is a dark red navigation bar with the following menu items: HOME, AHCCCS INFO, MEMBERS/APPLICANTS, PLANS/PROVIDERS (highlighted with a green box), AMERICAN INDIANS, RESOURCES, FRAUD PREVENTION, and CRISIS?. Below the navigation bar, the main content area is divided into three columns. The left column contains 'AHCCCS Online' with an external link icon, 'Health Plans' with a list of links including 'MCO Update Meetings', 'Minimum Subcontract Provisions', 'Reporting Third-Party Liability', 'ALTCES Electronic Member Change Request (EMCR)', 'Solicitations & Contracts', 'Encounters', 'Reinsurance', 'Quality Assessment and Performance Improvement Strategy', and 'New Providers' with a list of links including 'Freestanding Emergency Department', 'Provider Registration', 'Provider Reenrollment', 'Treat and Refer', and 'Minimum Subcontract Provisions Enrollment Fee'. The middle column contains 'Current Providers' with a list of links including 'Provider Website', 'Provider Reenrollment', 'CRS Referrals', 'ALTCES Electronic Member Change Request (EMCR)', 'Self Directed Attendant Care', 'Direct Care Workers', 'Nursing Facility Information', 'Hospital Assessment', 'Provider Survey', 'Non-Emergency Medical Transportation', 'EHR Incentive Program', 'Data Access', and 'Proposition 206', followed by 'Guides - Manuals - Policies'. The right column contains 'Rates and Billing' with a list of links including 'Managed Care', 'Fee-for-Service', 'Copayments', 'FQHC & RHC', 'Hospital Presumptive Eligibility', 'Hospital Reimbursement', 'PCP Parity', 'Pharmacy', and 'Targeted Investments'. A green arrow points from the 'Non-Emergency Medical Transportation' link in the middle column to the text below.

3. Under “Current Providers” select Non-Emergency Medical Transportation


Continued...

4. Select Exhibit 11-1; Daily Trip Report

NEMT Billing Instructions & Exhibits for FFS:

- Chapter 14:  Transportation Services
 - Exhibit 14-1 , Daily Trip Report
 - Exhibit 14-2 , Non-emergency Medical Transport Daily Trip Report Instructions

NEMT Billing Instructions & Exhibits for IHS:

- Chapter 11  : Transportation Services
 - Exhibit 11-1 , Daily Trip Report
 - Exhibit 11-2 , Non-emergency Medical Transport Daily Trip Report Instructions

5. The Daily Trip Report posted in this section will always be the most updated document.

Benefits to Completing the Daily Trip Report

- Ensure both timely and proper payment.
- Save time
- The Daily Trip Report can be used to stay current with your internal list of drivers, and vehicle information.
- Assure proper payment is received for the type of service provided (wheelchair vs car).
- Stay current on HIPAA requirements in order to avoid HIPAA penalties.
- Avoid recoupment of improper billing.

Upcoming Trainings

- 2018 First Quarter Training Schedule is posted on the AHCCCS Website at: [Training Schedule](#)
- Additional details are sent out via Constant Contact 7 days prior to the scheduled training.
- **Note:** DFSM Provider Training has transitioned from GoToWebinar to WebEx.

Please feel free to submit your *training* questions to:

ProviderTrainingFFS@azahcccs.gov

Thank you!





CHIP Funding



Children's Health Insurance Program ("CHIP") Update

- CHIP is 100% federally funded, covering approximately 24,000 children in Arizona.
- Funding expired on 9/30/17. Congress passed a continuing resolution in December 2017 extending funding through March 2018.
- Arizona has developed a contingency plan in the event the program is not reauthorized, to provide an additional 3 months of coverage.

Questions?





Policy & Billing Manual Updates



Policy & Billing Manual Updates

Where are the policy and billing manuals located?

- AHCCCS IHS/Tribal Provider Billing Manual:
<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html>
- AHCCCS DFSM Fee-For-Service Provider Billing Manual:
<https://tst.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>
- AHCCCS Medical Policy Manual (AMPM):
<https://www.azahcccs.gov/shared/MedicalPolicyManual/>
- AHCCCS Contractor Operations Manual (ACOM):
<https://www.azahcccs.gov/shared/ACOM/>

AIR Billing Manual Updates

The update is general in nature, containing information about UB-04 submissions and the number of AIRs that can be submitted for a member in one day.

The following chapters were updated:

- Chapter 8, Individual Practitioner Services
- Chapter 4, General Billing Rules
- Chapter 5, Claim Form Requirements
- Chapter 16, Claims Processing

AIR Billing Manual Updates

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

- For example: If a UB-04 claim form is submitted with 3 AIRs listed, 1 AIR for January 1st, 1 AIR for January 2nd, and 1 AIR for January 3rd, then all 3 AIRs will deny.

AIR Billing Manual Updates

Up to 5 AIR claims may be billed per member, per day, so long as each individual AIR claim is for a visit that is a **separate and distinct service**. The system is set up to **automatically deny** any AIR claim submissions in excess of five per member, per day.

AIR Billing Manual Updates

The AIR may not be submitted for Title XXI (KidsCare) members, even if the KidsCare member received services from an IHS/638 provider or facility.

AIR Billing Manual Updates

The AIR may be billed for prescription medications. The limit for pharmacy services AIR is 1 AIR per member, per facility, per day.

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

Vision Coverage

Routine eye examinations and prescription lenses (glasses) are covered for members under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) and Title XXI (KidsCare) programs.

Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service.

Vision Coverage

Routine eye examinations and prescription lenses (glasses) are **not** covered for adults 21 years of age and older. However, if a member requires an examination and subsequent treatment of a **medical condition of the eye** then that examination and treatment will be covered. Exams solely for the provision of lenses are **not** covered though.

Prescription lenses are considered medically necessary for adults *if* they are used as the sole prosthetic device following cataract surgery.

Family Planning

AHCCCS has expanded its covered services and now covers contraceptive counseling, medications, and supplies, including (but not limited to) the following:

- Oral contraceptives,
- Injectable contraceptives,
- Intrauterine devices (IUDs),
- Subdermal implantable contraceptives,
- Long-acting reversible contraceptives (LARCs),
- Diaphragms,
- Condoms,
- Foams,
- Suppositories,
- Natural family planning, and
- Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse.

Family Planning

Additionally AHCCCS also covers:

- Pregnancy screenings;
- Pharmaceuticals, when they are associated with medical conditions related to family planning or other medical conditions;
- Screening and treatment of Sexually Transmitted Infections (STIs);
- Pregnancy terminations, in limited circumstances that are outlined in AMPM 410, Maternal and Child Health; and
- Sterilizations, when the requirements in AMPM 420, Family Planning, are met.

Home Health Services

AMPM 310-I, Home Health Services, has been updated.

Per CFR § 440.70 the FFS Acute care population is now subject to our face-to-face encounter requirements in the following areas:

- Home Health Services
- Medical Supplies & Equipment

Home Health Services – Face-to-Face Requirements

AMPM 310-I addresses this in regards to home health services. The Face-to-Face encounter must meet the following criteria:

- It must relate to the primary reason the member requires home health services.
- For home health services the Face-to-Face must occur no more than 90 days prior to or 30 days following the start of services.
- The Face-to-Face may be performed by the ordering physician, a nurse practitioner, a clinical nurse specialist, a physician assistant under the supervision of the ordering physician, the attending acute or post acute physician for members who receive services immediately after an acute or post acute stay, or a certified nurse midwife. However, a CNM cannot do the Face-to-Face for medical equipment and supplies.
- Findings must be both reported back to the ordering physician and all clinical findings must be incorporated into a written or electronic medical record. Additional documentation required is the practitioner performing the encounter, the date of the encounter, and evidence that it occurred within the required time frame.
- The Face-to-Face encounter may occur through telehealth.

Medication Assisted Treatment for the Treatment of Opioid Use Disorder

AHCCCS Administration has expanded its provider reimbursement guidelines to allow Primary Care Practitioners (PCPs) to be reimbursed for the treatment of Opioid Use Disorder (OUD).

Medication Assisted Treatment for the Treatment of Opioid Use Disorder

Medication Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

Research has shown that a combination of medication and behavioral therapies, such as MAT, is effective in the treatment of substance use disorders, and it can help some people to sustain recovery by decreasing opioid use and opioid-related overdose deaths.

Medication Assisted Treatment for the Treatment of Opioid Use Disorder

A PCP can be reimbursed for professional fees, related prescriptions, laboratory costs and other diagnostic tests performed in the treatment of OUD.

PCPs include those licensed as an allopathic or osteopathic physician, physician assistants, and certified nurse practitioners, and all must meet the applicable licensure requirements for MAT.

The following chapters have been updated:

- ACOM Policy 432, Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services
- Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual
- Chapter 10, Pharmacy Services, of the IHS/Tribal Provider Billing Manual
- Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual

Modifiers 51 & 59

Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual has been updated to include revised information about Modifiers 51 and 59.

Modifier 51

Modifier 51 is used if there are multiple surgical procedures performed on the same member, on the same day, during the same session. When submitting a claim providers should list the principal procedure code on the first line of the CMS 1500 claim form and then list the secondary surgeries on subsequent lines *with* modifier 51.

If a claim is received without modifiers to indicate which procedures are the secondary procedures, then the AHCCCS system will identify the first procedure code on the claim as the principal procedure code and it will then price it accordingly.

Modifier 51

When two separate procedures are done on the same person, on the same day, during the same session the provider is typically able to use the same resources for both procedures.

For instance, if a biopsy is being performed and, upon beginning the procedure, a second tumor is found, the surgeon would not need to get out a second set of surgical tools, sterilization procedures would not need to be done to the surgical room and participating medical staff twice, and two surgical rooms would not need scheduled. Since there are shared resources for both procedures, the additional procedures would not need reimbursed at the full rate.

Modifier 59

Modifier 59 is often referred to as “the modifier of last resort.” It indicates that a second procedure performed on the same member, on the same day, was a *distinct or separate* procedure. Modifier 59 is a component code, and is used when the second procedure is not a part of the comprehensive services being billed for with the first procedure. Any procedure code being billed with modifier 59 must be able to be clinically justified in the medical record and will be subject to medical review.

Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

AMPM 310-JJ - Orthotics & Prosthetics

- A new policy was created to cover orthotics and prosthetics separately from medical supplies, equipment and appliances.
- A change to the coverage is that Augmentative Communication Devices (speech generating devices) are now covered when medically necessary, and they are classified as prosthetic devices.

AMPM 310-JJ - Orthotics & Prosthetics

Augmentative Communication Devices are considered medically necessary when the device is:

- Prescribed by a Primary Care Provider (PCP), attending physician, or practitioner; or
- Prescribed by a specialist upon referral from the PCP, attending physician, or practitioner; and
- Authorized as required by AHCCCS, Contractor, or Contractor's designee.

Additional requirements include:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines,
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
- The orthotic is ordered by a Physician or PCP.

Occupational Therapy

Effective date of service 10/1/2017 and later, occupational therapy is now covered for members 21 years of age and older. Acute care members may receive:

- 15 rehabilitative visits per contract year (October 1-September 30) to restore a particular skill or function the member previously had but lost due to injury or disease and to maintain that function once it is restored; and
- 15 habilitative visits per contract year (October 1-September 30) to attain or acquire a particular skill or function never learned or acquired and to maintain that function once it is acquired.

Outpatient OT services are covered when medically necessary for EPSDT, KidsCare, and ALTCS members.

Hepatitis C Treatment

- Previously, in order to qualify for prior authorization for the treatment of Hepatitis C with Direct Acting Antiviral Medications, members had to meet certain fibrosis level criteria.
- AHCCCS is excited to announce that the fibrosis level requirements have been removed as a qualifying prior authorization factor. This is primarily due to cost savings associated with the medication Mavyret. Complete information regarding the prior authorization criteria can be found in the updated policy, AMPM 320-N.

Behavioral Health Payment Responsibilities

- AMPM 432, Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services, along with Attachment A, Matrix of Financial Responsibility by Responsibility Party, were both updated to include the payment responsibility for Occupational Therapy claims (regardless of principle diagnosis) and to clarify payment responsibility for services associated with a PCP visit for the use of MAT for treatment of OUD.

Behavioral Health Chapter Updates

Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual has been updated. Updates include:

- The addition of MAT for the treatment of OUD,
- Information on billing for Methadone administration,
- Inpatient facility payment responsibilities,
- Emergency department payment responsibilities,
- The addition of court ordered evaluations and treatments, and
- Information on billing for professional services.

Behavioral Health Chapter Updates

Provider types that can bill for category of service 47 (mental health) include:

- 08 MD-physician with psychiatry and/or neurology specialty code 192 or 195
- 11 Psychologist
- 18 Physician Assistant
- 19 Registered Nurse Practitioner
- 31 DO-Physician Osteopath with psychiatry and/or neurology specialty code 192 or 195
- 77 Behavioral Health Outpatient Clinic
- 85 Licensed Independent Social Worker (LISW)
- 86 Licensed Marriage and Family Therapist (LMFT)
- 87 Licensed Professional Counselor (LPC)
- A4 Licensed Independent Substance Abuse Counselor
- BC Board Certified Behavioral Analyst

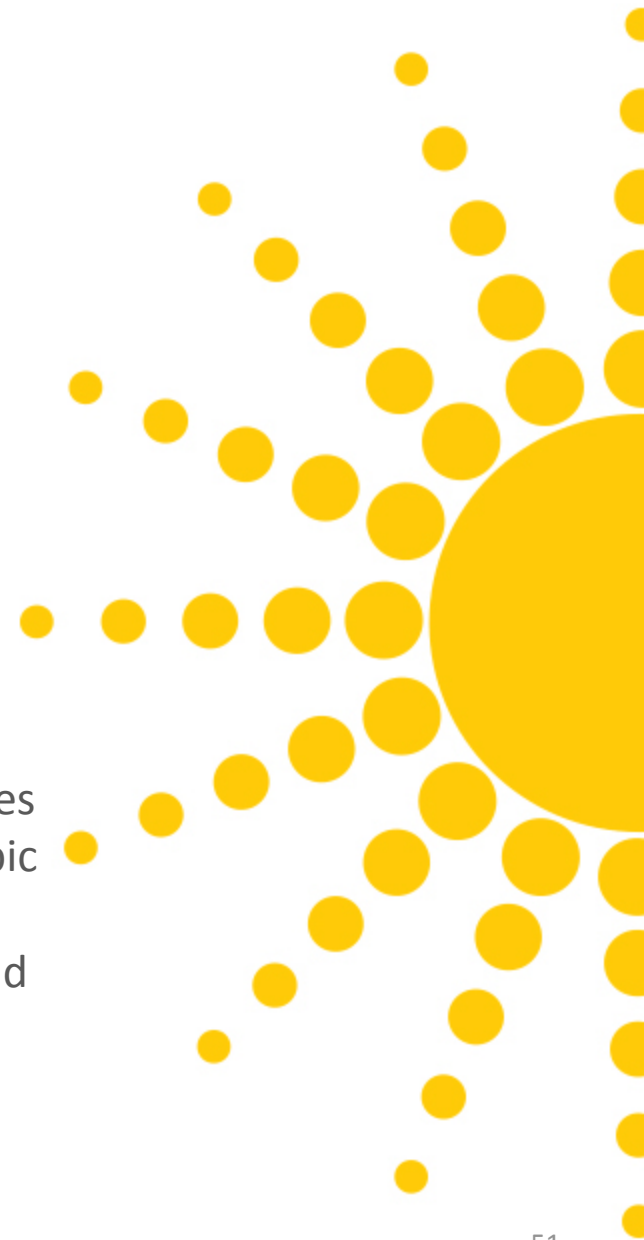
Behavioral Health Chapter Updates

IHS/Tribally Owned or Operated 638 Facilities

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

New chapter coming soon to an IHS/Tribal Provider Billing Manual near you!!!

AHCCCS is working on creating a chapter for this manual specifically on Medical Equipment & Appliances, Medical Supplies, Orthotics and Prosthetics . There will be no changes to coverage or billing, but due to many questions on this topic we are creating a one-stop shop to address these provider questions in the manual. When this is published we will send out a Constant Contacts.



Thank you.



Questions

1. Is it acceptable to add/remove sections from the daily trip report? Example, adding a “total calculations” section or removing the “escort information”.

It is unacceptable to make **ANY** changes to the Daily Trip Report. Making changes to the Daily Trip Report can result in claim denials, auditing and possible recoupment.

2. Where would I find the rates for different services/base codes? This is in reference to different vehicle types used for NEMT services, for example, the provider uses a van that has a wheelchair vs. a car.

The FFS Ground Transportation Rates can be found on the AHCCCS webpage at:

<https://www.azahcccs.gov/PlansProviders/Downloads/FFSrates/Transportation/04%202017%20Transportation%20Ground%20FFS.pdf>

3. For coverage on the CHIP program, what contingency plan will follow if the program is not reauthorized after the additional 3 months of coverage is exhausted?

On January 22, 2018, Congress passed a six-year extension of CHIP funding as part of a broader continuing resolution to fund the federal government. Therefore a contingency plan will not be necessary.

Questions

4. Is the 1 RX AIR included in the 5 total AIR claims allowed, per member, per day? Or is it 6 total AIR?

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

5. In chapter 8, when using Modifier 51 and then Modifier 59, you stated the first line would be reimbursed at 100% and the second would be reimbursed at 50%, correct? Will these be pended for medical review automatically? Will we have to upload documentation automatically?

The principal procedure is reimbursed at the lesser of 100% of the capped fee or billed charges. Each secondary surgical procedure is reimbursed at 50% of the capped fee or billed charges, whichever is less.

Claims submitted to AHCCCS utilizing modifier 59 will be subject to Medical Review. Medical records must reflect appropriate use of the modifier.

Questions

4. In the list of provider types that can bill for category of service 47, will existing provider types in the system be updated automatically? Will we need to go through Provider Registration?

Not all provider types can bill for all services. It is the providers responsibility to verify that category of service 47 can be billed by their facility/provider. If there is a category of service that should be added to the AHCCCS registered providers' account, please contact Provider Registration at 602-417-7670.

5. Regarding Face to Face Requirements, IHS/638 facilities do not register their Pharmacists because they bill the AIR. What requirements are there for AIR for prescriptions based on Provider type? For example, a family member may pick up the members RX and the pharmacist may not necessarily have a face to face with the member.

The new Face-to-Face requirements (42 CFR 440.70) are applicable to home health services and medical equipment/supplies only.

Thank you for joining us!

Next IHS/638 Quarterly
Forum will take place
April 25, 2018 at 2:00 PM.

