



IHS/638 Quarterly Billing Forum

Third Quarter 2021

Provider Training Unit
August 25, 2021

IHS 638 Quarterly Billing Forum Agenda

- Upcoming Meetings of Interest
- AHCCCS Tribal Consultation Meeting Recap
- Public Health Emergency (PHE) Updates
- Vaccines Memos and Guidance
- American Indian Medical Home (AIMH)
- APEP Updates
- Tribal Transportation Workgroup Update
- NEMT Reminders
- Transaction Insight Portal Reminders
- Transaction Insight Portal Update - Non-Person Entity
- Medical Equipment (DME) & Medical Supplies, Orthotics and Prosthetics
- Members with Dual Eligibility or Third Party Liability (TPL)
- Emergency Triage, Treat and Transport (ET3)



Upcoming Meetings of Interest

2021 AHCCCS Tribal Consultation Meeting Calendar

Date and Time	November Meeting Details
November 04, 2021 1:00 p.m. (MST) Quarterly Tribal Consultation	Registration Link: https://ahcccs.zoom.us/webinar/register/WN_u4GhRkwXTU2op64Jtkr95Q

NOTE REGARDING AHCCCS TRIBAL CONSULTATION MATERIALS: All meeting materials for AHCCCS Tribal Consultation meetings, including relevant slide decks and meeting recordings and/or summaries, are available on the [Tribal Consultation Meeting Materials webpage](#). Please check this website regularly for updated meeting materials.

Upcoming IHS/638 Quarterly Billing Forum

Date and Time	Meeting Details
Wednesday, November 17, 2021 2:00-3:30 p.m.	Registration Link https://ahcccs.zoom.us/webinar/register/WN_pH0wXp9qR3ewzKuUZtcKzW
Discussion of policy updates, changes, or challenges AHCCCS and the IHS/638 Facilities are experiencing. Session will be held via Zoom only.	

Tribal Consultation Recap

Amanda Bahe, AHCCCS Tribal Liaison

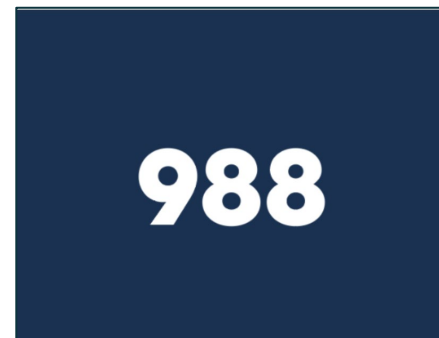
Tribal Consultation Recap

- 9-8-8 Legislation Update
- AHCCCS Provider Enrollment Portal
- 1115 Waiver Renewal Update
- State Opioid Response II (SOR II) Tribal Needs Assessment
 - o Fact Sheet: [SOR II Tribal Needs Assessment Fact Sheet](#)

9-8-8 Legislation

National Suicide Hotline Designation Act (S. 2661)

- Signed into law on October 17, 2020
 - Designates 988 as the dialing code for the Lifeline
 - Increased Lifeline federal appropriation
 - Clears a path for states to deploy a local telecommunications fee to fund 988 (similar to how 911 is funded).

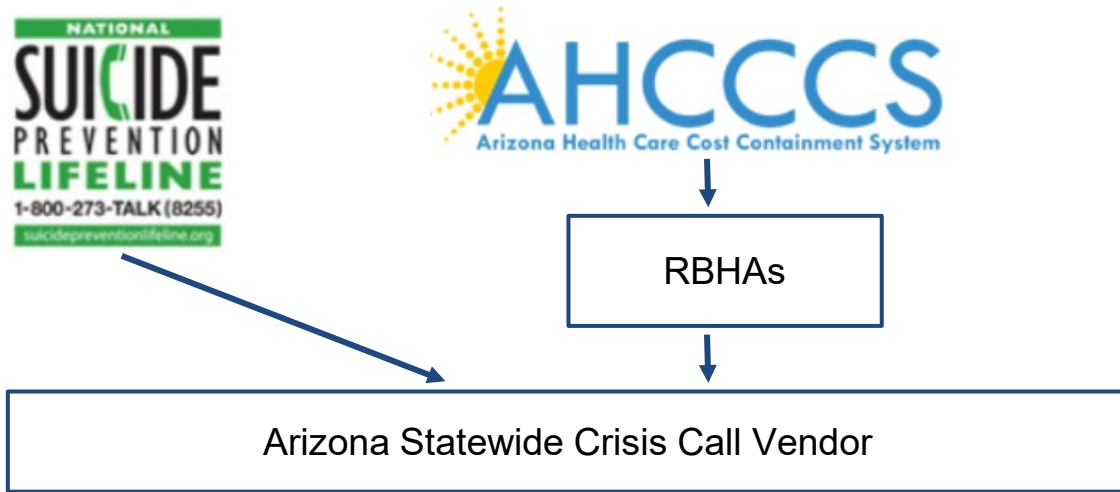


9-8-8 and Arizona Crisis Lines



9-8-8 Planning Grant

- \$135K awarded 2/1/21 for 9-8-8 implementation planning.
- Funds are used to establish a stakeholder coalition to discuss and consider consolidation of current in-state crisis call center services into a singular statewide network inclusive of 988, leveraging existing RBHA crisis call lines and the NSPL into a single statewide provider.



988 LeCroy Milligan Progress

- 4 Stakeholder meetings held
 - 4/19/21 Initial Overview of the project and plan
 - 5/18/21 Planning Session: recap and SWOT analysis of crisis system
 - 6/2/21 Planning Session: recap and SWOT analysis of crisis system
 - 7/13/21 Text and Chat options for crisis services
- Stakeholder meetings planned
 - 8/25/21 Messaging
 - 9/16/21 Listening session
 - 9/27/21 Next Steps
- Other Activities
 - Crisis Line Survey through 8/2021 for crisis line users/people with lived experience
 - Please feel free to share with your networks: bit.ly/ArizonaCrisisLineSurvey
 - LMA scheduling interviews with key stakeholders around best practices/standards of care
 - LMA to survey crisis providers around best practices/standards of care
 - Final report due end of January 2022

If interested in being interviewed, email Rachel Rios-Richardson at rachel.rios@lecroymilligan.com

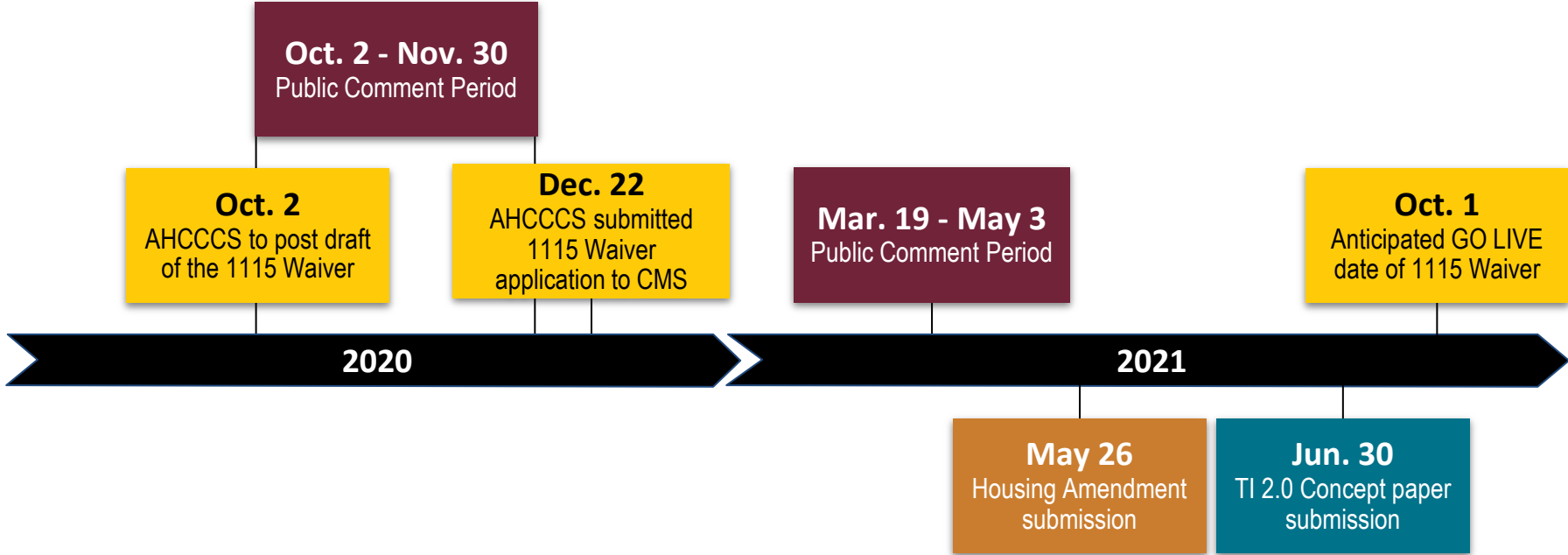
Upcoming 9-8-8 Feedback Sessions

- **August 25, 2021, 12 pm (MST)**
 - 988 Planning Meeting: Messaging and Communication
 - Zoom Meeting: <https://us02web.zoom.us/j/81716654583>
 - Meeting ID: 817 1665 4583
- **September 16, 2021, 4 pm (MST)**
 - 988 Planning Meeting: Messaging and Communication
 - Zoom Meeting: <https://us02web.zoom.us/j/81716654583>
 - Meeting ID: 817 1665 4583
- **September 28, 2021, 11 am (MST)**
 - Special/Ad hoc Tribal Consultation Session
 - Meeting Call-in information forthcoming

APEP

- APEP Training and Resources Available:
 - <https://azahcccs.gov/PlansProviders/APEP/APEPTraining/TrainingOnlineRegistration.html>
- Provider Assistance:
 - (602) 417-7670 option 5
- APEP Email:
 - APEPTrainingQuestions@azahcccs.gov

Arizona's 1115 Waiver Renewal Timeline

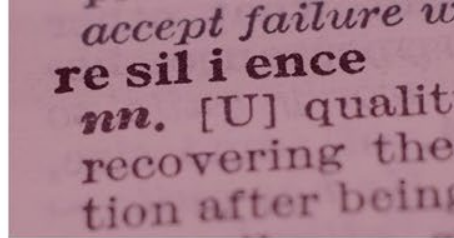


1115 Demonstration Waiver Renewal

- Current waiver is due to expire on September 30, 2021
- Possible short term extension of existing allowances
- Possible termination of certain allowances (i.e., AHCCCS Works, AHCCCS CARE)
- Further negotiation
 - Targeted Investments Program continuation,
 - Verbal consent in lieu of written signature for up to 30 days for ALTCS members,
 - Reimbursement for traditional healing services,
 - Reimbursement for adult dental services provided by IHS and Tribal 638 facilities, and
 - Housing and Health Opportunities (H2O) Initiative.

Revised Interim Evaluation Report

- AHCCCS is currently developing a revised Interim Evaluation Report:
 - Non-Survey measures
 - Survey Measures
 - Key Informant Interview Results
 - Focus Group Discussion Results
- Will be published on AHCCCS' website by the end of August 2021.



Public Health Emergency (PHE) Updates

Presented by Alison Lovell, Education Manager

Post COVID-19 Operations

- Due to the rise in COVID cases, AHCCCS has delayed the transition back to in-office operations to January 2022.
- The IHS/638 Quarterly Billing Forum will remain virtual until 2022.
- AHCCCS will continue to follow all health and safety protocols as directed.
- DFSM will continue to communicate externally regarding updates.

PHE Updates

To address Medicaid-related questions from providers about COVID-19, AHCCCS has developed a list of Frequently Asked Questions (FAQs).

- [COVID-19 FAQs](#)

As a result of flexibilities and changes made in response to the COVID-19 PHE, information presented in some FAQs will not align with various provisions set forth in the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Contractor Operation Manual (ACOM) Policies, the AHCCCS billing requirements, and/or other AHCCCS directives.

- In these instances, the FAQs take precedence and are controlling.

COVID-19 and Billing Reminders

AHCCCS covers COVID-19 testing. Please refer to [AHCCCS Medical Coding Resources](#) for the most current COVID-19 medical coding information on COVID-19 testing.

- **ICD-10 code for COVID-19:** U07.1, 2019-nCoV acute respiratory disease, effective in PMMIS for dates of service February 4, 2020 and thereafter.
- In addition the CDC released six new codes to better capture the disease progress of COVID-19. These new diagnosis codes are listed in the [COVID-19 Medical Coding Guidance](#) posted on the AHCCCS Medical Coding Resources web page, and are effective in PMMIS for dates of service 1/1/2021 thereafter.

COVID Vaccination Sites & NEMT Wait Time

As part of Arizona's COVID-19 vaccine distribution strategy, state and county drive-through vaccine sites have been created as a mechanism to administer the vaccine to eligible populations.

To ensure that AHCCCS members, who cannot provide or arrange their own transportation, have access to these vaccine distribution sites, AHCCCS is temporarily implementing modifications to the Non-Emergency Medical Transportation (NEMT) wait time billing rules and reimbursement through the end of the PHE.

Additional information, including billing guidelines and coding, can be found here: <https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html#NEMT>

Assistance with Scheduling Covid-19 Appointments

AHCCCS, in partnership with the Crisis Response Network, announced a COVID-19 appointment and transportation navigation program for Medicaid members. Now, Medicaid members who need assistance scheduling a COVID-19 vaccine appointment, as well as transportation to and from that appointment, can call 1-844-542-8201, 8 a.m. to 5 p.m., seven days a week.

Trained navigators are available to help callers find and schedule vaccine appointments, and, if needed, also assist with scheduling non-emergency medical transportation.

- <https://www.azahcccs.gov/shared/News/PressRelease/VaccineNavigators.html>



Vaccine Memos and Guidance

Flu and COVID-19

Presented by Alison Lovell, Education Manager

Vaccination Memos

AHCCCS has published guidance on the Flu and COVID-19 Vaccines for IHS/638 and Fee-for-Service providers.

These memos can be found on the DFSM Provider Training web page at the below links:

- [Flu Vaccine Memo](#)
- [Pharmacy AIR Reimbursement for the Flu Vaccine Administration](#)
- [Updated IHS/638 COVID-19 Vaccine Billing Guidelines \(3/31/2021\)](#)

COVID-19 Vaccine Billing Reminders for IHS/638 Clinics

IHS and 638 Facilities administering the COVID-19 vaccine as a clinic service may bill the current outpatient AIR in effect on the date of service for the administration of the vaccine on a UB-04 for Title XIX AHCCCS members.

The claim must include the NPI(s) of the ordering and rendering provider and the providers must be AHCCCS registered.

The facility may bill the AIR for the initial and second administration of the injection, so long as the memo requirements are met.

Retroactive billing will be allowed for the administration of the COVID-19 vaccinations as noted below:

- 12/14/2020 for the Pfizer vaccine
- 12/18/2020 for the Moderna vaccine
- 02/27/2021 for the Janssen vaccine

COVID-19 Vaccine Billing Reminders for KidsCare Members

For Fee-for-Service KidsCare members, the facilities are to bill AHCCCS for the administration fee(s) noted in the IHS/638 COVID-19 Vaccine Billing Guidelines Memo using the CMS 1500 Form or in the 837P format.

The facility may bill for the initial and second administration of the injection.

Retroactive billing will be allowed for the administration of the COVID-19 vaccinations as noted below:

- 12/14/2020 for the Pfizer vaccine
- 12/18/2020 for the Moderna vaccine
- 02/27/2021 for the Janssen vaccine

American Indian Medical Homes

Arcelia Velazquez
Integrated Services Specialist

What is an American Indian Medical Home?

The American Indian Medical Home (AIMH) is a care management model that puts AHCCCS American Indian Health Program (AIHP) members at the forefront of care.

AIMHs help address health disparities between American Indians and Alaskan Natives in Arizona by enhancing case management and care coordination through the use of Primary Care Case Managers (PCCM) and 24 hour access to the care team.

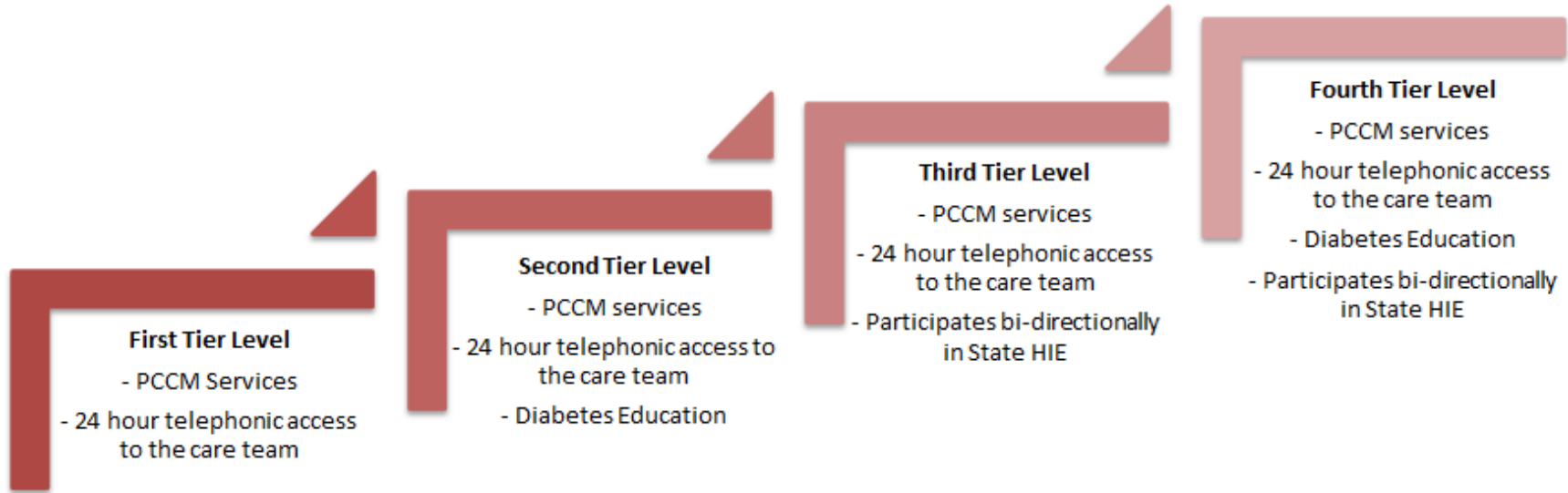
AIMH Medical Provider Types

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

AIHM Provider Requirements

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

AIMH Per Tier Levels



AIHM Reimbursement Rates 2021

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

Active American Indian Medical Homes

Tier 1

**Fort Yuma Indian
Health Center**
(12 Members)

Tier 2

**Phoenix Indian
Medical Center**
(5,241 Members)
WhiteRiver Indian Hospital
(5,932 Members)

- Approximately 26% of AHP members are empaneled with an AIMH.

Active American Indian Medical Homes

Tier 3

**Winslow Indian
Medical Center
(3,561 Members)**

Tier 4

**Chinle Comprehensive
Health Care
(13,407 Members)
San Carlos Apache Healthcare
(3,648 Members)
Tuba City Regional Hospital
(2,071 Members)**

- Approximately 26% of AIHP members are empaneled with an AIMH.

AIHM Resources and General Information

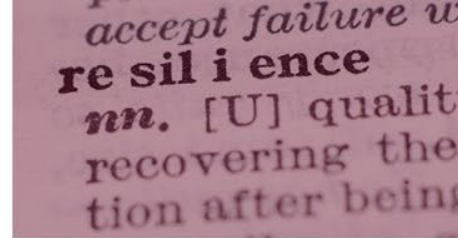
IHS/638 providers can send questions to AIMH@azahcccs.gov

Review AIMH information at

<https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/>

State Plan Amendment (SPA)

<https://www.azahcccs.gov/Resources/StatePlans/StatePlanAmendments.html>



APEP Updates

Anthony Enoch Jr.
Provider Training Specialist

APEP

Effective August 1, 2021, the Division of Member and Provider Services, Provider Enrollment will no longer accept paper submitted updates/modifications by mail, email, or fax.

Provider Enrollment transitioned from a paper process to the AHCCCS Provider Enrollment Portal (APEP) in the summer of 2020 and continues to standardize enrollment processes to improve the overall processing time. As the online application system approaches its one year anniversary, the agency is moving toward an entirely electronic process that eliminates paper.

- A modification, also known as an update or change request, is any type of change required to maintain the active provider ID. Modifications include changes to address(es), telephone number(s) demographics, license/certificate updates, etc.

NEMT & APEP Reminder

At this time the APEP system is unable to accept online modifications for Non-Emergency Transportation and Attendant Care providers who report employees.

Please continue to submit these via paper.

APEP Service Location Update

The APEP system now allows ***service addresses to be updated directly in APEP.***

- This means uploading the list of service addresses is no longer required.
- The service address(es) are updated in Step 2: Locations and require a minimum of one service address to complete the step.

For providers that submitted a list of service address(es) along with the application that has not been approved, the application will be placed back into an “In Process” status to allow the user to update the service address(es) and resubmit.

Providers in an approved status requiring a service address, If the user has domain permissions to access the file, submit a modification request in APEP and add the service address(es) in Step 2: Locations.

APEP FAQs

If you're seeking quick answers to common questions regarding APEP or enrolling as an AHCCCS provider, please visit the current list of common questions regarding the provider enrollment process.

The list of FAQs can be found at:

- <https://azahcccs.gov/PlansProviders/NewProviders/registration/APEP/faq.html>

APEP Assistance and Contact Information

- For assistance on creating the Single-Sign-On (SSO) or submitting a modification to an existing provider ID, please review the APEP training materials available on the AHCCCS website at <https://AZAHCCCS.GOV/APEP>
- For assistance on requesting the temporary 14 digit application ID or requesting domain permission, please contact Provider Assistance at: (602) 417-7670, option 5, or email Provider Enrollment at APEPTrainingQuestions@azahcccs.gov

Tribal Transportation Workgroup Updates

Christopher Ray

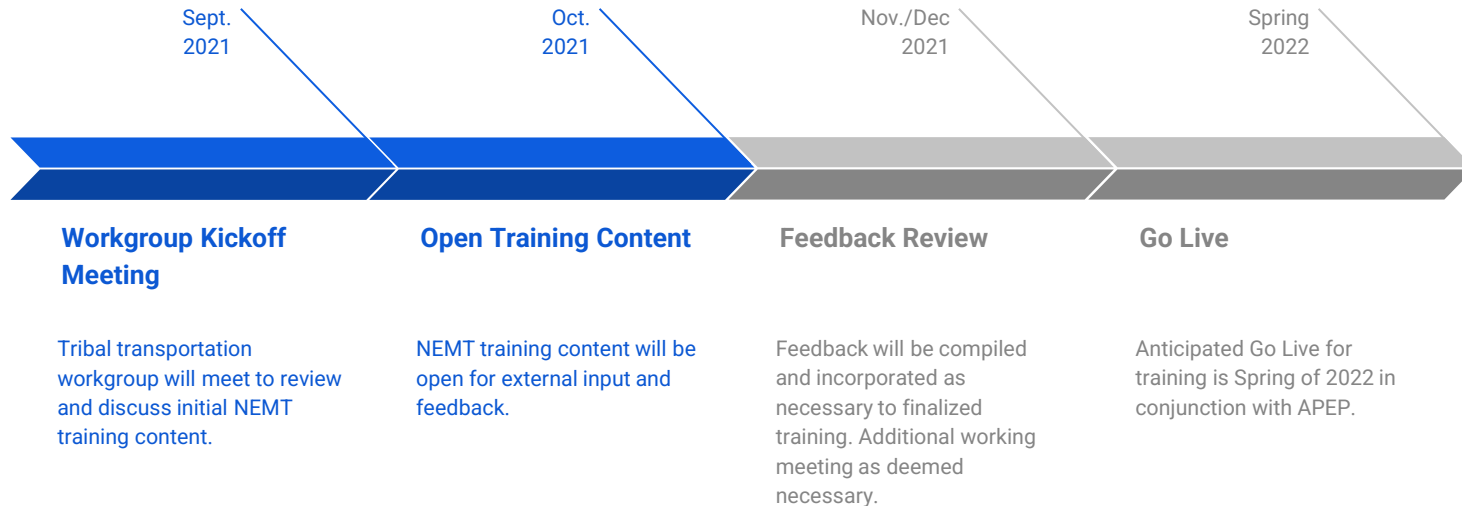
Claims, Audit and Education Administrator

Tribal Transportation Workgroup

- Reconvening the tribal transportation workgroup to review NEMT requirements (AMPM 310-BB) for the owners of NEMT companies.
- This will be a newly required component for certification (in alignment with APEP).
- Workgroup to convene in fall of 2021, training go live early 2022.

Tribal Transportation Workgroup Timeline

NEMT Required Training



NEMT Training Content Examples:

- NEMT Policy, Resources & Regulations
- Quality Management
- Prior Authorization (PA)
- Claims Submission

Contact Information

- For additional questions or to participate in the tribal transportation workgroup meeting:
- Chris Ray
 - christopher.ray@azahcccs.gov
- Email participation requests by 8/31/21

NEMT Reminders


Jennifer Gillmore
Provider Training Officer

AMPM 310-BB, Transportation

Transportation Policy

The transportation policy contains information on both emergency and non-emergency medical transportation.

Per the [Provider Participation Agreement \(PPA\)](#) that a provider signs when enrolling with AHCCCS, providers agree to follow AHCCCS policy.

 AHCCCS Arizona Health Care Cost Containment System		AHCCCS MEDICAL POLICY MANUAL SECTION 310 – COVERED SERVICES
310-BB - TRANSPORTATION		
EFFECTIVE DATES:	10/01/94, 07/01/18, 05/01/19	
APPROVAL DATES:	02/18/98, 10/01/99, 10/01/01, 11/01/04, 10/01/08, 03/01/12, 05/17/18, 02/07/19	
I. PURPOSE		
This Policy applies to AHCCCS Complete Care (ACC), ALTCS E/PD, DCS/CM/DP (CMDP), DES/DDD (DDD), and RBHA Contractors; Fee-For-Service (FFS) Programs as delineated within this Policy including: Tribal ALTCS, TRBHAs, the American Indian Health Program (AIHP); and all FFS populations, excluding Federal Emergency Services (FES). (For FES, see AMPM Chapter 1100). This Policy establishes requirements for coverage of transportation.		
II. DEFINITIONS		
AIR AMBULANCE	A helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated by A.R.S. §36-2201 to be used in the event of an emergency to transport members or to obtain services.	
AMBULANCE	A motor vehicle licensed by ADHS pursuant to A.R.S. §36-2201 especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.	
AMBULATORY TRANSPORTATION	A vehicle other than a taxi but includes vans, cars, minibus or mountain area transport. The AHCCCS member shall be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.	
EMERGENCY TRANSPORTATION	Ground and air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the individual's condition. Emergency transportation is needed when due to a sudden onset of a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in: a. Placing the member's health in serious jeopardy, b. Serious impairment of bodily functions, or c. Serious dysfunction of any bodily organ or part, or d. Serious physical harm to self or another person	

NEMT Policy

Provider Participation Agreement

Per the PPA, “...AHCCCS and the Provider do hereby acknowledge and expressly agree as follows:

B. General Terms and Conditions

2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-for-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.”

By becoming an AHCCCS-registered NEMT provider, or provider rendering NEMT services, the provider agrees to follow all AHCCCS policies.

NEMT Policy

Coverage of NEMT Services

NEMT is covered under three conditions.

- The medical or behavioral health service for which the transportation is needed is an AHCCCS covered service *and* medically necessary.
- The member is not able to provide, secure, or pay for their own transportation, and free transportation is not available.
- The transportation is provided to and from the nearest appropriate AHCCCS-registered provider.

NEMT Policy

Coverage of NEMT Services

If a member is not able to provide, secure, or pay for their own transportation, and free transportation is not available, non-emergency transportation services are also covered under the following circumstances:

- To transport a member to obtain Medicare Part D covered prescriptions, and
- To transport a member to participate in local [community based support programs](#) as identified in the member's service plan.
 - NOTE: Transportation coverage to these programs is limited to transporting the member to the nearest program capable of meeting the member's needs as identified on the member's service plan. Covered local community-based support programs are limited to those specified in [Attachment A of AMPM 310-BB](#).

NEMT Policy

NEMT providers MUST adhere to the following:

1. The member must not require medical care en route.
2. Passenger occupancy must not exceed the manufacturers specified seating occupancy.
3. Members, transports, and other passengers must follow state laws regarding passenger restraints for adults and children.
4. Vehicle must be driven by a licensed driver, following applicable state laws.
5. Vehicles must be insured.
6. Vehicles must be in good working order.
7. Members must be transported inside the vehicle.

NEMT Daily Trip Report

AHCCCS requires the use of the AHCCCS standard Daily Trip Report, which is [Exhibit 11-1 in the IHS Tribal Provider Billing Manual](#).

Per [Chapter 11, Transportation, of the IHS Tribal Provider Billing Manual](#), **“The AHCCCS Daily Trip Report must be submitted with the claim.”**

- Claims submitted without a complete AHCCCS Daily Trip Report, will be denied. These must be *fully filled out*.

Transaction Insight Portal Reminders

Jennifer Gillmore
Provider Training Officer

Transaction Insight Portal Reminders

To use the Transaction Insight Portal, providers must have a valid Username and Password.

Providers must keep their login information safe and secure. Sharing their account information (username and password) is prohibited.

To request a Username/Password account for the Transaction Insight Portal, contact: servicedesk@azahcccs.gov

Use the category: Information Technology (IT)>EDI Transactions>275 – Transaction Insight (TI) Web Upload Attachment Add New User

To logon to the **Transaction Insight Portal Production Environment:**

<https://tiwebprd.statemedicaid.us>

Transaction Insight Portal Reminders

For any issues uploading attachments on the Transaction Insight Portal, providers must open a ticket through servicedesk@azahcccs.gov using the following category:

- **Information Technology (IT)>EDI Transactions>275 - Transaction Insight (TI) Web Upload Attachment Submission Issues**

When opening a ticket, please provide the Service Desk team with at least five claims and their corresponding Transaction Insight Portal information. The Transaction Insight Portal information that is needed should include all of the following:

- First and last name of the staff who uploaded the attachment,
- Dates and times the attachments were uploaded,
- The 10-digit NPI or 6-digit AHCCCS Provider ID number, and
- The Payer Claim Control Number or Provider Attachment Control Number.

Transaction Insight Portal Reminders

AHCCCS has been seeing multiple errors amongst providers who are submitting documentation as a **Non-Person Entity (2)**.

- **Do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.**

If you select Non-Person Entity (2) and then enter information into the Provider First Name field, this will cause an error and your attachments will not link to the claim.

- **This will cause your claim to be denied for missing documentation.**

Transaction Insight Portal Reminders

Incorrect

Provider Entity Type Qualifier: Person (1) **Non-Person Entity (2)**

Provider Last or Organization Name: Organization Name

Provider First Name: **Organization Name (If you put something here, the documentation will not attach and the claim will be denied).**

Correct

(Provider First Name must be left blank/empty)

Provider Entity Type Qualifier: Person (1) **Non-Person Entity (2)**

Provider Last or Organization Name: Organization Name

Provider First Name:

Transaction Insight Portal Reminders

The Provider First Name field **must** be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the

I

Submitter Last or Organization Name	ORGANIZATION NAME	*
Provider Entity Type Qualifier	<input type="radio"/> Person (1) <input checked="" type="radio"/> Non-Person Entity (2)	*
Provider Last or Organization Name	ORGANIZATION NAME	*
Provider First Name		

Transaction Insight Portal Reminders

Please also review page 8 (Submitter Last or Organization Name) in the guide: [Transaction Insight Web Upload Attachment Guide](#)

If you encounter problems logging on to the Transaction Insight Portal, please open a ticket to servicedesk@azahcccs.gov

Download the latest training on the new web upload attachment layout here: <http://files.constantcontact.com/6b827043601/e18b3a77-26ca-4030-93a7-6815b9731fb6.pdf>

For any additional questions regarding training on the Transaction Insight Portal, please contact: ProviderTrainingFFS@azahcccs.gov

Transaction Insight Portal

Question: Can external users get access to the Document and the Transmission Summary Pages in the Transaction Insight Portal?

Answer: External users are not permitted to access these segments. As an option, it is suggested for providers using the Transaction Insight Portal to keep track of uploads internally. This can be done by creating a tracking tool to meet your specific needs. We have provided an example of a tracking tool on the next slide.



Transaction Insight Portal

Example: PWK Tracking Tool

Format: Excel

Claim Submission Information			Transaction Insight (TI) Portal Information				
Claim Source (837 or Online/Web)	Claim Record Number (CRN)	Claim #PWK		First Name and Last Name of staff who uploaded the trip reports	Date/Time Trip Reports were uploaded	10-digit NPI or 6 Digit Provider ID No.	Payer Claim Control Number or Provider Attachment Control Number



Medical Equipment (DME) & Medical Supplies, Orthotics and Prosthetics

Peri Smith
Provider Training Officer

Medical Equipment and Medical Supplies

Medical Equipment & Supplies

AHCCCS covers medically necessary Medical Equipment, Medical Appliances and Medical Supplies (including incontinence briefs), and under the home health services benefit, that are suitable for use in any Setting in Which Normal Life Activities Take Place, when the following conditions are met:

- a. Provided in Settings in Which Normal Life Activities Take Place,
- b. Ordered by the member's physician or beginning March 1, 2020 ordered by the member's:
 - i. Nurse practitioners,
 - ii. Physician assistants, or
 - iii. Clinical nurse specialists, as a part of the plan of care and is reviewed by the practitioner annually,
- c. Authorized as required by AHCCCS, Contractor, or Contractor's designee, and
- d. Face-To-Face encounter requirements for FFS Programs are followed and documented

Medical Equipment and Medical Supplies

Medical Equipment & Supplies

The term “medical equipment” refers to both medical equipment and appliances. Any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic, and

1. Is customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness, disability, or injury,
2. Can withstand repeated use, and
3. Can be reusable by others or removable.

NOTE: *Medical Equipment & Supplies are often referred to as Durable Medical Equipment (DME)*

Medical Supplies

Health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].

Medical Equipment and Medical Supplies

What else should a provider know about Medical Equipment & Supplies?

- Medical Equipment and Medical Supplies cannot be limited to members who are homebound.
- Coverage of Medical Equipment is not restricted to the items covered as DME in the Medicare program.
- Coverage of Medical Equipment and Supplies cannot be contingent upon the member needing nursing or therapy services.
- Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary equipment can be obtained at no cost.

Durable Medical Equipment (DME) Rental vs Purchase

Important Notes on DME Rentals and Purchases

- All DME items requiring PA are reviewed depending on the item's purpose, cost, and duration for use of the equipment.
- The total expense of renting the equipment shall not exceed the purchase price (i.e. if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item).
- Prior authorization is required for all medical equipment rentals, purchase, and repairs.
- Purchase requests will be reviewed and approved based on the member's medical needs.

Medical Equipment and Medical Supplies Reference

- Refer to [AMPM Policy 310-P, Medical Equipment, Medical Appliances & Medical Supplies](#) for complete information regarding coverage of medical equipment and supplies, including face-to-face requirements.
- Refer to <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/800/820.pdf> for complete information on FFS Prior Authorization requirements for covered services.

Orthotics & Prosthetics

Orthotics

Devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, or prevent or correct physical deformity or malfunction, (42 CFR 440.120, A.A.C. R9-22-212).

Prosthetics

Devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed, or malfunctioning portion of the body, such as artificial upper and lower limbs (A.A.C. R9-22- 212).

Orthotics & Prosthetics

Orthotics & Prosthetics

AHCCCS covers medically necessary orthotic and prosthetic devices, when

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

Note: PA is required for the purchase of orthotic and prosthetic devices exceeding \$300.00.

Orthotics

Orthotics

Orthotic devices are covered for member when medically necessary as specified below:

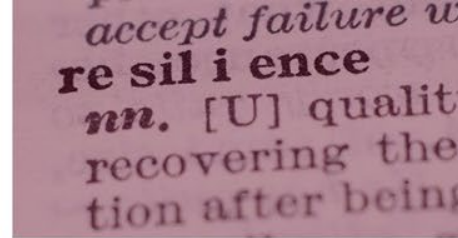
- o Orthotics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430.
- o Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:
 - i. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines,
 - ii. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
 - iii. The orthotic is ordered by a Physician or PCP.

Prosthetics

Prosthetics

Prosthetics are covered for member when medically necessary as specified below:

- a. Prosthetics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430, and
- b. Prosthetics are covered for AHCCCS members age 21 and older when medically necessary for rehabilitation, except as specified in Exclusions within [AMPM 310-JJ, Orthotics and Prosthetics.](#)



Members with Dual Eligibility or TPL

Peri Smith
Provider Training Officer

Payer of Last Resort

AHCCCS is considered the “Payer of Last Resort” (per A.A.C. R9-22-1003), unless specifically prohibited by federal or state law. AHCCCS shall be used as a source of payment for covered services ***only after all other sources of payment for covered services have been exhausted per A.R.S. 36-2946.***

- NOTE: This means that AHCCCS has liability for payment of benefits ***after*** other first and third-party payer benefits have paid on the claim.

Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

IMPORTANT: The claims submitted to AHCCCS **must** exactly match the original claims submitted to the primary payer source.

Payer of Last Resort

- **IMPORTANT:** If a member's record indicates the existence of first or third-party coverage, but no insurance payment is indicated on the claim (EOB for example) from that first or third-party coverage source, **then the claim submitted to AHCCCS Medicaid will deny.**
- When a member has Medicare, first or third-party coverage, and EOB will be required by AHCCCS in order for AHCCCS to process the claim.
 - **This is required even IF the provider knows in advance that the service is not covered by the other payer source and that no payment will be made.** The provider must still submit to the other payer source first to obtain documentation of the valid denial (such as an EOB).

Verifying Member Enrollment

Provider Responsibility to Verify Member Enrollment

It is a provider's responsibility to verify a member's enrollment!

Health care providers may use any one of several verification processes to obtain eligibility and enrollment information for a Medicaid member, including any information regarding their Medicare or Third Party Payer Liability (if available).

- <https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFSChapter2Eligibility.pdf>

Fee-for-Service Member Enrollment and Eligibility

Verification Processes Available to Providers Include:

1. AHCCCS Online Provider Portal
2. Interactive Voice Response
3. Medical Electronic Verification System (MEVS)
4. AHCCCS Batch 270/271 Eligibility Verification Request and Response

Member Verification - Available Options

1. AHCCCS Online Provider Web Portal

- This allows AHCCCS providers to verify eligibility and enrollment status.
- AHCCCS providers can view ,Third Party Liability , Copayments (if applicable), Medicare Coverage, Behavioral Health Services, Share of Cost, Special Program enrollment and Additional Benefits information.

To create an online account and begin using the application, providers must go to <https://azweb.statemedicaid.us>.

Member Verification - Available Options

2. The Interactive Voice Response System (IVR)

- This allows an unlimited number of phone verifications by entering information on a touch-tone telephone.
 - Providers may call IVR at:
 - Phoenix: (602) 417-7200
 - All others: 1-800-331-5090

Member Verification - Available Options

3. The Medical Electronic Verification System (MEVS)

- This uses a variety of applications to provide member information to providers.
- For information on MEVS, please contact EMDEON at: <https://www.changehealthcare.com/contact-us>

Member Verification - Available Options

4. AHCCCS Batch 270/271 Eligibility Verification Request and Responses

- Providers can also verify information through a batch process (270/271), in which the provider sends a file of individuals to AHCCCS. AHCCCS returns this file with its responses the following day.
- Information on that process can be obtained by calling the AHCCCS Help Desk at (602) 417-4451.

Eligibility and Enrollment Processes

1 AHCCCS
Online
Portal

2 Interactive
Voice Response
(IVR)

3 Medical Electronic
Verification System
(MEVS)

4 AHCCCS Batch 270/271 Eligibility
Verification Request and Responses:

Third Party Liability

How Does the Process Work?

Once the provider has identified a member's TPL and submitted a claim to the TPL/Medicare, and intends to submit the claim for additional consideration to AHCCCS:

- A copy of the primary payer's Explanation of Benefits (EOB) will be required for consideration of the claim, ***even when the service provided is a non-covered service for the primary payer.***
- Even if a provider has the reasonable expectation that a service will *not* be reimbursed under the member's primary payer (such as their health plan), a claim must still be submitted to that primary payer to obtain a formal determination (such as a denial/EOB).
- This denial/EOB must then be submitted to AHCCCS with the claim.

Responsibility to Appeal

Appealing the Primary Payer is the Provider's Responsibility

If the first- or third-party payer (such as a health plan) denies a claim for a covered service, then the provider must follow that health plan's appeal process.

The provider **must** exhaust all remedies before the claim can be submitted to AHCCCS, and before AHCCCS can consider the covered service.

Once all other payer sources have been utilized, then the provider **must** submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission. If this is not done, then the claim submitted to AHCCCS may deny.

TPL and Payment Amounts

Reimbursement

The AHCCCS Administration's reimbursement responsibility is limited to no more ***than the difference between the Capped Fee-For-Service schedule and the amount of the first- or third-party liability.***

An AHCCCS registered provider agrees to accept the Capped Fee-For-Service rate as payment in full.

- Note: For IHS/638 Providers, the All-Inclusive Rate (AIR) is considered the Capped Fee-For-Service rate, for claims for offered services that meet AIR reimbursement criteria.

TPL and Payment Amounts

How Does Reimbursement Work When Fee Schedules Have Different Allowed Amounts?

Insurance payers may have a different fee schedule or allowed amount assigned to each CPT/HCPCS code. Some payers allowed amounts may be higher or lower than others.

If the first- or third-party coverage **paid more** than the Capped Fee-For-Service rate, then no further reimbursement is made by AHCCCS.

- **IMPORTANT:** AHCCCS *will not* issue a payment when the primary insurance payer's payment exceeds the AHCCCS allowable amount.

If the primary insurance allowed amount is **less than** the AHCCCS allowed amount, it is possible that a payment will be considered (based on review).

TPL and Payment Amounts

How Does Reimbursement Work When Fee Schedules Have Different Allowed Amounts?

Sometimes members have 3 or more coverage plans.

Should more than one coverage plan make payment and the total amount paid by *all the coverage plans* is more than the AHCCCS Capped Fee-For-Service fee schedule amount, then there will be no AHCCCS payment.

- **IMPORTANT:** The provider cannot balance bill the member for any amount. Arizona Revised Statute §36-2903.01(K) prohibits providers from billing AHCCCS members, including QMB Only, for AHCCCS-covered services.

Differences Between TPL and Medicare

With **TPL**, AHCCCS pays the difference between the AHCCCS Capped Fee-for-Service fee schedule and the total amount paid by *all the coverage plans*.

- If the total amount already paid by the member's TPL(s) is more than the AHCCCS Capped Fee-For-Service fee schedule amount, then there will be no AHCCCS payment.

With **Medicare**, what AHCCCS pays is based on the type of Medicare coverage the member has (QI1-Part B, SLMB, QMB Dual, or Non-QMB Dual).

Specified Low-Income Medicare Beneficiary (SLMB) Program

Specified Low-Income Medicare Beneficiary (SLMB) Program (Health Plan ID# 008040)

For members enrolled as SLMB, please note that this is a Medicare Savings Program that pays *only* the member's Medicare Part B premium.

AHCCCS does not reimburse providers for the Medicare cost-sharing amounts (copay/coinsurance/deductible).

AHCCCS SLMB-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. **No claim payments are done by AHCCCS Administration.**

Qualified Income (QI1)-Part B Buy In

Qualified Income (QI1) Program-Part B Buy In (Health Plan ID# 008050)

For members enrolled as QI1, please note that this is a Medicare Savings Program that pays *only* the member's Medicare Part B premium.

AHCCCS does not reimburse providers for the Medicare cost-sharing amounts (copay/coinsurance/deductible).

AHCCCS QI1-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. **No claim payments are done by AHCCCS Administration.**

Qualified Medicare Beneficiary (QMB) Only

Qualified Medicare Beneficiary (Health Plan ID# 008715)

Members who are QMB Only qualify for Medicare, but not Medicaid.

AHCCCS can reimburse the provider for the Medicare deductible, coinsurance, and copay.

If Medicare denies the service and upholds the denial upon the provider's appeal, then AHCCCS makes no payment.

Balance billing of QMBs is prohibited by Federal Law.

- Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost sharing.

QMB Dual

Qualified Medicare Beneficiary Dual

A QMB Dual member is an individual who qualifies under the federal QMB program and Medicaid (AHCCCS). Per A.A.C. R9-29-302:

1. AHCCCS will pay the following costs for FFS members when the services are received from an AHCCCS registered provider and the service is covered:
 - a) By Medicare only, then AHCCCS pays only the Medicare deductible/coinsurance/copay;
 - b) By Medicaid only, then AHCCCS pays the FFS rate; or
 - c) By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible/coinsurance/copay.
2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

QMB Dual

Qualified Medicare Beneficiary Dual (#008715)

A.A.C. R9-29-302.E. advises:

“A QMB Dual eligible member who receives services under 9, A.A.C. 22, Article 2 or 9, A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges.”

Non-QMB Dual

Non-Qualified Medicare Beneficiary Dual

Non-QMB Dual – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as “Dual Eligible”).

Per A.A.C. R9-29-303:

1. AHCCCS will pay the following costs for FFS members when services are received from an AHCCCS registered provider and the service is covered:
 - a) By Medicare only, then AHCCCS shall not pay the Medicare deductible or coinsurance or copay;
 - b) By Medicaid only, then AHCCCS pays the FFS rate; or
 - c) By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible, coinsurance or copay.

Non-QMB Dual

Non-Qualified Medicare Beneficiary Dual

Non-QMB Dual – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as “Dual Eligible”).

Per A.A.C. R9-29-303:

2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

TPL Examples - Medicare QMB Dual

Example 1 (IHS or 638 Clinic)

An IHS or 638 free-standing clinic submits a claim to Medicare for a clinic-definable service (PCP visit), for a dual eligible member (QMB Dual).

- Medicare pays \$50.00 for the office visit, and this is applied to the member's deductible.
- The AHCCCS Capped FFS schedule allows \$519.00 (the 2021 AIR) for the office visit.
- However, AHCCCS does not pay \$469.00 on the claim (the difference between the Capped FFS schedule and what Medicare paid), since for QMB Dual members AHCCCS' payment liability is limited to Medicare Cost Sharing. In this case, that is the deductible. In this example, AHCCCS would pay \$50.00.

TPL Examples - Medicare QMB Dual

Example 2 (Service Not Covered by Medicare)

A provider renders a service that is statutorily *not* covered by Medicare.

However, the member is a *dual eligible member* (QMB Dual) with both Medicare and AHCCCS Medicaid, and the service rendered *is* covered by Medicaid.

The provider still must submit a claim to Medicare for the service rendered, even though they have the reasonable expectation that it will be denied.

- This is a necessary step to obtain a formal determination and to obtain the denial/EOB.

When the claim is submitted to Medicare, it is submitted with the Modifier GY.

- **Modifier GY** – to be used when physicians, practitioners, or suppliers want to indicate that the items or services are statutorily non-covered or are not a Medicare benefit.

TPL Examples - Medicare QMB Dual

Example 2 (Service Not Covered by Medicare) Continued...

Once the provider obtains the denial from Medicare, they submit the denial and the claim to AHCCCS Medicaid for the service.

- Medicare pays \$0.00 for the statutorily non-covered service.
- AHCCCS pays the AHCCCS Capped FFS rate for the Medicaid covered service.
- The claim must be submitted to AHCCCS *exactly* as it was submitted to Medicare.

TPL Examples - Private Insurance

Example 3 (IHS or 638 Clinic)

An IHS or 638 free-standing clinic submits a claim to a private insurance for a clinic-definable service (PCP visit).

- The TPL pays \$50.00 for the office visit, and this is applied to the member's deductible.
- The AHCCCS Capped FFS schedule allows \$519.00 (the 2021 AIR) for the office visit.
- AHCCCS pays \$469.00 on the claim, since that is the difference between the payment made by the first party payer (TPL) and AHCCCS' FFS rate.

RECAP

It is important for providers to understand the following:

1. If a member has a TPL (such as Medicare or a private insurance plan), they must submit the claim to the TPL/Medicare first.
2. If the claim is denied, the provider **must exhaust all appeals options with the TPL/ Medicare.** A provider cannot receive a denial, then submit a claim to AHCCCS without first doing this. AHCCCS will deny the claim in these situations.
3. If the TPL/Medicare claim has been denied, **and the provider has exhausted all appeals options with TPL/Medicare,** a provider must know the claim will not crossover to AHCCCS automatically. This means that if a provider would like additional consideration, a provider must submit the following to AHCCCS:
 - The Claim
 - The EOB
 - Copy of the Final Appeal Decision by the TPL/Medicare

TPL and Payment Amounts

Training Opportunities

The Division of Fee-for-Service Management's (DFSM) Provider Training Team offers a TPL-specific training for providers.

For additional questions please visit the [DFSM Provider Training webpage](#).

- Under Trainings by Subject, select “Third Party Liability” for a PDF copy of the training; *or*
- Under Training Schedule, sign up for the next group TPL training session.



Emergency Triage, Treat and Transport (ET3)

Alison Lovell
Education Manager

What is ET3?

- Emergency Triage, Treat, and Transport (also known as ET3) is a payment model designed to reduce unnecessary transport to emergency departments
- ET3 seeks to remedy the challenges currently faced by EMS providers by providing greater flexibility to ambulance care teams following a 911 call
- AHCCCS ET3 will be effective 10/1/21, subject to CMS approval

ET3 Components

- 1. Transport of Member to Alternate Destination** (e.g., urgent care center, BH provider, or PCP's office)
- 2. Treatment in Place by a Qualified Health Care Practitioner *In Person*** (e.g. EMS personnel provide treatment at member's existing location, using standing orders)
- 3. Treatment in Place/Triage by Qualified Health Care Practitioner** (e.g. medical triage of member via telehealth, with EMS personnel assisting as needed)

How Does ET3 Impact Providers?

- Increased efficiency in the EMS system by:
 - Allowing EMS providers to provide treatment in place (when clinically appropriate) and reducing unnecessary transports,
 - Allowing EMS providers to transport members to alternate destinations when a different level of care is appropriate, reducing member/provider wait times in EDs,
 - Freeing up EDs for patients who require that level of care,
 - Helping EMS entities establish triage line for low-acuity 911 calls, and
 - Getting ambulances back in service more quickly, to more readily respond to and focus on high-acuity cases (e.g. heart attacks and strokes, by reducing unnecessary transports to Emergency Rooms).
- Permits reimbursement for triage, treat, and/or transport to an alternative site
- Easy for AHCCCS-registered emergency transport providers to participate

Who Can Participate in AHCCCS ET3?

- Any AHCCCS Registered Emergency Transportation Provider (**Provider Type 06**) has the opportunity to participate in ET3
 - Provider type 06 includes Tribal EMS providers
- Providers will participate by in ET3 by:
 - Adhering to AHCCCS ET3 Policy
 - Billing appropriate codes with proper modifier (CG). Codes billed without the CG modifier will not qualify as ET3.

Billing for ET3

Billing for Transport to an Alternate Destination

Claim Form: CMS 1500 Claim Form

Codes:

- A0426 – Ambulance Service, *Advanced Life Support*, Non-Emergency Transport Level 1
- A0428 - Ambulance Service, *Basic Life Support*, Non-Emergency Transport

Modifier: CG

Rate: Rates will align to the existing ambulance service rates on the proposed fee schedule with the requirement that modifier CG is utilized when billing for these services

Billing for ET3

Billing for Treatment in Place by a *Qualified Health Care Practitioner* (*In person*)

Claim Form: CMS 1500 Claim Form

Codes:

- A0998 – Ambulance Response and Treatment, No Transport

Modifier: CG

Rate: Rates will align to the existing ambulance service rates on the proposed fee schedule with the requirement that modifier CG is utilized when billing for these services

Billing for ET3

Billing for Treatment in Place/Triage by a *Qualified Health Care Practitioner (e.g. Telehealth)*

Scenario Example

An ambulance provider arrives at a member's home and during their assessment identifies that the patient is diabetic and hypoglycemic. The EMS personnel on scene administer oral glucose (a BLS service) and set the member up with a telehealth appointment with their PCP.

- In this scenario the ET3 provider may bill for Treatment in Place with A0998 CG.
- The PCP may bill for the office visit done by telehealth, following standard telehealth policies and billing guidelines.

How is ET3 different from Treat and Refer?

ET3	Treat & Refer
Does not require additional ADHS certification as a Treat & Refer provider	Requires ADHS certification as a Treat & Refer provider
Does not require a separate NPI	Requires a separate NPI for the Treat & Refer Provider Type
Open only to Certificate of Necessity (CON) providers, and Tribal providers who have submitted an attestation of CON equivalency to AHCCCS (part of the registration process as a PT 06 with AHCCCS)	Open to both CON and non-CON providers
Must be registered with AHCCCS as Provider Type 06 (Ambulance Provider)	Must be registered with AHCCCS as Provider Type TR (Treat & Refer)

How is ET3 different from Treat and Refer?

ET3	Treat & Refer
<p>ET3 reimburses for:</p> <ol style="list-style-type: none">1) Treatment in Place (by EMS personnel); and2) Treatment in Place/Triage by a Qualified Health Care Practitioner (Telehealth); and3) Transportation to an Alternate Destination.	<p>Treat & Refer reimburses for:</p> <ol style="list-style-type: none">1) Treatment in place (by EMS personnel)
<ul style="list-style-type: none">• Rates will align to the existing ambulance service rates on the proposed fee schedule with the requirement that modifier CG is utilized when billing for these services (for Treatment in Place by EMS personnel and Transportation to an Alternate Destination).• Rates for Qualified Health Care Practitioners providing telehealth services (e.g. PCP or specialist), will align to existing telehealth rates for those providers.	<p>Rates will align with existing Treat & Refer rates.</p>

ET3 Resources

AHCCCS ET3 Updates Page

- <https://www.azahcccs.gov/AHCCCS/Initiatives/ET3/>

Fee-for Service Provider Billing Manual

- [Transportation Chapter](#)
 - ET3 Updates Coming Soon

AHCCCS Medical Policy Manual (AMPM)

- [AMPM 310-BB, Transportation](#)
 - ET3 Updates Coming Soon



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
- Coding - Questions on AHCCCS Coding should be directed to the coding team at 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

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

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:

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

Thank You.