AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

June 2023

Multi-Systemic Therapy (MST)

This is a reminder about the delivery of Multi-Systemic Therapy (MST) services. MST services for juveniles are provided by behavioral health providers who meet the standards to provide MST services. MST services may be submitted to AHCCCS (Arizona Health Care Cost Containment System) FFS under the code H2033.

Providers of this service must be trained and licensed by MST Services, Inc. in South Carolina which provides a training, support, and quality assurance system aimed at achieving targeted outcomes through treatment fidelity.

Multi-Systemic Therapy is a family and community-based intervention for youth between the ages of 12 and 17 years old who have engaged in serious antisocial or delinquent behaviors that would warrant arrest. Youth appropriate to receive this intervention are at risk for out-of-home placement or are transitioning back from an out-of-home setting.

The primary goal is to develop independent skills among parents and youth with behavioral problems to cope with family, peers, school, and neighborhood problems through a period of brief but intense treatment typically lasting from three to five months.

Billing: Only one date of service can be billed per claim line. MST may not be billed on the same day as inpatient service and billers/coders should adhere to standard coding guidelines. Provider types that bill under their group billing provider ID number must identify the practitioner that rendered the MST services. Practitioners that are individually registered with the FFS program must bill MST services using their individual NPI number as the rendering/servicing provider.

CR Modifier and DR Condition Code Covid-19 Emergency Related

CR modifier and DR Condition Code COVID-19 Emergency Related - "CR" Modifier - Catastrophe/Disaster.

The "CR" Catastrophe/Disaster ***modifier*** must not be reported on any codes starting with May 12, 2023, and after. The CR modifier was only allowed during the PHE as related to the COVID-19 pandemic.

The DR ***condition code*** must not be reported on any codes starting May 12, 2023, and after. The DR condition code was applicable to inpatient stays for which a member had received a COVID-19 diagnosis.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

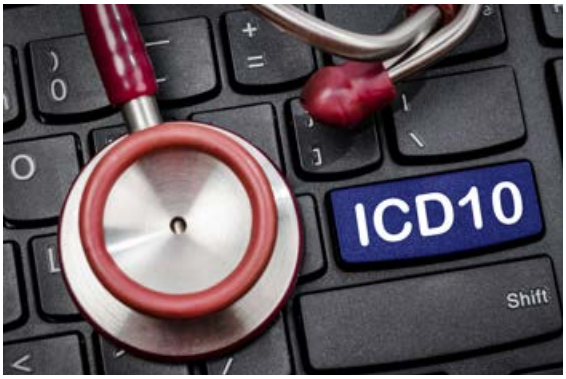
Transaction Insight Portal (TIBCO/ TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address: servicedesk@azahcccs.gov

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

Medical Coding Resources - Code Coverage Changes



Medical Coding Resources provides updated changes for coverage codes. The following codes are closed by CMS and not allowed for reporting for all providers and facilities. They will show as coverage 04 (not covered) effective May 12, 2023.

Any claims with May 12, 2023, and after will receive the appropriate denial.

G2023 Specimen collection for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source.

G2024 Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source.

U0003 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), amplified probe technique, making use of high throughput technologies as described by CMS-2020-01-R

U0004 2019-nCoV coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets), non-CDC, making use of high throughput technologies as described by CMS-2020-01-R.

U0005 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), amplified probe technique, CDC or non-CDC, making use of high throughput technologies, completed within 2 calendar days from date of specimen collection (list separately in addition to either HCPCS code U0003 or U0004) as described by CMS-2020-01-R2.

Community Health Workers and Community Health Representatives (CHW/CHR)

Effective April 1, 2023, the following codes can be reported. You can find more information on the Community Health Worker and Community Health Representatives (AHCCCS CHW/CHR) web page, including the CHW/CHR Frequently Asked Questions. The approved provider types are listed on the FAQ page. There will be a policy update published shortly, please watch for this policy.

The following codes can be reported by those who meet the criteria. There are limits of 4 units in one day and not more than 60 units in 30 days. Each unit is 30 minutes per code description.

The limits are for either a single code or a combination of the codes listed and not 60 units per code.

- 98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.
- 98961 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients.

98962 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients.

CLAIMS CLUES

Check out the May 2023 Claims Clues for additional Prior Authorization Information!

Transaction Insight Portal for Outpatient Behavioral Health Providers How to Attach Documentation for Specific BH Service Codes

In follow up to the notice released on May 3, 2023, AHCCCS Division of Fee for Service

Management informed fee-for-service (FFS) providers who render services to members enrolled in the Fee-for-Service and American Indian Health Program (AIHP), when billing more than 8 units of any of the HCPCS codes listed below in one day are required to provide the following documentation with the submission of the claim: a copy of the most recent comprehensive assessment, treatment plan, and the medical record documentation for the services billed on the service date.

Service Codes:

- H0004 (Behavioral Health Counseling and Therapy)
- H0038 (Self-Help/Peer Services)
- H2011 (Crisis Intervention Service)
- H2014 (Skills Training and Development)
- H2015 (Comprehensive Community Support Services)
- H2017 (Psychosocial Rehabilitation Services)
- H0025 (Behavioral Health Prevention Education Service)
- H2027 (Psychoeducational Service)
- S5150 (Unskilled Respite Care, Not Hospice)
- T1016 (Case Management)
- T1019 (Personal Care Services)
- H0034 (Medication Training and Support)

Providers that are rendering services to members enrolled in the AHCCCS Fee-for-Service and the American Indian Health Program (AIHP), can submit required documentation to an existing FFS claim using the Transaction Insight Portal (TIBCO) application.

How to Request a Transaction Insight Portal Account Each member of your team who has a service need to use the Transaction Insight Portal must send an individual email requesting a user account, if they do not have an active account. The TIBCO log-in credentials will be sent to the email address provided on the service desk request.

Important Note: Regardless of how the claim was initially submitted, paper, EDI or on the AHCCCS Online portal, the Transaction Insight Portal is the most effective way to attach required documentation to a FFS claim.

To request a Transaction Insight Portal account, FFS providers can email servicedesk@azahccccs.gov and please include the following information:

- Name of your organization and Provider Identification Number,
- Your full name, and
- Correct (work) email address.

Once you receive your login information, you can access the Transaction Insight Portal.

Transaction Insight Portal Continued

General Transaction Insight Portal (TIBCO) Information and Set Purpose Code Selection

Set Purpose Code 11 - If you have submitted a claim using one of the following methods, the AHCCCS Online Provider Portal, company software, clearinghouse, or billing company, you can still use TIBCO to attach the required documentation to your claim without having to resubmit the claim a second time. If there is a current claim on file, to attach the documentation to that claim, you will use the AHCCCS 12-digit claim reference number as your linking or attachment reference number. When using the claim number as the attachment number, please make sure to select **Set Purpose Code 11**.

For step-by-step instructions on how to use Transaction Insight Portal - Set Purpose Code 11

Set Purpose Code 02 - For those providers that are using the AHCCCS Online Provider Portal for the submission of the claim, in addition to completing the required tabs, you must also complete the "Attachment" tab. Doing this will prompt the system that you will be attaching documentation to that initial claim submission using the Transaction Insight Portal (TIBCO). The submitter will create a PWK number and please make sure to select **Set Purpose Code 02** when this option is selected. Please see the complete instructions listed in the training presentation below on how to create a PWK number for **Set Purpose Code 02**.

TIBCO Foresight (TI Web Upload Attachment Guide)

Prior Authorization Tips For Provider Type 71 Psychiatric Hospital

Prior authorization requests for Inpatient Psychiatric facility (PT71) must include the following documents:

- Completed copy of the Certificate of Need (CON) must include the date of admission, signed by DO/MD and credentials and DO/MD name must be legible on the document.
- The Certificate of Need (CON) is due within 72 hours of the admission.
- Psychiatric Evaluation.
- Multidisciplinary Treatment Plan.
- Daily MD progress notes signed and legible.
- Discharge Summary must include the date of discharge with the aftercare plan and must be signed by the attending medical provider.
- Providers should only upload the required documentation.
- All required documentation should be uploaded in one or two file uploads.

A Recertification of Need (RON) is required on the 4th covered day of the stay and must be provided weekly (7 days) thereafter until discharge. The RON can be signed by Medical Doctor (MD), Doctor of Osteopath (DO), Nurse Practitioner (NP) and Physician's Assistant (PA).

The **Event Type** must be BI **(Psychiatric Inpatient)** and the **Activity** tab must include the level of care identified by the revenue code and include the number of days.

Diabetes Self-Management Training (DSMT)

Reminder, effective October 1, 2022, coverage is available for Diabetes Self-Management Training (DSMT) outpatient services. DSMT is a nationally recognized program that supports individuals with developing the knowledge and skills to self care for their diabetes condition.

DSMT consists of individual sessions or group sessions which may be furnished by the following AHCCCS registered provider types:

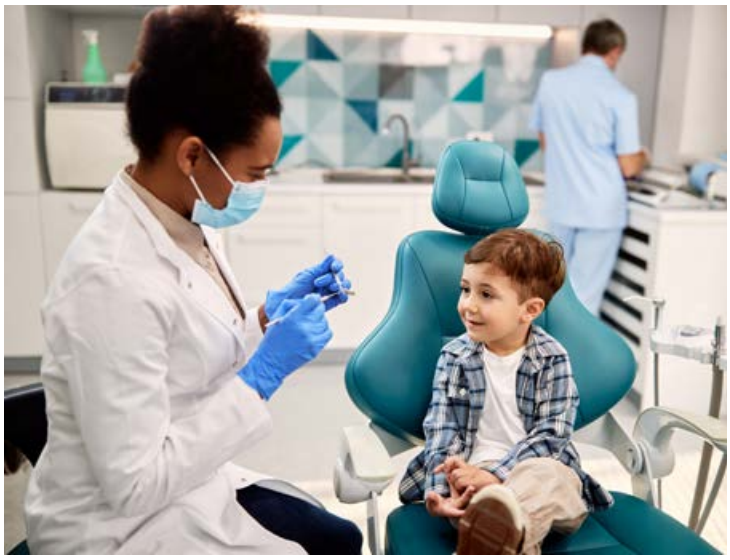
- Physician (MD) (provider type 08),
- Physician Osteopath (DO) (provider type 31) Physician's Assistant, (provider type 18)
- Registered Nurse Practitioner, (provider type 19)
- Registered Dietician (provider type 47)

The services must be prescribed by a primary care practitioner in one of the following circumstances:

1. the member is initially diagnosed with diabetes or,
2. the member was previously diagnosed with diabetes but a change has occurred in the member's diagnosis, medical condition or treatment regimen or the member is not meeting appropriate clinical outcomes.

Limitations: DSMT services are limited to 10 hours, annually. Beneficiaries of the EPSDT benefit may receive services in excess of the 10-hour limitation.

Dental Tooth Code Number Assignment



When submitting a claim for dental services that involve the identification of the tooth, the tooth number field must be entered as a two-digit number, for example tooth #3 must be entered as 03. If a single digit is entered, it will result in a denial of the service line.

Dental Claim Denial Edits:

L159.1 Tooth number field is required, field is blank.

- Correction Step: Review the claim and submit a correction claim if required.

L159.3 Tooth number field is not on file.

- Correction Step: Review the claim to verify if the tooth number was entered as a single digit or is missing entirely.

L184.3 Dental claim error tooth number missing or extracted already.

- Correction Step: Review the claim/dental records to determine if a correction claim is required.

Prior Authorization Guidelines

Before certain services are provided, health care providers may need to submit a prior authorization request. Prior Auth requests for FFS members must be submitted using the AHCCCS Online Provider Portal. Providers must first verify the member's eligibility for the service and confirm if a PA is required.

Note: Untimely PA requests may result in request for additional information which may result in a delay with the review process.

For step-by-step instructions on completing a Prior Authorization submission: Prior Authorization - General Requirements, how to submit for PA, and how to status a PA using the AHCCCS Online Provider Portal

Reminder: AHCCCS FFS has updated the Prior Authorization forms, to access the current webpage to view the fillable FFS Prior Auth Forms.

Principal Diagnosis versus Admitting Diagnosis Codes UB-04

Per the AHCCCS FFS Provider Billing Manual, Chapter 19 Behavioral Health Services Principal Diagnosis
The condition established to be chiefly responsible for occasioning the admission or care for the member, as indicated by the principal diagnosis on a UB-04 claim form from a facility, or the first-listed diagnosis on a CMS 1500 claim form.

The principal diagnosis should not be confused with the admitting diagnosis or any other diagnosis on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

Institutional (UB-04) Claim Form

The Principal diagnosis should be recorded in form locator 67 of the UB-04 form. Other or secondary diagnoses, complications and comorbidities should be listed in form locators 67 A-Q. The admitting diagnosis (if different from the principal diagnosis) should be listed in form locator 69.

The Admitting diagnosis is the POA (present on admission) and principle diagnosis is the discharge diagnosis for what is determined to be the reason the admission, they can be the same they can be different.

Examples:

When the principal diagnosis on the claim is a behavioral health diagnosis, the Event Type should be BP.

When he principal diagnosis on the claim is a medical/physical health diagnosis, the Event Type should be IP (Inpatient).

Provider Actions:

1. If the information submitted for the PA request does not support the type of PA request, for example behavioral health admission versus medical admission, the PA team will add comments/notes advising the provider what is inconsistent which will prompt the provider to review the PA and make the appropriate corrections.
2. If the information on the claim submission does not match the information on the prior authorization, this will result in a prior authorization mismatch and result in a denial of the claim. In this example the provider has the responsibilty to review their PA request and the claim submission to make any necessary / appropriate corrections.

All Patient Refined Diagnosis Related Groups (APR-DRG) Classification System DRG Ungroupable Denials

Edit Code: H310.4 DRG Processing Edits III; DRG is Ungroupable

This edit identifies that there was some information on the claim submission that prohibited the claim for qualifying for a specific APR-DRG. The term "ungroupable" is typically used to identify this as an APR-DRG pricing issue. The DRG field will indicate "956" ungroupable.

- The Severity of Illness (SOI) refers to the relative levels of loss of function and mortality that may be experienced by patients with a particular disease. The SOI field will show "O".
- The Risk of Mortality (ROM) field will show "0" to identify the claim is "ungroupable".

APR-DRG claims that deny as "ungroupable" will require the provider to review the details of the claim and submit a correction claim, correcting any fields that are in error. It is the provider's responsibility to review and make any necessary corrections to the claim.

The call center representatives cannot advise or instruct a provider which fields are in error.

Filing a Reconsideration for APR-DRG Payments

Before filing a reconsideration or claims dispute for APR-DRG claims, providers will need to verify the calculation of the expected payment and DRG-SOI.

The AZ APR-DRG Calculator that is available on the AHCCCS website is for hospitals to get an estimate of the expected payment, but it does not capture all editing and pricing complexities associated with the claim when it is processed through the 3M Navigant application and cannot be used to file a reconsideration or appeal of the final APR-DRG payment.

When and How to File An APR-DRG Reconsideration: The hospital must first provide a copy of the actual 3M Navigant DRG worksheet calculation (current version is 38) that validates the provider's expected payment and submit this information for review to the DFSM claims department. If the 3-M Navigant worksheet confirms the DRG-SOI that was initially assigned to the claim, then no additional action would be warranted.

Reminder: Billing Vaccines for Children (VFC)

When billing under the Vaccines For Children (VFC) program, VFC vaccines must be used and providers must be registered under the VFC program. Under the federal VFC program, providers are paid a capped fee for administration of vaccines to members 18 years old and younger. Because the vaccine is made available to providers free of charge, providers must not bill for the vaccine itself.

Beginning with dates of service 1/1/2013, AHCCCS will require all providers to submit two CPT codes for VFC program services, both billed with modifier SL:

- One code will identify the vaccine administrative service as described by codes 90460, 90461, 90471, 90472, 90473 and 90474 and billed with SL modifier.
- The second code, with the SL modifier, will identify the actual vaccine administered.

Additional information can be found in Chapter 10, FFS Provider Billing Manual, Individual Practitioner Services

Reminder: Missing AHCCCS 835 and Paper Remittance Advice

835 Electronic Remits Requests: Providers can submit a ticket to servicedesk@azahcccs.gov and request the service ticket to be assigned to **ISD Finance**.

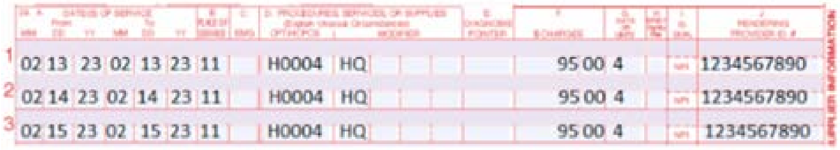
Paper Remittance Advice: The Division of Business Finance provides support for providers that are receiving the Paper Remit/Paper EOBs (Explanation of Benefits) only.

Claim Date Span Billing Requirement

Effective with dates of service beginning February 17, 2023 and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service.

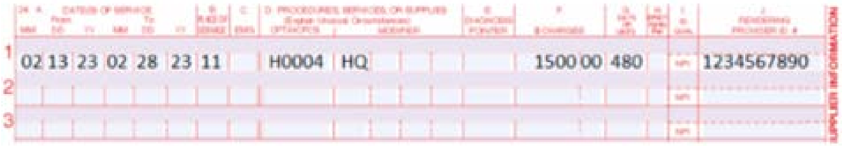
AHCCCS DFSM will deny any claim line submitted by a provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Example of a Correct Claim Submission:



	From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	Days or Units	ID Qual.	Rendering Provider ID #
1	02	13	23	02	13	23	11		H0004	HQ		95 00	4	NPI	1234567890
2	02	14	23	02	14	23	11		H0004	HQ		95 00	4	NPI	1234567890
3	02	15	23	02	15	23	11		H0004	HQ		95 00	4	NPI	1234567890

Example of an Incorrect Claim Submission:



	From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	Days or Units	ID Qual.	Rendering Provider ID #
1	02	13	23	02	28	23	11		H0004	HQ		1500 00	480	NPI	1234567890
2														NPI	
3														NPI	