Fee-For-Service FAQs

Basic Information

What are the Fee-for-Service (FFS) Programs?

Fee-For-Service Programs and Populations include the following:

- The American Indian Health Program (AIHP);
- Tribal Regional Behavioral Health Authorities (TRBHAs);
- Tribal ALTCS (including Gila River Indian Community, Hopi Tribe, Navajo Nation, Pascua Yaqui Tribe, San Carlos Apache Tribe, Tohono O'Odham Nation, White Mountain Apache Tribe, and Native American Community Health),
- Federal Emergency Services Program (FESP);
- FFS Regular;
- FFS Temporary;
- FFS Prior Quarter Coverage; and
- Hospital Presumptive Eligibility (HPE).

Medicare Savings Programs include the following:

- SLMB Part B Buy-In-Only,
- QI1 Part B Buy-In-Only, and
- QMB Only.

Third Party Accounts and Pharmacy Benefits

Who can treat FFS members?

Any AHCCCS registered provider that accepts fee for service may treat FFS members. The AHCCCS FFS Program does not contract with individual providers.

Do FFS Members require referrals to see an AHCCCS registered provider?

No, FFS members do not require a referral to see an AHCCCS registered provider.

Prior Authorization Questions

Prior Authorization - Which services require PA for FFS Members?

Prior authorization is **not** required for emergency services.

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Please see the following resources to review PA requirements:

- The AHCCCS FFS Prior Authorization webpage;
- AMPM 820, Prior Authorization;
- Chapter 6, Authorizations, in the IHS/638 Provider Billing Manual;
- Chapter 8, Authorizations, in the FFS Provider Billing Manual; and
- **For FESP members** requiring outpatient dialysis services 3 times or more per week, please refer to AMPM Chapter 1110 for information on extended services enrollment.

Please note that PA is **not** required for Title XIX, AIHP members, when seen at an IHS/Tribal 638 facility.

Are there any services that cannot have prior authorization submitted for via the AHCCCS Online Provider Portal?

Long term care service requests for Tribal ALTCS members are submitted to the member's Tribal case manager and are not submitted via the AHCCCS Online Provider Portal.

If an urgent authorization is required, as defined in A.A.C. R9-34-306 (B) (if following the standard time frame for a request could seriously jeopardize the FFS member's life or health, ability to attain, maintain, or regain maximum function), what is the appropriate method for submitting an urgent prior authorization request?

Urgent requests should be submitted online, with documentation attached that supports medical necessity for the request. An urgent submission should be followed up with a call to the PA line to notify PA staff that an urgent request has been submitted.

Note: No prior authorization is required for **emergency** services.

Can a date span for dialysis transportation be prior authorized?

Yes, a date span for dialysis transportation can be prior authorized. However, non-emergency medical transportation (NEMT) does not require prior authorization, unless the total trip distance (one-way or round trip) is over 100 miles.

Note: NEMT is **not** a covered service for FESP members.

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When a claim is submitted, the date(s) on the NEMT claim must fall within the date span that was prior authorized.

Is prior authorization required for a date span for dialysis?

No, dialysis does not require prior authorization, so no prior authorization request would need to be submitted.

Can a prior authorization request be submitted for a date span for hospice?

Hospice prior authorization requests may be entered using a date span.

What is the process to submit a prior authorization request?

Providers can submit a PA request in the following ways:

1) AHCCCS Online Provider Portal

   The primary method of submission is online via the AHCCCS Online Provider Portal at: https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f.

   PA requests must be accompanied by documentation that supports the medical necessity for the request.

   Level 1 Behavioral Health Admission requests must also be accompanied by the initial Certification of Need (CON) form or, for continued stay reviews, the Recertification of Need (RON) form.

2) Fax Submissions

   All prior authorization requests submitted by fax must be submitted with the mandatory Prior Authorization Request Form available at: https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

   Corrections or changes to prior authorization requests that were submitted by fax must be submitted with the Prior Authorization Correction Form. The form must be completed in its entirety.

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If medical documentation is requested during the review of a prior authorization request, the additional documentation must be submitted using the Fee-For-Service Medical Documentation Form. This form is also used for the submission of additional documentation for concurrent review.

Fax Numbers:
Behavioral Health Prior Authorization - (602) 253- 6695
Prior Authorization - (602) 256-6591
UR - (602) 254-2304
Long Term Care - (602) 254-2426
Transportation - (602) 254-2431

3) Telephone
1-602-417-4400 (Phoenix area direct line to the PA Area)
1-800-433-0425 (In state direct line to the PA Area)
1-800-523-0231 (Out of state line to AHCCCS switchboard; ask for the PA Area)

4) Mail
AHCCCS-Division of Fee-for-Service Management
Care Management Systems Unit (CMSU)
Mail Drop 8900
701 East Jefferson
Phoenix, AZ 85034

Which Form to Use and When?

The following FFS fax forms must be used when a PA request is submitted via **fax**. Fax requests submitted without the completed FFS form as the 1st or 2nd page of the fax will not be processed.

When an initial PA request is submitted via the AHCCCS Online Provider Portal, these fax forms are **not required.**

Supporting medical documentation may also be attached through the AHCCCS Online Provider Portal. No fax form is required when attaching documentation through the AHCCCS Online Provider Portal unless requested by PA staff.

Fax Forms

- Prior Authorization (PA) Request Form

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  - Providers should use this form when initially requesting a PA. This form should be used as the cover sheet for any documentation submitted with the PA request.
  - https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/AUTHFORMMarch2017.xlsx
- Prior Authorization Correction Form
  - Providers should send this form when a correction to an existing authorization is needed. This form should be used as the cover sheet for any additional documentation submitted with the correction request.
  - https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/CorrectionFORMMarch2017.xlsx
- Fee-For-Service Medical Documentation Form
  - Providers should use this form as the cover sheet when submitting medical documentation to AHCCCS, FFS.
  - https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/MedicalDocumentationFormMarch2017.xlsx
- Initial Dialysis Case Creation Form (FESP)
  - Providers should use this form to enroll qualifying Federal Emergency Services Program (FESP) members with End State Renal Disease (ESRD) on Extended Services (ES). Extended Services covers dialysis and dialysis related services for FESP members requiring dialysis at least 3 times per week.
  - https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/InitialDialysisCaseCreationForm.pdf
- Monthly Certification of Emergency Medical Condition Form (FESP)
  - Providers must certify monthly that members on Extended Services (ES) continue to meet ES requirements. The Monthly Certification of Emergency Medical Condition Form must be kept on file at the certifying physician's office.
  - https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/MonthlyCertificationEmergencyMedicalCondition.doc
- FFS Medication Request Form (AKA: Rx Prior Authorization Form)
  - Providers should send this form to the current Pharmacy Benefit Manager (PBM) when a requested medication requires PA.
  - https://www.azahcccs.gov/PlansProviders/Downloads/PharmacyUpdates/AHCCCSFFSPAForm.pdf

If a provider refers a member to a specialist for a consult, who submits the PA request?

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Consultations with specialists are an evaluation and management service, which do not require prior authorization for FFS members.

For services that require prior authorization, the provider actually rendering the service should submit the prior authorization request. This is because the PA must be submitted under the rendering provider's ID and also must include the codes that the rendering provider plans to bill for on their claim. Other providers typically will not have this information.

If a Tribal ALTCS member has a Case Manager and the provider is unable to reach them, what is the process for obtaining prior authorization for long term care services?

In the event that a Tribal ALTCS Case Manager is unavailable, their supervisor and/or lead can be notified of the PA request. The supervisor and/or lead can review the request and if approved, enter the service(s) in the service plan. All Tribal ALTCS Contractors provide this secondary point of contact.

Claims Questions

Where should a provider send their claims for FFS members?

If...	Then...
If a member is a Title XIX, FFS Member that is not enrolled with a MCO and seen at a non-IHS/Tribal 638 facility….	Claims are submitted to the AHCCCS Division of Fee-for-Service Management (DFSM).
If a member is enrolled in a MCO and services are NOT provided at an IHS/Tribal 638 facility…	Claims are submitted directly to the MCO.
If a member is a Title XXI member enrolled in a MCO and seen at a non-IHS/Tribal 638 facility…	Claims are submitted directly to the MCO.
If a member is a Title XXI member **not** enrolled in a MCO and seen at a non-IHS/Tribal 638 facility…	Claims are submitted to the AHCCCS Division of Fee-for-Service Management (DFSM).
If a member is receiving Behavioral Health Services that are **not** provided at an IHS/Tribal 638 facility...	Claims are submitted to the member's RBHA or to DFSM for TRBHA members.
If a member is receiving Behavioral Health services at an IHS/Tribal 638 facility…	Claims are submitted to the AHCCCS Division of Fee-for-Service Management (DFSM).

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If...	Then...
If a member enrolled in a RBHA is receiving Behavioral Health Services, regardless of where the services were received…	Claims are submitted to the member's RBHA.
If a member receives Transportation and Case Management services for Behavioral Health, regardless of where the services were received…	Claims are submitted to the member's RBHA or to DFSM for TRBHA members.

How should a claim be submitted to the AHCCCS Division of Fee-for-Service Management (DFSM)?

The preferred method of claims submission is via the HIPAA-compliant 837 electronic transaction process. Claims may also be submitted via the AHCCCS Online Provider Portal. Paper claims submitted on the CMS 1500 or UB-04 claim forms may only be submitted by mail; they may not be submitted by fax. Paper claims submitted on an ADA form may be submitted by fax or mail.

Claims can be submitted and reviewed on the AHCCCS Online Provider Portal at:

https://azweb.statemedicaid.us/

Paper claims should be mailed, with adequate postage, to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

Claims can be submitted via fax at: 602-253-5472

When additional documentation is requested for a previously submitted claim, what should a provider do?

When additional documentation is requested, it must be submitted to the specific area making the request. If additional documentation is requested by the claims department, then the information must be submitted to the claims department and the provider must submit a **replacement** claim.

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Note: When additional documentation is submitted to the claims department, please include the CRN.

Information sent in to another division is not available to the claims department. For instance, when information is faxed or mailed to CMSU (the Prior Authorization area of DFSM), the claims department will not be able to access it.

For information on how to submit a replacement claim please see the section on Replacements in Chapter 4, General Billing Rules of the Fee-For-Service Provider Billing Manual.

What are some additional resources for questions on FFS eligibility, coverage, and provider billing rates?

- The AIHP Webpage
- The IHS/Tribal Provider Billing Manual
- AHCCCS Medical Policy Manual (AMPM)
- FFS Provider Billing Manual
- Provider Billing Rates
- Behavioral Health Services Guide

If you have further billing questions, please call Claims Customer Service at *(602) 417-7670* and select option *4*.

AHCCCS Publications (Prior Authorization & Claims)

AHCCCS provides several publications to assist providers with the prior authorization and claim submission processes.

- **The Fee-for-Service Provider Billing Manual** provides detailed information on general billing rules, claim forms, benefits, provider registration, authorization processes, and a host of other topics. It can be found at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html
- **The IHS/Tribal Provider Billing Manual** provides detailed information on general billing rules, claim forms, benefits, provider registration, authorization processes, and a host of other topics. It can be found at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

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- **Claims Clues** is a newsletter for FFS providers that is published periodically by the AHCCCS claims department of DFSM. It provides updates about changes to the program, system changes, billing policies and requirements. It can be found at the following web address:
  https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html
- **Constant Contacts** sends updates straight to a provider's email inbox with information about everything from upcoming trainings to claim submission tips. You can sign up at the following address:
  Constant Contact Sign Up
- **The Communications/Connectivity Information (CCI) Companion Guide** provides information about the HIPAA-compliant 837 transaction processes. It can be found at:
  https://www.azahcccs.gov/Resources/Downloads/EDIchanges/CommunicationsConnectivityInformationCCICompanionGuide.pdf.