



Telehealth Services and Billing Guidelines

IHS/638 Presentation

*Materials are designed for FFS programs, including AIHP, TRBHAs and Tribal ALTCS

September 2020





Telehealth Services

Telehealth Services

AHCCCS recently updated its telehealth policies. Updates can be found in:

- [The AHCCCS Medical Policy Manual \(AMPM\) 320-I, Telehealth Services](#)
- [Chapter 10, Individual Practitioner Services, of the Fee-for-Service Provider Billing Manual](#)
- [Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manuals](#)

In light of these updates, the Telehealth Training Manual was retired, as it contained outdated information (our policies were provided expanded telehealth services).

Telehealth Services

AHCCCS covers medically necessary, non-experimental, cost-effective telehealth services provided by an AHCCCS registered provider. There are no geographic restrictions for telehealth; services delivered via telehealth are covered by AHCCCS in rural and urban regions.

Telehealth may include healthcare services delivered via teledentistry, telemedicine, or asynchronous (store and forward).

What services are covered via telehealth?

The first thing to know is that there is a difference between real time telehealth (synchronous) and store and forward (asynchronous), and the types of services that that are covered.

- **Asynchronous** provides access to data after it has been collected, and involves communication tools such as secure email or telehealth software solutions.
- **Synchronous** is the “real time” two-way interaction between the patient and provider, using interactive audio and video.

Telehealth Services

In order for a service to be covered via telehealth, it must be:

1. An AHCCCS covered service;
2. Rendered by an AHCCCS registered provider; and
3. Must meet the requirements as outlined in AHCCCS Medical Policy and within AMPM 320-I, Telehealth Services.



Synchronous Telehealth Services

Synchronous Telehealth Services

The following list is not comprehensive, but are examples of services covered by real time telehealth:

Real Time (Synchronous) Telehealth Service Examples

*Not all inclusive list.

Behavioral Health	Cardiology	Dentistry	Endocrinology
Hematology / Oncology	Home Health	Infectious Diseases	Inpatient Consults
Medical Nutrition Therapy (MNT)	Outpatient Consultations	Office Visits (adults & pediatrics)	Oncology / Radiation
Ophthalmology	Orthopedics	Obstetrics/Gynecology	Neurology
Pain Clinic	Pathology & Radiology	Pediatrics & Pediatric Subspecialties	Pharmacy Management
Rheumatology	Surgery Follow-Up	Surgery Consultations	



Asynchronous Telehealth Services

Asynchronous Telehealth Services

- The following services are covered via asynchronous telehealth (store & forward):

Asynchronous (Store & Forward) Telehealth Services *All inclusive list.			
Behavioral Health	Cardiology	Dermatology	Neurology
Ophthalmology	Pathology	Radiology	Infectious Disease

Telehealth Definitions

Telehealth – Modes of Service Delivery

Service delivery via telehealth can be done via:

1. Teledentistry,
2. Telemedicine, or
3. Asynchronous (store and forward).

Telehealth – Modes of Service Delivery

Asynchronous or “Store and Forward” means the transmission of recorded health history (e.g. pre-recorded videos and digital images, such as x-rays and photos) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render consultative services outside of a synchronous (real-time) interaction.

As compared to a real-time visit, this service provides access to data after it has been collected, and involves communication tools such as secure email or telehealth software solutions.

Telehealth – Modes of Service Delivery

Teledentistry is the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by an AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.

Telehealth – Modes of Service Delivery

Telemedicine is the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation.

Telehealth – Modes of Service Delivery

Service delivery via telemedicine can occur in one of two ways:

- **Real time (synchronous)** means the two-way interaction between a person (patient, caregiver, or provider) and a provider using interactive audio and video. The patient is at the originating site and the provider is at the distant site. It includes the transfer of information and medical data between two sites simultaneously: the distant site and the originating site.
- **Remote patient monitoring** is the personal health and medical data collection from an individual in one location via electronic communication technologies, which is transmitted to a provider (sometimes via a data processing service) in a different location for use in providing improved chronic disease management care and related support.

Telehealth Service Sites

What is the difference between the Distant Site (Hub) and Originating Site (Spoke)?

- **Distant site** means the site at which the provider delivering the service is located at the time the service is provided via telehealth. (Formerly hub site.)
- **Originating site** means the location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates. (Formerly spoke site.)
 - The originating site is considered the place of service (POS).



Telehealth Policy Information

Limitations & Exclusions

Telehealth Policy Reminders

- Synchronous (Real Time) Telemedicine and Remote Patient Monitoring **will not** replace provider and member choice for healthcare delivery modality.
- All telehealth services shall be provided by an **AHCCCS registered provider.**
- Confidentiality standards for Telehealth services should adhere to all applicable statutes and policies governing Telehealth.
- Informed consent standards for Telehealth services shall adhere to all statutes and policies governing telehealth, including A.R.S. §36-3602.

Telehealth Policy Reminders

- Medical records for telehealth visits must be maintained by any provider receiving reimbursement.
 - This includes documentation showing the procedure code and appropriate modifier.
 - The timeframe for maintaining medical records/documentation from telehealth visits, is the same as it is for in-person visits. This varies by provider type and service rendered.
- Telehealth and telemedicine visits may qualify as an FQHC/RHC visit if it meets the requirements specified in AMPM 320-I, Telehealth.

Arizona Revised Statute §36-3602 & Telehealth Services

36-3602. Delivery of health care through telemedicine; requirements; exceptions:

- A. Except as provided in subsection E of this section, before a health care provider delivers health care through telemedicine, the treating health care provider shall obtain verbal or written informed consent from the patient or the patient's health care decision maker. If the informed consent is obtained verbally, the health care provider shall document the consent on the patient's medical record.

Arizona Revised Statute §36-3602 & Telehealth Services

- A.R.S. 36-3602. Delivery of health care through telemedicine; requirements; exceptions (continued):
- B. The patient is entitled to all existing confidentiality protections pursuant to section 12-2292.
 - C. All medical reports resulting from a telemedicine consultation are part of a patient's medical record as defined in section 12-2291.

Arizona Revised Statute §36-3602 & Telehealth Services

A.R.S. 36-3602. Delivery of health care through telemedicine; requirements; exceptions (continued):

- D. Dissemination of any images or information identifiable to a specific patient for research or educational purposes shall not occur without the patient's consent, unless authorized by state or federal law.

Arizona Revised Statute §36-3602 & Telehealth Services

A.R.S. 36-3602. Delivery of health care through telemedicine; requirements; exceptions (continued):

E. The consent requirements of this section do not apply:

1. If the telemedicine interaction does not take place in the physical presence of the patient.
2. In an emergency situation in which the patient or the patient's health care decision maker is unable to give informed consent.
3. To the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Specific Telehealth Services

Behavioral Health Services, Teledentistry, and
Non-Emergency Medical Transportation (NEMT)

Telehealth Services – Behavioral Health

Behavioral health telehealth services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) members. Covered behavioral health services can include, but are not limited to:

- Diagnostic consultation and evaluation,
- Psychotropic medication adjustment and monitoring,
- Individual and family counseling, and
- Case management.

***This includes Naturalistic Observation Diagnostic Assessment (NODA).

Telehealth Services - Teledentistry

AHCCCS covers Teledentistry for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members when provided by an AHCCCS registered dental provider.

- Teledentistry does not replace the dental examination by the dentist; limited periodic and comprehensive examinations cannot be billed through the use of Teledentistry alone.

Teledentistry includes the provision of preventative and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.

- For additional information on [Affiliated Practice Dental Hygienists, see AMPM 431.](#)

Telehealth Services and Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation (NEMT) is covered to transport a Title XIX or Title XXI member to and from the originating site, in order to receive an AHCCCS covered medically necessary consultation or treatment.

Telehealth Services – Office Settings

Office visits (adults & pediatrics) are covered for Title XIX and Title XXI members via telehealth.

- This includes prolonged preventive services beyond the typical service of the primary procedure. These may require direct patient contact and may occur in either the office or another outpatient setting.



Four Walls Discussion

Four Walls Review

Consistent with CMS guidance, AHCCCS does not intend to review claims for services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021.

CMS released FAQs on January 18, 2017, regarding the review of services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021.

This response can be found in Question #13, in the FAQs at:

- <https://www.medicaid.gov/sites/default/files/federalpolicy-guidance/downloads/faq11817.pdf>.

AHCCCS will continue to follow the “Four Walls” issue since CMS is considering extending that timeline.

Telehealth Billing for IHS and 638 Providers

The following scenarios cover telehealth billing for IHS and 638 providers under normal circumstances (a non-emergency state).

PLEASE NOTE that until January 30, 2021, that CMS will not review the “Four Walls” requirement for free-standing IHS/638 clinics.

Four Walls Applicability and the AIR

The “Four Walls” of an IHS/638 Clinic refer to the physical building the clinic operates within.

The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that “clinic services” do not include any services delivered outside of the “four walls” of the clinic, except if services are provided to a homeless individual. Under normal circumstances, the “Four Walls” applies as follows:

- The “Four Walls” provision **does** apply to free-standing IHS/638 clinics
- The “Four Walls” provision **does not** apply to IHS/638 hospitals or to their hospital-affiliated (provider-based) outpatient clinics
- The “Four Walls” provision **does not** apply to 638 FQHCs

Four Walls Applicability

IHS/638 Hospitals (four walls do not apply) are a permanent facility, run by either IHS or tribally owned and run, which contains inpatient beds, organized staff including physician services, continuous nursing services and that provides comprehensive health care including diagnosis and treatment.

IHS/638 Hospital-affiliated, outpatient clinics (four walls do not apply) are a permanent facility run by either IHS or tribally owned and run, that provide outpatient services and bill under the hospital provider type. (Also known as Provider-based clinics.)

Four Walls Applicability

IHS/638 Free-standing Clinics (four walls do apply) are a permanent clinic that provides comprehensive health care including diagnosis and treatment, but cannot bill for services provided outside of the four walls of the clinic.

638 FQHCs (four walls do not apply) are a permanent facility that provides comprehensive health care including diagnosis and treatment.

IHS/638 Hospitals and the AIR

The “Four Walls” do not apply to IHS and 638 hospitals.

- Regardless of the originating site of the service, if the IHS/638 hospital submits a reimbursable claim to AHCCCS for a facility service, it will be reimbursed at the All Inclusive Rate (AIR). Neither the patient nor the provider need to be physically located within the four walls in order for the Hospital to bill the All Inclusive Rate for services otherwise considered to be facility services.
- This is per page 691 of the State Plan, which covers Reimbursement of Indian Health Service and Tribal 638 Health Facilities, and states that “Encounters/visits include covered telemedicine services” when discussing visits qualifying for reimbursement at the AIR.

Hospital-Affiliated IHS/638 Clinics and the AIR

The “Four Walls” do not apply to hospital-affiliated IHS/638 outpatient clinics (also called provider-based clinics).

- Regardless of the originating site of the service, if the IHS/638 hospital-affiliated outpatient clinic submits a reimbursable claim to AHCCCS that constitutes a facility service, it will be reimbursed at the All Inclusive Rate (AIR). Neither the patient nor the provider need to be physically located within the four walls in order for the Provider-Based Clinics to bill the All Inclusive Rate for services otherwise considered to be facility services.
- This is per page 691 of the State Plan, which covers Reimbursement of Indian Health Service and Tribal 638 Health Facilities, and states that “Encounters/visits include covered telemedicine services” when discussing visits qualifying for reimbursement at the AIR.

Free-Standing IHS/638 Clinics and the AIR

The “Four Walls” does apply to free-standing IHS/638 clinics.

- If either the member or the provider is located inside the four walls of the 638 clinic, and a telehealth visit is being done, and the IHS/638 clinic submits a reimbursable claim (and the service provided met the definition of a clinic visit) to AHCCCS, it will be reimbursed at the All Inclusive Rate (AIR).
- If neither the member or the provider is located inside the four walls of the IHS/638 clinic (i.e. if the member is in their home and the provider is in their home office, so neither member or provider is at the IHS/638 clinic), and the IHS/638 clinic submits a reimbursable claim (even if the service provided met the definition of a clinic visit) to AHCCCS, it cannot be reimbursed at the AIR. It would have to be billed at the capped FFS rate.

Free-Standing IHS/638 Clinics and the AIR

The “Four Walls” does apply to free-standing IHS/638 clinics.

- NOTE: CMS had granted a grace period extending to January 30, 2021, before CMS will review claims for services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic.

Clinic Service

Section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that “clinic services” do not include any services delivered outside of the “four walls” of the clinic, except if services are provided to a homeless individual.

In order for an outpatient service to be reimbursed at the AIR, it must meet the definition of a clinic visit.

What Services Count as a Clinic Service?

Per CFS § 440.90 Clinic services:

- Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:
 - (a) Services furnished at the clinic by or under the direction of a physician or dentist.
 - (b) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

Billing for Telehealth Services

Billing Guidelines

Please note the following billing differences:

- **Institutional Claims (UB-04 Claim Forms)**
 - For billing at the All Inclusive Rate (AIR)
- **Professional Claims (CMS 1500 Claim Forms)**
 - Place of Service (POS) Field
 - For billing at the Capped FFS Rate

Professional Claims and the Place of Service

Place of Service (POS)

The Place of Service shall be listed on a CMS 1500 Claim Form.

- Note: This applies to claims submitted for reimbursement at the capped FFS rate *only*. The UB-04 Claim Form does not have a POS field.

Previously the distant site (hub) was used as the Place of Service (POS) on claims for telehealth services.

Now the originating site (spoke) is used as the POS on claims for telehealth services.

Professional Claims and Place of Service Example 1

This applies to claims submitted for reimbursement at the capped FFS rate. The UB-04 Claim Form does not have a POS field.

- A member is located in their home (originating site) and the consulting provider is located in the IHS free-standing clinic (distant site). The POS listed on the claim (submitted by the IHS free-standing clinic) will be POS 12 (Home). The POS will not be the IHS free-standing clinic (distant site).
- NOTE: Please note this is one example of many potential scenarios. This example is not the only way to submit claims.

Professional Claims and Place of Service Example 2

This applies to claims submitted for reimbursement at the capped FFS rate. The UB-04 Claim Form does not have a POS field.

- A member is located in their home (originating site) and the consulting provider is located in the IHS free-standing clinic (distant site). The POS listed on the claim (submitted by the IHS free-standing clinic) will be POS 12 (Home). The POS will not be the IHS free-standing clinic (distant site).
- NOTE: Please note this is one example of many potential scenarios. This example is not the only way to submit claims.

Telehealth Billing – What Has Changed?

Geographic Restrictions

There are no geographic restrictions for telehealth services.

Telehealth services may be rendered to members both in rural and urban/metropolitan areas.



Telehealth Billing – What Has Changed?

Providers and Facility Types Permitted to Serve as Originating and/or Distant Sites

There are no longer restrictions for the provider types and facilities that can serve as the originating and distant sites.

- They simply need to be AHCCCS registered providers.

Telehealth Billing – What Has Changed?

Provider Types

We do not prohibit certain provider types from billing for telehealth and telephonic services.

However, please note that provider types can bill for telehealth and telephonic services, only to the extent that their scope, licensure and standards of care allow.

What is a Telepresenter?

At the time of service delivery via real time telehealth an individual who is familiar with the member's condition may be present with the member.

This person is called a telepresenter.

Telepresenter services are **not** billable.

Telehealth Billing for IHS/638 Providers – Reimbursement at the AIR

IHS/638 Providers billing for reimbursement at the All-Inclusive Rate (AIR) should continue to bill using the UB-04 Claim Form.

- **Reimbursement Rate:** All-Inclusive Rate (AIR)
- **Claim Form:** UB-04 Claim Form
- **Caveats:** IHS/638 Providers and Facilities, when rendering a qualifying service.

Telehealth Billing for IHS/638 Providers – Reimbursement at the Capped FFS Rate

IHS/638 Providers billing for reimbursement at the Capped FFS Rate should continue to bill using the CMS 1500 Claim Form.

- **Reimbursement Rate:** Capped FFS Rate
- **Claim Form:** CMS 1500 Claim Form

Telehealth Billing for IHS and 638 Providers - Coding

Providers should follow national coding standards when using HCPCS, CPT and UB-04 Revenue Codes.

- When billing for reimbursement at the AIR, providers should continue to use the appropriate Revenue Code: 0510 Clinic Visit; 0512 Dental Visit; or 0516 Urgent Clinic.

For a complete code set of services, along with their eligible place of service and modifiers, that can be billed as telehealth please visit the AHCCCS Medical Coding Resources web page at:

- <https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>

Telehealth Billing for IHS and 638 Providers – Coding and Modifiers

For IHS and 638 providers submitting for reimbursement at the All Inclusive Rate (AIR), whom are using the UB-04 Claim Form and submitting revenue codes, the submission of telehealth and telephonic modifiers is optional (not required).

For IHS and 638 providers submitting for reimbursement at the capped FFS rate, the appropriate CPT/HCPCS code must be used, along with the applicable modifier to indicate telehealth and/or telephonic services.

Telehealth Billing for IHS and 638 Providers - Modifiers

*For use when billing at the Capped FFS Rate.

MODIFIER	DESCRIPTION
GQ	Asynchronous (“store and forward”) telehealth services must be billed using the “GQ” modifier to designate the service being billed as a telehealth service.
GT	Real time (interactive audio and video) telehealth services must be billed using the “GT” modifier to designate the service being billed as a telehealth service.
UD	Indicates the service provided was telephonic.

Reporting Services Provided as a Result of COVID-19

Modifier CR

- AHCCCS has designated the CR modifier to be used on all claims for services provided as a result of, or related to COVID-19.
- Providers should be using the modifier as appropriate in order for AHCCCS to identify the costs of services attributable to this emergency.
- All other guidance regarding use of modifiers continues to be applicable.

Telehealth Billing for IHS and 638 Providers – Modifiers

For a full list of available POS and appropriate modifiers, refer to the AHCCCS Medical Coding Resources webpage at:

- <https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>
 - *Note: For use when billing at the capped FFS rate.

Billing for Telehealth and Telephonic Services as a free-standing IHS/638 Clinic

Telehealth Billing for Free-Standing IHS and 638 Clinics - Billing Examples

The following slides present several scenarios regarding telehealth and telephonic services and discuss when the All-Inclusive Rate (AIR) is or is not appropriate to bill. These slides present billing options.

These examples vary in the following ways:

- Location of member;
- Location of provider (consulting provider) performing the telehealth/telephonic service; and
- Whether or not the consulting provider has an agreement in place with the IHS/638 clinic that allows the clinic to bill for them and later reimburse them (such as a CCA).

Telehealth Billing for Free-Standing IHS and 638 Clinics - Billing Examples

Example 1

- A member is located in their home (originating site) and the provider is located inside the “four walls” of the free-standing IHS/638 clinic (distant site).
 - In the above scenario, if an AIR-eligible service was provided, then the clinic could bill for reimbursement at the AIR.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 2

A member is located at a free-standing IHS/638 clinic (originating site) and the consulting provider is located inside a home office, or an office not within the “four walls” of the free-standing IHS/638 clinic (distant site).

In this scenario, the provider has an agreement in place with the IHS/638 clinic for the clinic to bill for the services provided. The clinic will submit the claim for these services, not the provider.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 2 (Continued)

In the example two scenario, if an AIR-eligible service was provided, then the clinic could bill for reimbursement at the AIR; and

Since the IHS/638 clinic is doing the billing for the consulting provider, then the clinical documentation is maintained by the facility; and

The clinic and the provider cannot both bill for the same service. Either the clinic bills for the AIR, or the provider bills at the capped FFS rate. It cannot be both.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 3

A member is located at a free-standing IHS/638 clinic (originating site) and the consulting provider (who will submit the claim in this example) is located inside a home office, or an office not within the “four walls” of the free-standing IHS/638 clinic (distant site).

In this scenario the provider will submit the claim, not the clinic.

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 3 (Continued)

In the example three scenario, even if an AIR-eligible service was provided, the consulting provider would submit the claim for reimbursement at the capped FFS rate; and

In this scenario the consulting provider does not have an arrangement, such as a CCA, that would permit the IHS/638 clinic to bill for the service and to later reimburse the consulting provider; and

The clinic and the provider cannot both bill for the same service. Either the clinic bills for the AIR, or the provider bills at the capped FFS rate. It cannot be both. In the above scenario, due to the lack of arrangement between the provider and clinic, the consulting provider is the one to submit the claim for reimbursement at the capped FFS rate .

Telehealth Billing for Free-Standing IHS and 638 Clinics

Example 4

A member is located in their home (originating site) and the consulting provider is located inside a home office, or an office not within the “four walls” of the free-standing IHS/638 clinic (distant site).

In the above scenario, even if an AIR-eligible service was provided, then either the clinic or the consulting provider may bill for the reimbursement at the capped FFS rate. Neither clinician nor member was within the “four walls” of the free-standing clinic, so it is not an AIR eligible visit.

NOTE: The clinic and the provider cannot both bill for the same service. Either the clinic bills for the AIR, or the provider bills at the capped FFS rate. It cannot be both.



Billing Medicare Dual Claims

Telehealth Billing for IHS and 638 Providers – Medical Dual Claims

For Medicare Dual members, claims may be submitted with the POS listed as 02 (Telemedicine) to comply with Medicare guidelines.

The POS 02 (Telemedicine) will designate the service being provided as a telehealth service.

- (e.g. A member is located at a 638 clinic (originating site) and the consulting provider (who will submit the claim) is located in their office (distant site). The POS listed on the claim (submitted by the consulting provider) will not be the 638 clinic, but will instead be listed as POS 02)

Telehealth Billing for IHS and 638 Providers – Medicare Dual Claims

For Medicare Dual members, the POS on a CMS 1500 Claim Form should be the originating site, however AHCCCS will also accept POS 02 (Telemedicine).

However, POS 02 should only be used on Medicare claims that are crossing over to AHCCCS.



FAQ Recap

Telehealth Billing for IHS and 638 Providers

Question 1: How does an IHS/638 Provider bill telehealth services?

Answer 1: Telehealth is billed consistent with the guidance outlined in the IHS/638 billing manual. IHS and 638 hospitals (including their satellite clinics) and free-standing IHS/638 clinics have the ability to bill for telehealth and telephonic services. This includes the newly released telephonic services released due to COVID-19. For information on when the AIR can be billed, please see the next question.

For specific billing instructions regarding telehealth and telephonic services, please see Chapter 8, Individual Practitioner Services, of the IHS-Tribal Provider Billing Manual. The Division of Fee-for-Service Management has not changed the way to bill for telehealth services, but has expanded what services can be delivered via telehealth and telephonically.

Telehealth Billing for IHS and 638 Providers

Question 2: For IHS and 638 providers, what services are eligible for reimbursement at the All Inclusive Rate (AIR), and which are not?

Answer 2: Reimbursement depends on:

- The provider type billing;
- Whether or not the “4 Walls” apply to that provider type;
- If the “4 Walls” does apply, the location of the member and provider rendering services; and
- Whether or not the service being provided meets the definition of a clinic visit.

Telehealth Billing IHS and 638 Providers

Answer 2 (Continued):

The “4 Walls” of an IHS/ 638 Clinic refers to the physical building the clinic operates within. The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that “clinic services” do not include any services delivered outside of the “four walls” of the clinic, except if services are provided to a homeless individual. The All Inclusive Rate (AIR) may only be billed for clinic services.

Telehealth Billing IHS and 638 Providers

Answer 2 (continued):

If the provider is an:

- IHS/638 hospital or an IHS/638 hospital-affiliated (provider-based) satellite clinic. (The “4 Walls” provision **does not** apply.)
- An 638 FQHC (The “4 Walls” provision **does not** apply.)
- Free-standing IHS or Tribally-owned or operated/638 clinic. (The “4 Walls” provision **does** apply to free-standing IHS or tribally-owned or operated 638 clinics (Provider Types 05, 77, ICs).)

Telehealth Billing IHS and 638 Providers

Answer 2 (continued): When the provider is a free-standing IHS/638 clinic, the location of member and provider matter.

- **AIR May Be Billed:** If either the member or the provider/clinician is located inside the four walls of the free standing tribally-owned or operated IHS/638 clinic, and the service provided meets the definition of a clinic visit/facility-defined service, the AIR may be billed by the clinic.
- **AIR May Not Be Billed:** If neither the member or the provider/clinician is located inside the four walls of the free standing tribally-owned or operated IHS/638 clinic (i.e. if the member is in their home and the provider is in an office not located inside the “4 Walls” of the clinic, meaning that neither member nor provider is within the “4 Walls” of the IHS/638 clinic), it cannot be reimbursed at the AIR. It would have to be billed at the capped FFS rate. (Unless the service is being provided to a homeless individual.)



DFSM Provider Education and Training Unit

Education and Training Questions?

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](#))
- ❖ How to status a claims and prior authorization request through the AHCCC Online Provider Portal ([FFS programs, including AIHP, TRBHAs and Tribal ALTCS](#))
- ❖ Submission of documentation using the Transaction Insight Portal (e.g. The AHCCCS Daily Trip report, requested medical records, etc.)

Additionally the DFSM education and 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.

Education and Training Questions?

The DFSM Provider Training Team can be outreached at providertrainingffs@azahcccs.gov .

Questions?

Thank You.