CLAIMS CLUES

A Publication of the AHCCCS Claims Department

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INFORMATION FROM THE OFFICE OF THE INSPECTOR GENERAL

The Arizona Health Care Cost Containment System (AHCCCS) Office of Inspector General has identified a number of claims and/or encounters that are in violation of AHCCCS Rules and Policy related to "Rendering Providers".

This communication should serve as notice that all claims and/or encounters submitted MUST list the appropriate rendering provider as defined below.

6.5.4 CMS- 1500 Provider Definitions

...Rendering Provider:
The rendering provider is the individual who provided the care to the client. In the case where a substitute provider was used, that individual is considered the rendering provider.

An individual such as a lab technician or radiology technician who performs services in a support role is not considered a rendering provider.

The AHCCCS Participating Provider Agreement #19 states that "No provider may bill with another provider's ID number, except in locum tenens situations". [*AHCCCS Administration will recognize locum tenens arrangements restricted to the length of the locum tenens registration with the AMA. The locum tenens provider must submit claims using the AHCCCS provider ID number of the physician for whom the locum tenens provider is substituting or temporarily assisting.]*

Additionally, the AHCCCS Fee for Service Provider Manual states that "Hospitals and clinics may not bill AHCCCS Administration or its Contractors for physician and mid-level practitioner services using the hospital or clinic NPI number. Physicians and mid-level practitioners must register with AHCCCS and bill for services under their individual NPI numbers".

As an example, the following scenario illustrates one of many possible inappropriate billing practices.

An AHCCCS member receives services from a mid-level practitioner, (*physician assistants, registered nurse practitioners, certified nurse-midwives, certified registered nurse anesthetists (CRNA's), surgical first assistants, and affiliated practice dental hygienists.)* following receipt of services, a claim or encounter is then submitted listing another AHCCCS registered provider (typically a physician) as the rendering provider.

The Office of Inspector General will continue auditing claims and/or encounters to identify this improper activity which may result in the denial of claims, recoupment of funds or the issuance of Civil Monetary Penalties.

CLAIM TIPS AND REMINDERS:

- When submitting a paper Fee for Service claim to AHCCCS providers MUST indicate the claims "from date of service" and the "to date of service" in order for the claim to be processed properly in our claims system.
- Outlier claim records- please be sure to submit all records required for outlier review. The easiest way to decide what to send is to review your IZ. If the charge appears on the IZ, we will require records to substantiate that charge. Frequently Medication Administration records are not submitted on outlier claims.

PERM 2012 ERRORS

As part of our PERM corrective action plan, we are required by CMS to find solutions for any errors or deficiencies that were cited against us during the PERM audit. We thought that we would share with our providers the errors and deficiencies that were found during the recent PERM audit. In some instances, referrals to the Office of the Inspector General have been made regarding these errors or audits have been initiated. CMS will closely monitor these errors during future PERM audits to see if they become a trend.

Errors:

- Insufficient documentation of services performed
    - Provider billed for 99238 but did not have documentation to support the service being performed.
- Wrong number of units billed
    - Provider billed 90960 but could only provide documentation for 2 of 4 services.
- Improper billing
    - Provider billed for services never performed.

Deficiencies:

- Billing for Wrong Date of Service

What can be learned from the errors & deficiencies listed above?

- Providers must bill for services that are actually being performed. Referrals to the Office of the Inspector General will be made for any potential fraud.
- Providers must use the correct codes that correspond to the type of service provided
- Provider should not bill for missed appointments.
- Providers must only bill for the dates when services were actually performed.

VACCINE ADMINISTRATION REPORTING CHANGES- INCLUDING THE VFC PROGRAM

The Affordable Care Act (ACA) mandates that vaccine administration fees paid to certain physicians and other providers administering vaccines to Medicaid-enrolled members, including those administered to children under the Vaccines for Children program, be increased as of January 1, 2013. AHCCCS is currently revising our systems to allow physicians who qualify for the increased administration fee to receive those fees for vaccine administrations. The methodology and payment of the enhanced rate requires CMS approval, which could be delayed as late as July 1, 2013. Therefore enhanced payments for qualifying claims with dates of service on or after January 1, 2013 will not begin January 1 but will be made retroactively once CMS approval is received.

In addition to the increased fees for vaccine administrations, final regulations implementing this section of the ACA requires that vaccines be reported in a different manner than AHCCCS has utilized in the past. Previously, vaccines were reported with the CPT codes that identified the particular vaccines given, and for VFC, the SL modifier was attached to that vaccine code. Physicians and other providers also reported one vaccine administration code, which was not separately paid, regardless of how many vaccines were administered on that date of service.

With the changes under the ACA, both the specific vaccine code and the vaccine administration code must be reported by all providers reporting vaccine administration services. If the vaccine is provided through the VFC program, the SL modifier **must be added to both the vaccine code and the vaccine administration code.** Do not add the SL modifier to vaccine and

administration codes used to report services provided to members who are over 18 years of age or for vaccines that are not covered under the VFC program administered to children.

CPT codes identifying the vaccine or toxoid given under the VFC program should be identified with the appropriate CPT code to identify the vaccine, the SL modifier, and the charge listed as $0.00. Vaccines should be identified with the appropriate CPT code and the charge for that vaccine for members 18 years of age or older or for vaccines **not** covered under the VFC program.

When vaccines are administered separately, i.e., through separate injections, an administration fee will be paid for each separate administration. Additional administration fees are not paid when multiple vaccines are administered through a single injection. Physicians should not separate vaccine toxoids typically administered together into separate syringes to report multiple vaccine administration codes.

Reporting multiple injections depends on which vaccine administration codes are used to report the services. When more than one vaccine is administered with counseling to a member 18 years of age or younger, each injection is reported with CPT code 90460 and SL modifier. Providers will be paid a separate fee for each injection. If more than one vaccine/toxoid is included in a single injection, the additional toxoids should be identified with the appropriate CPT code and the administrations of those other toxoids may be identified with CPT code 90461. AHCCCS will not make additional payment for administration of other additional toxoids included in the injection identified with CPT code 90460 and providers are not compelled to report 90461 for the administration of those additional toxoids.

When more than one injection is given to a member who is over the age of 18 or to a child without counseling, the administration of the first injection is identified with CPT code 90471 and additional injections are identified with CPT code 90472. Each vaccine or toxoid component should be identified with the appropriate CPT code on the claim form along with the charge for that toxoid. When more than one toxoid is included in the injection, each toxoid should be listed but only one administration code is reported (90471 for a single injection; 90471 and 90472 for multiple injections).

For example, a DTaP vaccine should continue to be administered through a single syringe and the physician should report a single administration code even though three vaccine toxoids are included in that syringe. If, however, the physician also administers a Hepatitis B vaccine through a separate injection site, s/he may report a second administration code. Please refer to the “New Requirements for Submission of Claims for Vaccine Administration” FAQs for more information at http://www.azahcccs.gov/commercial/ProviderBilling/rates/PCSrates.aspx

New Requirements for Submission of Claims for Vaccine Administration
Frequently Asked Questions

Revision Date: 2/11/2013 (Vaccine code examples have been amended & additional FAQs appended)

Q1	**When does the provider need to start billing using the new methodology?**
A1	Per the federal requirements, January 1, 2013.
Q2	**Do all providers need to use the new claims billing method?**
A2	Yes, all providers need to use the new claims billing method.
Q3	**When will eligible providers see an increase from the current VFC administration rate?**
A3	Enhanced payments for qualifying claims with dates of service on or after January 1, 2013 will not begin January 1 but will be made retroactively once CMS approval of the required Arizona state plan amendment and methodology is received. Providers must meet the requirements as noted in the 12/11/12 memo http://www.azahcccs.gov/commercial/downloads/rates/PCPInfoMemo.pdf to be eligible for the enhanced payment. CMS approval may delayed as late as July 1, 2013.
Q4	**Is the SL modifier used for both the vaccine and the vaccine administration codes?**
A4	Yes, the SL modifier is used for both the vaccine and the vaccine administration codes under VFC only. Vaccines for adults or non-VFC vaccines for children do not have the SL modifier added.
Q5	**Will providers only receive payment for one administration code regardless of how many vaccines were administered?**
A5	No, if the provider individually administers more than one vaccine, the provider can bill for the administration of each vaccine, provided the additional vaccines are administered through a separate injection. The provider will not be paid for additional toxoids in the same syringe. This mirrors the current payment policy. Providers cannot divide vaccines commonly administered in a single injection in order to report multiple administrations. When medically necessary and appropriate to administer a second injection, a second administration fee may be paid.
Q6	**Is 90461 an open code?**
A6	AHCCCS has opened this add-on code as of 1/1/13. However, under VFC no additional payment is made for additional toxoids in the same syringe.
Q7	**Can AHCCCS provide examples of code use?**
A7	The following examples illustrate several vaccine coding situations

With the changes under the ACA, both the specific vaccine code and the vaccine administration code must be reported by all providers reporting vaccine administration services.

- If the vaccine is provided through the VFC program, the SL modifier **must be added to both the vaccine code and the vaccine administration code.** Do not add the SL modifier to vaccine and administration codes used to report services provided to members who are over 18 years of age or for vaccines not covered under the VFC program administered to children.

- CPT codes identifying the vaccine or toxoid given under the VFC program should be identified with the appropriate CPT code to identify the vaccine, the SL modifier, and the charge listed as $0.00.

- Vaccines for members 18 years of age or older or for vaccines not covered under the VFC program should be identified with the appropriate CPT code and the charge for that vaccine.

As noted in Q5, more than one vaccine administration payment can be made if multiple injections are given to the member. Reporting multiple injections depends on which vaccine administration codes are used to report the services. When more than one vaccine is administered with counseling to a member 18 years of age or younger, each injection is reported with CPT code 90460. Providers will be paid a separate fee for each injection. If more than one vaccine/toxoid is included in a single injection, the additional toxoids should be identified with the appropriate CPT code and the administrations of those other toxoids may be identified with CPT code 90461. AHCCCS will not make additional payment for administration of other additional toxoids included in the injection identified with CPT code 90460. Providers are not compelled to report 90461 for the administration of those additional toxoids.

When more than one injection is given to a member who is over the age of 18 or to a child without counseling, the administration of the first injection is identified with CPT code 90471 and additional injections are identified with CPT code 90472. Each vaccine or toxoid component should be identified with the appropriate CPT code on the claim form along with the charge for that toxoid. When more than one toxoid is included in the injection, each toxoid should be listed but only one administration code is reported (90471 for a single injection; 90471 and 90472 for multiple injections).

Example 1 child 18 or under receiving one injection

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units

1/1/13-1/1/13	11		90460 SL	1	$xx.xx	1
1/1/13-1/1/13	11		90700 SL	1	0.00	1

Example 2 child 18 or under receiving three separate injections

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90460 SL	1	$xx.xx	3
1/1/13-1/1/13	11		90700 SL	1	0.00	1
1/1/13-1/1/13	11		90655 SL	1	0.00	1
1/1/13-1/1/13	11		90707 SL	1	0.00	1

Example 3 over 18 receiving one injection

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90471	1	$xx.xx	1
1/1/13-1/1/13	11		90656	1	$xx.xx	1

Example 4 over 18 receiving three injections

24. A	B	C	D	E	F	G
Dates of Service	Place of Service	EMG	Procedures, Services or Supplies	Diagnosis Pointer	$ Charges	Units
1/1/13-1/1/13	11		90471	1	$xx.xx	1
1/1/13-1/1/13	11		90472	1	$xx.xx	2
1/1/13-1/1/13	11		90656	1	$xx.xx	1
1/1/13-1/1/13	11		90670	1	$xx.xx	1

	1/1/13-1/1/13	11		90703	1	$xx.xx	1
Q8	**Are G0008, G0009 and G0010 administration codes eligible for the enhanced rate?**						
A8	No they are not. Under 42 CFR 447.400, only CPT codes 90460, 90461, 90471, 90472, 90473 and 90474 or their successor codes are eligible for the enhanced rate. Note that these codes are eligible for the enhanced rate only if they are open codes within the State Medicaid program.						
Q9	**Recently several specialty societies issued guidance directing providers reporting vaccine and vaccine administration services on the same date of service as an Evaluation and Management (E&M) service, including Preventive Medicine exams, to add Modifier 25 to the E&M code. Do these instructions apply to claims submitted to AHCCCS?**						
A9	CMS has added numerous code pairs to the Correct Coding Initiative (CCI) list of codes Procedure to Procedure code edits. These new edits, effective 1/1/13, pair the vaccine administration codes (90460, 90461, and 90471-90474) with the E&M codes. These CCI edits do not allow both the vaccine administration service and the E&M service to be paid for the same date of service unless the E&M service is identified with modifier 25. AHCCCS must adopt these CCI edits. Providers administering vaccines and performing an E&M service on the same date of service must add modifier 25 to the E&M code. Modifier 25 is not added to the vaccine administration codes.						
Q10	**Will the AHCCCS VFC administration rate increase to the new regional maximum for all providers?**						
A10	No. AHCCCS has elected not to adopt the new regional maximum VFC rate. Providers who are eligible for enhanced payment rates will receive the enhanced rate of $21.33 for vaccine administration **under VFC**. For all other vaccine administrations under VFC, the AHCCCS rate of $15.43 remains unchanged.						

GENERAL REMINDERS FROM THE UM/CM UNIT'S PA UNIT

Lodging Providers (provider types 55 & 56):

Effective 01/01/2013, lodging services will require prior authorization. Providers can fax lodging requests to the UM/CM Unit's FFS Prior Authorization area, with supporting documentation, using the completed Fee For Service Authorization Request form. Use of the FFS Authorization Request Form is mandatory. Some of the information that should be provided with your lodging request is:

What care member is receiving
Why member needs lodging
Information supporting the number of nights requested for lodging
Dates and times of all appointments and/or procedures occurring during the lodging dates
MD name
Facility name
Escort name and relationship, when applicable
HCPCS codes for lodging services
Dollar amount requested for each HCPCS code Invoice

Transportation Reminders:

Some NEMT providers are not using the FFS mandatory forms when submitting transport documentation. These forms must be present when faxing information to the FFS Prior Authorization area or your documents will be returned.

Reminder: Extra miles billed because a provider is dropping off members at the home of a family's member will be denied. This is not a covered transportation service.

The preferred method of requesting an authorization for transportation services is via the online system. Please keep in mind that NEMT services and Lodging services are two separate services and should not be confused with one another.

When submitting a request to correct a previously authorized date of service, please fax a request to revoke the old date of service using the FFS Authorization Correction form after entering your new authorization request for the new date of service online. Corrections to date of service are still subject to guidelines related to timeliness. Authorization requests and corrections to date of service should occur before the service is rendered.

Once a member's eligibility posts to the system, NEMT authorization requests for the date the eligibility posted and forward are subject to guidelines regarding timeliness