AHCCCS
Arizona Health Care Cost Containment System

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CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

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Billing Reminder

Foot and ankle services by a Podiatrist (DPM) are not AHCCCS covered services. AHCCCS covers medically necessary foot and ankle care when ordered by a member's primary care provider, attending physician or practitioner, within certain limits, for eligible members. Foot and ankle care services may be reimbursed if rendered by another clinician such as a physician, NP, or PA.

Refer to the AHCCCS Medical Policy Manual (AMPM) and the FFS Provider Billing Manual, available online, for coverage and limitations.

Did You Know …?

Providers may ***NOT*** bill QMB Only and QMB Dual recipients for Medicare cost-sharing. 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. Specifically, the statute provides that the Medicare payment and any Medicaid payment are considered payment in full to the provider of services rendered to a QMB.

A QMB recipient cannot waive this right under Medicare by signing a document accepting liability for treatment costs. Providers who bill a QMB for costs above the Medicare and Medicaid payments (even when Medicaid pays nothing) are subject to sanctions.

For more information read the CMS materials on balance billing practices: Medicare Learning Network Matters Article and Center for Medicaid and CHIP Services Informational Bulletin.

When AHCCCS Requests Medical Documentation

AHCCCS encourages providers to electronically submit claims, EOBs/remits, records and medical documentation. The DFSM Training staff will be structuring a more robust training program around the electronic submission of records. When DFSM identifies a provider who consistently submits paper documentation, the Training staff will be notified and will reach out to the provider with training for electronic submission of their medical documentation.

******2 Policy Changes for NEMT Providers*******

Effective 10/1/2014 prior authorizations will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration.

Effective 9/1/2014 all services for the recipient's transport ***must*** be billed on one claim using multiple lines for that date of service. A claim submitted with base code only and second claim with mileage only will be denied, as split-billing the transport service is inappropriate.

REMINDER: Transition from ICD-9 to ICD-10 code sets delayed until 10/1/2015

On April 1, 2014 the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which states The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations.

Electronic claims submitted to the AHCCCS Administration with ICD-10 codes will be rejected from our validation system and will not be accepted into our claims system. Therefore, timely filing will not begin until a claim is submitted that is compliant with the national standard HIPAA code set transaction.

Paper claims submitted to the AHCCCS Administration with ICD-10 codes will be returned to the provider and timely filing will not begin until a claim is submitted that is compliant with the national standard HIPAA standard code set transaction.