CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

September 2015

Reminder: Transition from ICD-9 to ICD-10 on 10/1/2015

Effective on date of service 10/1/2015, and effective on inpatient discharge date 10/1/2015, all CMS 1500 and UB-04 claims must be submitted with valid ICD-10 diagnosis codes. It is AHCCCS intent to implement fully integrated "native" processing of ICD-10 code sets and fully review and remediate all impacted policies, rules and processes. All chapters in both provider billing manuals that reference "ICD-9" have been updated and published to the AHCCCS website.

ICD-10 Diagnosis Code on ADA Claim Form – CORRECTION

AHCCCS has revised the provider billing manuals for the ADA 2012 Form field 34a diagnosis code requirement. Diagnosis codes will be "Required if applicable" to conform to the ADA's 2012 form instructions which state:

> "This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient's oral and systemic health conditions."

AHCCCS will require diagnosis codes when the dental procedure is being billed due to a medical condition.

ICD-10 Implementation and Prior Authorization Changes

The online web portal will not accept entry of ICD-10 diagnosis codes until on or after 10/01/2015. Authorization requests for dates of service on or after 10/01/2015 can be submitted via the online portal on 10/01/2015 or later. As a temporary alternative, if it is necessary to submit an authorization request in advance of 10/01/2015 for services occurring within the first few days of October, the request may be submitted via the prior authorization fax line.

Reminder: Claims Received 9/28/15 and 9/29/15

AHCCCS has scheduled a project implementation on Monday 9/28/15 and Tuesday 9/29/15. All claims submitted on these days will be held and processed on 9/30/15, which will still meet the 48 hours processing timeline. Payments should not be impacted.

Please be aware of this processing hold and wait until the morning of 10/1/15 to verify that claims submitted on 9/28 are processed.

Reminder: Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web.

Delayed: Changes to AHCCCS Covered Behavioral Health Services

Changes to the behavioral health benefit coordination and financial responsibilities for AHCCCS covered behavioral health services are delayed and will not be effective on 10/01/2015 as indicated in the August Claims Clues.

Dental Service Requirements for IHS and Tribal 638 Providers

EPSDT includes dental services for recipients under age 21. Dental records are not required to be submitted for EPSDT dental claims. Prior Authorization is not required for IHS/638 providers or for services rendered at the IHS/638 facility. Refer to IHS/Tribal Provider Billing Manual Chapter 6 for more information.

Dental service requirements for IHS and Tribal 638 Providers providing treatment at a non-IHS/638 facility:
If the EPSDT recipient is referred to a non-IHS/638 facility for non-emergent surgical procedures, including non-emergent dental procedures, the non-IHS/638 facility is required to obtain prior authorization for their services. Authorization requests for dental surgical procedures at non-IHS/638 facilities are reviewed to ensure that members are receiving quality care that is medically necessary and appropriate for the member receiving treatment. Non-emergent dental procedures being performed at non-IHS/638 facilities should be scheduled after authorization approval has been obtained.
Refer to IHS/Tribal Provider Billing Manual Chapter 8 for more information.

This is not a change in policy for EPSDT dental services.

Adult (age 21 years and older) dental service claims must be submitted with the dental records. Refer to IHS/Tribal Provider Billing Manual Chapter 8 “Individual Practitioner Services” page 8 for adult dental limitations and criteria for coverage.