AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES
A Publication of the AHCCCS DFSM Claims Department

November 2018

Emergency Dental Services

AHCCCS covers emergency dental services for adult members (21 years of age and older). In 2017, the Arizona legislature approved this as a new benefit for AHCCCS members with Senate Bill 1527.

This dental benefit applies to all Fee-For-Service members who are 21 years of age and older, and our ALTCS and Tribal ALTCS members who are 21 years of age and older.

Emergency dental has the following requirements:

- The benefit must be for emergency dental services only;
- The benefit does not cover comprehensive dental services (such as cleanings); and
- The annual benefit amount is not to exceed $1,000 per member, per contract year (October 1st to September 30th).

A dental emergency is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma. Extractions may be covered, if determined to be emergent.

Any unused benefits for Fee-For-Service members, 21 years of age and older, will not be permitted to “carry-over” into the next contract year.

- For instance, if a member used $400 of their $1,000 limit for emergency dental services, they would not have $600 carry over into the next year. On October 1st of the following contract year, the member would have a $1,000 benefit, and not a $1,600 benefit.

It is the responsibility of the provider to check with the member, to determine the amount of dental benefit already used within each contract year.

EPSDT and KidsCare Members

EPSDT and KidsCare members under the age of 21 receive dental services separate from this emergency dental benefit. For additional information please see AMPM 431, Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment Aged Members.

PROVIDER BILLING MANUAL REMINDER:

The Fee-For-Service Provider Billing Manual is intended to outline billing requirements for providers who are billing the AHCCCS FFS unit for reimbursement.

REGARDING PROVIDER ACC QUESTIONS

For questions about registration:
AHCCCS Provider Registration Unit
In Maricopa County: 602-417-7670 and select option 5
Outside Maricopa County: 1-800-794-6862
Out-of-State: 1-800-523-0231

For questions about Enrollment Verification of members refer to the Eligibility And Enrollment Verification flyer on our website.

For questions about the American Indian Health Program:
Prior authorization technical assistance: 602-417-4400
Claims customer service: 602-417-7670, option 4
azahcccs.gov/AmericanIndians/AIHP/

For questions about the ACC health plans:
Available Health Plans
Care1st Health Plan (ID 010254)
www.care1staz.com

Steward Health Choice Arizona (ID 010497)
www.StewardHealthChoiceAZ.com

Magellan Complete Care (ID 010500)
www.mccofaz.com

Mercy Care (ID 010306)
www.mercycareaz.org

Banner-University Family Care (ID 010314)
www.bannerufc.com/acc

UnitedHealthcare Community Plan (ID 010158)
www.uhccommunityplan.com

Arizona Complete Health Complete Care Plan (ID 010422)
www.azcompletehealth.com/providers.html

CONTACT US:

If you have additional questions please outreach the DFSM Provider Training email inbox at: ProviderTrainingFFS@azahcccs.gov

Request for Electronic Remittance Advice (ERA) or 835 Transaction Setup (FAQs)

Who is a candidate for ERA/835?

AHCCCS registered providers receive the remittance advice from AHCCCS as a result of Fee-For-Service (FFS) claims adjudication. To further explain, AHCCCS reimburses providers for services in only two ways:

1. Our AHCCCS health plans directly reimburse providers who subcontract with them and/or provide services to their enrolled members. Each AHCCCS health plan is considered the payer, and providers submit claims for AHCCCS health plan enrolled members directly to the member's AHCCCS health plan.

2. AHCCCS reimburses providers on a FFS basis for services rendered to members eligible for AHCCCS or ALTCS, when they are not enrolled with an AHCCCS health plan. FFS populations include, but are not limited to, members in the Federal Emergency Services (FES) Program, members enrolled in the American Indian Health Program (AIHP), or American Indian members enrolled in a Tribal ALTCS Program. For these members AHCCCS is considered the payer, and providers submit their FFS claims directly to AHCCCS.

On claims for AHCCCS members enrolled with one of our AHCCCS health plans, you would want to contact the health plan regarding their ERA setup requirements. A list of the AHCCCS health plans can be found on our website.

If an AHCCCS registered provider is not actively submitting FFS claims to AHCCCS, the provider would not be a candidate for AHCCCS ERA/835 setup.

Who can request ERA/835 setup?

AHCCCS considers the provider their trading partner and a request for electronic remittance advice (ERA) or 835 transaction setup must come from an authorized individual from within the provider's organization; it cannot be initiated by the provider's clearinghouse, software vendor, or billing service.

For clarification purposes, the authorized individual must be someone from within the provider's own organization that has the authority to accept the electronic Trading Partner Agreement (TPA) executed from the Community Manager (CM) web portal. Only the provider can accept the TPA as it is a contractual agreement between the provider and AHCCCS. **The provider's CM account activation cannot be done by the provider's clearinghouse, software vendor, or billing service.**

How do I request ERA setup?

AHCCCS Information Services Division EDI Customer Support is the first point of contact for questions related to electronic transactions or to request transaction setup. The preferred method of contact is email.

Note: If providing PHI data, please make sure your email is secured.

All inquiries will result in the assignment of a Service Request or Incident for AHCCCS reporting purposes. Contact information:

Email: EDICustomerSupport@azahcccs.gov

Telephone Number: (602) 417-4451

Hours: 7:00 AM – 5:00 PM Arizona Time, Monday through Friday

What information does AHCCCS need from a provider requesting ERA/835 setup?

Customer Name
Provider Name
Customer Email Address
AHCCCS 6 digit Provider ID and/or NPI
Will the provider be retrieving their own ERA/835 or be using a clearinghouse to retrieve the ERA/835 on the provider's behalf?
If a clearinghouse is to be used, provide the name of that clearinghouse

Integration Billing Information

RBHA-Enrolled Members transitioning to an ACC plan or AIHP

For non SMI members enrolled with a RBHA, who transitioned to an ACC plan or AIHP, it is essential for behavioral health providers to check the member's new enrollment.

Members without an SMI designation may have been transitioned to:

- An ACC plan; or
- The American Indian Health Program (AIHP);

  For members who were transitioned to the American Indian Health Program (AIHP), a Tribal Regional Behavioral Health Authority (TRBHA) will have been a choice if the member's area is serviced by a TRBHA.

Most members (without an SMI designation) will no longer be assigned to a RBHA as of October 1st, 2018.

This means that claims for non-SMI members will no longer be sent to the RBHA as of October 1st, 2018.

Claims for members enrolled with an ACC plan, should be sent to the ACC plan.

Claims for members enrolled with AIHP, should be sent to AHCCCS.

TRBHA-Enrolled Members

American Indian members may choose to receive their behavioral health services through a Tribal Regional Behavioral Health Authority (TRBHA), if they live in an area served by a TRBHA. For members enrolled with a TRBHA, the claims will be sent to AHCCCS for Title XIX services. Non-Title XIX services are available via the TRBHA.

American Indian Health Program (AIHP) Enrolled Members

Claims for AIHP enrolled members should be sent to AHCCCS for both physical and behavioral health services.

AIHP is available state-wide.

ACC Enrolled Members

Claims for ACC enrolled members should be sent to the ACC Plan the member is enrolled in.

Members will have the following ACC plans available to them, based on the Geographic Service Area (GSA) they live in.

North GSA (Apache, Coconino, Mohave, Navajo and Yavapai Counties)	Care 1st Steward Health Choice Arizona
Central GSA (Maricopa, Gila and Pinal Counties)	Banner University Family Care Care 1st Steward Health Choice Arizona Arizona Complete Health Magellan Complete Care Mercy Care UnitedHealthcare Community Plan
South GSA (Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz and Yuma Counties)	Banner University Family Care Arizona Complete Health UnitedHealthcare Community Plan (Pima County only)

Note: Zip codes 85542, 85192, 85550 (mostly in the San Carlos Tribal area) are included in the South GSA.

For additional information on Integration please visit the AHCCCS website ACC page.

NEMT AHCCCS Daily Trip Report Reminders

NEMT providers are reminded that use of the ***updated*** **AHCCCS Daily Trip Report** is required.

The updated version was effective July 15th, 2018. A 60 day grace period had been granted, between May 15th and July 15th, 2018, for providers. Additionally, several provider training sessions were offered for review of the updated trip report. Providers were notified that, as of July 15th, 2018, claims submitted with the old version of the AHCCCS Daily Trip Report could be returned to the provider.

- Use of the old version of the AHCCCS Daily Trip Report can result in claim denials.

The AHCCCS Daily Trip Report and instructions for filling out the AHCCCS Daily Trip Report are available on the AHCCCS website in the following locations:

- Exhibit 14-1, in the Fee-For-Service Provider Billing Manual;
- Exhibit 11-1, in the IHS/Tribal Provider Billing Manual; and
- On the NEMT Provider webpage

The AHCCCS Daily Trip Report is available in both PDF and Excel file formats.

NOTE: The AHCCCS Daily Trip Report is available as an Excel file; however, it may not be altered. The Excel file has been provided, per provider request, so that the additional information section may be expanded, if needed.

Providers **must** convert the Excel file to a PDF before submitting back to AHCCCS. Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Report will be denied.

- Please note that different versions of the Daily Trip Report may ***not*** be used or submitted. The attachment in the billing manuals is ***the only*** version that may be submitted.
- Providers are not permitted to create their own versions of the Daily Trip Report for submission.

Only the AHCCCS approved Daily Trip Report can be used.

The AHCCCS Daily Trip Report may be filled out in either blue or black ink.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, so long as all federal and state requirements for the protection of member information are taken, including but not limited to HIPAA compliance and adherence to the AHCCCS Security Rule Compliance Summary Checklist (found in ACOM Policy 108, Attachment A).

If the AHCCCS Daily Trip Report is filled out electronically it may be submitted by printing it out and mailing it in, or electronically submitting it through the 275 provider portal as a PDF file.

AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.

- AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was only included online per provider requests.
- AHCCCS **will** accept PDF files of the AHCCCS Daily Trip Report.

If you have questions please feel free to contact DFSM Provider Training at ProviderTrainingFFS@azahcccs.gov

Pharmacy Services for AIHP Members

OptumRx

Members enrolled in the American Indian Health Program (AIHP) may have their prescriptions filled at any of the following:

- An Indian Health Service (IHS) facility,
- A Tribal 638 Facility, or
- Pharmacies that are part of Optum's network.

Prescriptions filled outside of an IHS or 638 pharmacy will be run through OptumRx, AHCCCS' Pharmacy Benefit Manager (PBM), beginning on October 1st, 2018.

The prescription benefit coverage for members enrolled in AIHP will not change.

If pharmacy staff have questions about a member's prescription coverage, they may contact OptumRx at 1-855-577-6310.

Additional information is also available on the Optum website.

BriovaRx Specialty Pharmacy

BriovaRx is OptumRx's Specialty Pharmacy. BriovaRx is part of the PBM for members who are receiving specialty medications, and will provide the special treatments needed for complex conditions like cancer and arthritis. To learn more about BriovaRx, please call 1-855-427-4682 or visit the website at www.BriovaRx.com.

If a member has been receiving hemophilia factor or Ceprotin from BriovaRx or a different specialty pharmacy, their prescriptions for Factor or Ceprotin will be provided by CVS Specialty Pharmacy beginning on October 1, 2018.

Members will have received a letter notifying them of the change. For questions, please contact CVS Specialty Pharmacy at 1-800-237-2767.

Direct Care Worker Agencies

In August 2019, the AHCCCS Division of Fee-for-Service Management (DFSM) will conduct annual monitoring of Direct Care Service Agencies serving Tribal ALTCS members who live in their own homes. The monitoring is to ensure the provision of the following: 1) service delivery in accordance with authorizations and members' needs; 2) quality of care for members; and 3) training and supervision of direct care workers.

Starting January 2019, AHCCCS DFSM will provide informational sessions to direct care worker agencies to explain the monitoring process/ standards, monitoring tool, and provide assistance on how to meet the requirements. These informational sessions will be held via webinar or at the AHCCCS Office.

The monitoring will be a desk level audit, meaning direct care worker agencies will be responsible for faxing/emailing/mailing files and documents to DFSM. The audit will be consistent with Chapters 900 and 1200 of the AHCCCS Medical Policy Manual. There will be an administrative review and a review of member files. The administrative review will consist of service utilization, employee screening, policies and procedures of each agency. The review of member files will consist of customer satisfaction, service provision, quarterly and supervisor visits, and contingency plans.

General information about direct care worker agencies can be found on the AHCCCS website.

If there are questions about the upcoming audit on direct care worker agencies on tribal lands, please email the following: DCWAgencies@azahcccs.gov

Reminder

The Fee-For-Service and IHS/Tribal Provider Billing manuals provide guidance for F**ee-For-Service claims *only*** and it is **not** intended as a substitute or a replacement for a health plan's or a program contractor's billing manual.

- If you contract with and/or provide services to members enrolled with an AHCCCS ACC health plan or program contractor, please continue to follow their instructions when providing and billing for services rendered to a member enrolled with that health plan or program contractor.

Fee for Service Authorization Reminders

Authorization Reminders

General Reminders

- To improve the efficiency of the ongoing review process FFS providers should include the latest Rx or Certificate of Medical Necessity along with the latest clinical notes, CPT codes, quantities, and by report prices with each request submitted.
- Providers and facilities may have separate authorization requirements. Each FFS provider is responsible for obtaining authorization for the services they intend to bill for.
- Providers requesting authorization must verify they are using the correct identifier (NPI or AHCCCS ID#) on their authorization requests. All authorizations must be requested under the NPI or AHCCCS ID# that is assigned to the provider rendering the service.
- Providers must verify member eligibility prior to requesting authorization or assistance from the FFS Prior Authorization area.

Web Portal Use Reminders

AHCCCS registered providers, including behavioral health providers, are now able to submit prior authorization requests for acute services* via the AHCCCS Online Provider Portal.

- Multiple clinical documents should be uploaded as a *single* file.
- All hospital admission notifications and/or authorization requests for hospital admissions must be accompanied by the facility's face sheet, and the history and physical document for the admission.
- Hospital authorizations pended for a discharge date should be updated online by the facility. Facility providers must attach the discharge summary using the web portal attachment feature.
- The status of all prior authorization requests can be viewed using the Web Portal. Prior authorization staff will no longer provide authorization status or issue standard authorizations to callers over the phone.
- *Urgent/Expedited medical requests should be submitted online with supporting documentation, **AND** a call must be made to the FFS Prior Authorization line to notify PA staff that a request requiring *expedited* review has been submitted.

  *Note: Submission of requests on short notice does not constitute an urgent request. An urgent/ expedited request can take up to three days to review. Requests submitted as urgent that are determined to be routine in nature will be processed in accordance with standard review timeframes.

- **Effective August 1, 2018** Providers with access must use the online system to submit requests for non-ALTCS members. PA still will not verify the status of authorizations over the phone. Authorization status can be verified online for all FFS members.
- Authorization requests submitted online automatically generate a pended authorization number that also serves as verification of receipt of the request, while allowing providers to check the status of their request via the online portal. Clinical documentation can be uploaded with the online request, so faxing of supporting documents is no longer necessary.
- Providers who continue to submit PA requests via fax will receive notification indicating that their request should be re-submitted online.
- The Web Portal is only for use by providers rendering services to FFS plan members.

Fee for Service Authorization Reminders Continued

- **Online authorization submission does not apply to Federal Emergency Services Plan (FESP) members. Please refer to the information in the FESP section at the end of this article for instructions and requirements.**

*Exceptions:

- Authorization requests for acute services (e.g. hospital stays, surgeries, lodging) rendered to Tribal ALTCS members must continue to be faxed, however, the status of these authorizations must be checked using the online web portal.
- Note: Authorization requests for long term care (non-acute) services for Tribal ALTCS plan members must be submitted to the member's Tribal Case Manager.
- Access to the Web Portal can be requested from AHCCCS' ISD.
- If submission of a Prior Authorization request or documentation is not possible due to internet outage or other unforeseen events, then it can be done through the fax method. The Prior Authorization Request Form must continue to be utilized with all faxed documents.

Face to Face (F2F) Requirements

- The following providers satisfy the F2F ordering provider requirement: MD, DO and DPM.
- F2F documentation elements must include information specifically documenting the practitioner who conducted the F2F encounter, and that the encounter findings were communicated to the ordering provider.
- F2F requirements apply to service initiation, not to renewals for continuation of the same service.

Physical Health vs. Behavioral Health Authorization Requests

- Hospitals submitting authorization requests for inpatient admissions involving the provision of both physical and behavioral health services during the same admission must bill a single claim for the entire admission using either a behavioral health principle diagnosis OR a physical health principle diagnosis. The authorization type entered online must be submitted with diagnosis and billing codes that are appropriate for the admission type that will be billed on the claim. The claim billed must match the services authorized.

Medical inpatient hospital admissions are authorized for diagnosis related grouping (DRG) reimbursement and behavioral health inpatient hospital admissions are authorized for per diem reimbursement using revenue codes.

See below for a brief description of the code types used to enter authorization requests for inpatient hospital admissions, surgical requests, and outpatient facility services online.

Service Type	Authorization Event Type	Corresponding Activity Type	Corresponding Activity Codes
Physical Health/Medical Acute Inpatient Hospital Admission ALL FFS Members (including Tribal ALTCS)	**IP** (Medical Inpatient)	**D** (Not required for hospitals outside Arizona)	**DRG** (Not required for hospitals outside Arizona)
Behavioral Health Acute Inpatient Hospital Admission	**BI** (BH Inpatient) FFS members, excluding Tribal ALTCS members	**R**	**0114, 0116, 0124, 0126, 0134, 0136, 0154, 0156**
Behavioral Health Acute Inpatient Hospital Admission	**PI** (BH Inpatient) Tribal ALTCS members	**R**	**0124**
Surgical Requests Physician and Ambulatory Surgery Centers	**MD (medical)** (Not for use by hospitals)	**H**	**CPT or HCPC billing codes**
Hospital Outpatient	**OP**	**N/A**	**N/A**

Fee for Service Authorization Reminders Continued

NOTE: All acute hospitals (provider type 02 or 71) located in Arizona must enter Activity information on their authorization requests for inpatient admissions.

Training

- Providers requiring assistance with the online authorization entry process are encouraged to review training resource materials.

For general questions about the PA process please contact the Prior Authorization line at 602-417-4400 or 800-433-0425 (In-state-outside the Phoenix area). PA staff will direct providers requiring in-depth instruction related to authorization entry to the FFS Training area.

Crisis Services

A crisis is any situation in which a person's behaviors put them at risk of hurting themselves and/or others, and/or when they are not able to resolve the situation with the skills and resources available to them. Persons in a crisis present with sudden, unanticipated, or potentially dangerous behavioral health conditions, episodes or behaviors.

Crisis services include mobile team services, telephone crisis response, and urgent care inpatient services including those provided at a hospital, sub-acute and/or residential treatment center. Crisis stabilization services will continue to include related transportations and facility charges.

Crisis services for American Indian/Alaskan Native (AI/AN) members enrolled in either an ACC health plan or AIHP are the responsibility of the Regional Behavioral Health Authority (RBHA).

Note: Integration begins on 10/1/2018, and there will be no change in crisis services for Title XIX and XXI members. RBHAs will continue to serve the same geographic service areas that they served prior to 10/1/2018.

For AIHP members, for the first 24 hours, crisis services should be billed to the RBHA. Services up to and including the fifth hour should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

After the first 24 hours (i.e. the 25th hour forward), crisis services should be billed to AIHP. Services, up to and including the fifth hour, should be billed using the hourly code S9484. Services over the fifth hour, up to and including the 24th hour, should be billed per diem using S9485.

In situations where the crisis services overlap days, the per diem code can span the two dates. The crisis provider would bill the first per diem as described above the dates of service 1 and 2, and the second per diem for dates of service 2 and 3, if applicable. The crisis provider may also bill hourly as described above, if applicable, in addition to the admin day.

For further information regarding what services are considered a crisis service and when the RBHA and ACC health plan or AIHP are responsible for payment, please see Exhibit 12-1, Matrix of Financial Responsibility for Crisis Services.

Example 1: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 6 p.m. on October 9th (Tuesday – Day 2).

- Billing for Day 1 (the first 24 hours):
  - The per diem code should be billed once to the RBHA for the first 24 hour time frame. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 3 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for the first 5 hours of Day 2:
  - An hourly rate for 3 hours (from 3 p.m. to 6 p.m.) should be billed to AIHP. This covers the 3 hours beyond the 24th hour on October 9th (from 3 p.m. to 6 p.m.).

Example 2: Crisis services were initiated at 3 p.m. on October 8th (Monday – Day 1) and ended at 11 p.m. on October 9th (Tuesday – Day 2).

Crisis Services Continued

- Billing for Day 1 (the first 24 hours):
  - The per diem code should be billed once to the RBHA for the first 24 hour time period. This date span is from 3 p.m. on October 8th (Monday – Day 1) to 3 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for Day 2:
  - "Day 2" started at 3 p.m. on October 9th. Since crisis services extended beyond the 5th hour of Day 2, the provider should bill the per diem to AIHP.

Example 3: Crisis services were initiated at 10 a.m. on October 8th (Monday – Day 1) and ended at 2 p.m. on October 12th (Friday, Day 5).

- Billing for Day 1 (the first 24 hours):
  - The per diem code should be billed once to the RBHA for the first 24 hour time period. This date span is from 10 a.m. on October 8th (Monday – Day 1) to 10 a.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for Day 2:
  - Since the member received crisis services all day on Day 2, the provider should bill the per diem rate to AIHP. This date span is from 10 a.m. on October 9th (Tuesday, Day 2) to 10 a.m. on October 10th (Wednesday, end of Day 2).
- Billing for Day 3:
  - The provider should bill the per diem rate to AIHP. This date span is from 10 a.m. on October 10th (Wednesday, Day 3) to 10 a.m. on October 11th (Thursday, end of Day 3).
- Billing for Day 4:
  - The provider should bill the per diem rate to AIHP. This date span is from 10 a.m. on October 11th (Thursday, Day 4) to 10 a.m. on October 12th (Friday, end of Day 5).
- Billing for Day 5:
  - Since the member received less than 5 hours of crisis services on Day 5, the provider should bill the hourly rate for 4 hours (10 a.m. to 2 p.m.) to AIHP. This covers the 4 hours beyond the 4th "day's" 24th hour.

Example 4: Crisis services were initiated at 10 p.m. on October 8th (Monday – Day 1) and ended at 2 a.m. on October 11th (Thursday, Day 3).

- Billing for Day 1:
  - The per diem code should be billed once to the RBHA for the first 24 hour time period. This date span is from 10 p.m. on October 8th (Monday – Day 1) to 10 p.m. on October 9th (Tuesday – end of the first 24 hour time frame).
- Billing for Day 2:
  - Since the member received crisis services all day on Day 2, the provider should bill the per diem rate to AIHP. This date span is from 10 p.m. on October 9th (Tuesday, Day 2) to 10 p.m. on October 10th (Wednesday, end of Day 2).
- Billing for Day 3:
  - Since the member received less than 5 hours of crisis services on "Day 3" (the 3rd 24 hour time frame), the provider should bill the hourly rate for the 4 hours (10 p.m. on Wednesday, October 10th to 2 a.m. on Thursday, October 11th) to AIHP. This covers the 4 hours beyond the 2nd "day's" 24th hour.

For mobile services, H2011 should be used and the HT modifier added for the two-person multi-disciplinary team.

For additional information on crisis services please visit the Crisis Services FAQs on the AHCCCS website.

Crisis Hotlines

If you or someone you know is experiencing a behavioral health crisis, please contact:

24-Hour Crisis Hotlines – National

1-800-273-TALK (8255) - National Suicide Prevention Lifeline

1-800-662-HELP (4357) - National Substance Use and Disorder Issues Referral and Treatment Hotline

Text the word “HOME” to 741741

Suicide/Crisis Hotlines by County

Maricopa County:
1-800-631-1314 or 602-222-9444

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties:
1-866-495-6735

Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties:
1-877-756-4090

Gila River and Ak-Chin Indian Communities:
1-800-259-3449

Especially for Teens
Teen Life Line phone or text:
1-602-248-TEEN (8336)

Global OB Billing for IHS/638 Facilities

Q: How do IHS/638 facilities bill for labor and delivery services?

A: The hospital bills the inpatient All Inclusive Rate (AIR), on a UB-04 claim form, for all inpatient services. The AHCCCS global obstetrical (OB) codes are billed on a CMS 1500 claim form.

Evaluation and management (E/M) codes for office and/or hospital/clinic visits may not be

unbundled from the global OB code and billed separately. Claims for these services will be denied when billed in addition to the global code.

For more information on how to bill the Global OB code please refer to the AHCCCS Billing Manual for IHS/Tribal Providers, chapter 8, Individual Practitioner Services.

The outpatient clinic/AIR is not billable for pre-natal or post-natal visits.

Q: If a patient comes in and has a UTI, back pain, or other injuries not related to pregnancy, can the service be billed to AHCCCS?

A: Please refer to the previous guidance regarding billing for laboratory, radiology and prenatal services.

For example:

- If a patient comes in for an OB visit and also complains about a sore throat, the OB/G provider may examine and treat the sore throat during the OB visit. This is NOT billable as an AIR clinic visit.
- If the OB/G prescribes a medication for the sore throat, AND/OR for the pregnancy, and the patient picks up the medication at the pharmacy on the same day, then this pharmacy encounter is billable as one (1) AIR.
- However, if the patient comes in for an OB visit, then goes to the walk-in clinic and is seen by another provider who examines and treats for the sore throat, then this clinic visit is billable as an AIR clinic visit.
- If the patient then goes to the pharmacy window and picks up medications prescribed by both the OB/G and walk-in clinic, then this pharmacy encounter visit is billable as one (1) AIR.