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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

January/February 2022

Payment Error Rate Measurement (PERM) Audit

What is Payment Error Rate Measurement (PERM) AUDIT

The PERM Audit is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Improvement Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 IPERIA). The improper payment rates are based on reviews of the Fee-for-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the year under review.

Provider Billing Reminders:

It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement. For each claim submitted, you must be sure to include the correct member name and AHCCCS ID number, date(s) of service, revenue, procedure codes, units, and charge amounts (etc). Claims should adhere to standard coding practices to also include modifiers if applicable. Providers should utilize the respective state and federal billing & coding resources to ensure claims meeting the appropriate billing guidelines. www.azahcccs.gov/Resources/Training/DFSM_Training.html

Responding to PERM Documentation Requests:

Providers must submit the requested information by the due date noted on the request. Please note that it will be the responsibility of the provider identified on the claim to ensure that all supporting medical records, from the provider who rendered a AHCCCS covered service for which the claim payment under review was requested, is submitted in a timely manner. www.azahcccs.gov/PlansProviders/OtherProviderProgramsAndInitiatives/PERM.html

CMS Extension of "Four Walls" Grace Period for IHS and Tribal 638 Facilities

On October 4, 2021, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin that extended the grace period previously granted to Indian Health Service (IHS) facilities, and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), which permits IHS/Tribal facilities to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate (AIR)) for services provided outside of the "four walls" of the facility.

Extension of the grace period will allow states and Tribes to continue the work needed to make an informed decision about the Tribal FQHC option described in a January 15, 2021 Informational Bulletin (referred to in that CIB as "the Tribal FQHC option") and take steps to effectuate that option.

The bulletin extends the grace period to end nine months after the end of the COVID-19 public health emergency.

- Learn more here: Further Extension of Grace Period Related to the "Four Walls" Requirement under 42 C.F.R. § 440.90 for Indian Health Service and Tribal Facilities to Nine Months after the COVID-19 PHE Ends

ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address of servicedesk@azahcccs.gov

TRAINING AND CONTACTS

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website at: https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

The DFSM Provider Training Team's First Quarter Training Schedule is posted on the DFSM Provider Training web page.

For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at ProviderTrainingFFS@azahcccs.gov

- Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website.
- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5

Prior Authorization Questions FFS PA Line (602) 417-4400

Claims Customer Service Billing Questions (602) 417-7670 - Option 4

Provider Registration Process Questions (602) 417-7670 - Option 5

Provider Registration – Fax Applications (602) 256-1474

Electronic Payment Sign Up (Remittance Advice Sign Up/835)

ELECTRONIC PAYMENT SIGN UP

ISDCustomerSupport@azahcccs.gov OR call 602-417-4451

COVID FAQ

FAQs on the AHCCCS website.

First Quarter Provider Training Schedule Posted

The DFSM Provider Training Team offers quarterly group training sessions on a variety of topics, designed to guide a provider on how to successfully submit claims and be reimbursed for services rendered to AHCCCS members. Topics include, but are not limited to:

- Checking a Member's Eligibility
- Submitting a Prior Authorization Request on the AHCCCS Online Provider Portal
- Submitting a Claim on the AHCCCS Online Provider Portal
- Checking a Claim's Status on the AHCCCS Online Provider Portal
- Submitting Documentation with a Claim on the Transaction Insight Portal
- Documentation Requirements for Claims and Concurrent Review
- Trainings for Individual Provider Types (Non-Emergency Medical Transportation Providers, Direct Care Worker Agencies, Behavioral Health Residential Facilities, etc.)

The first quarter provider training schedule can be found on the AHCCCS DFSM Provider Training web page.

General Requirements for the Submission of Paper Claim Forms

When submitting paper claim forms to AHCCCS, the following are the general rules that apply to the ADA 2012, the CMS-1500, and the UB-04 claim forms:

1. No handwriting is permitted on any part of the claim form, including in the top margins, sides, and remarks sections. The only exception to this is the signature field, where a written signature will be accepted.
2. The preferred font for claim submission is Lucinda Console and the preferred font size is 10.
3. ICD-10 codes are required on all claim forms. Claims submitted with an ICD-9 diagnosis will be denied.
4. CPT and HCPCS procedure codes and modifiers must be used to identify other services rendered on the CMS-1500 and UB-04 claim forms.
5. Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system, so should not be used.
6. Liquid paper correction fluid ("White Out") may not be used.
7. Correction tape may not be used.
8. Labels and stamps on claim forms will not be accepted. The only exception to this is in the signature field, where a stamped signature will be accepted.
9. Instructions on filling out each individual claim form type can be found in the Fee-For-Service Provider Billing Manual on the AHCCCS website.

Transportation Requests

Transportation requests should not be included in the meals and lodging requests, since doing so will delay the authorization. They need to be submitted separately.

Transportation should be arranged as soon as the scheduled appointment has been made. The member and/or the treating facility should arrange transportation with an AHCCCS registered transport provider.

Prior authorization is required for non-emergency transportation more than 100 miles one way or roundtrip.

AHCCCS requires a referral with a letter of medical necessity from the referring facility if services are not available or there is a medical reason for the member to receive services beyond the closest facility.

- The referral can be submitted to AHCCCS PA via fax at 602 254-2431.
- The information should be sent using the AHCCCS Fee For Service Prior Authorization Medical Documentation Form.

Transportation Passes/Bus Passes

Effective 10/1/2021, providers with a Category of Service (COS) 31 may offer Public Transportation options to FFS members (such as a bus pass) when they travel to and from an AHCCCS approved service, in accordance with AMPM 310-BB.

The following shall be considered when offering public transportation to a member:

1. Location of the member to a transportation stop.
2. Location of the provider of services to a transportation stop.
3. The public transportation schedule in coordination with the member's appointment.
4. The ability of the member to travel alone on public transportation.
5. Member preference

Provider types that are eligible to claim reimbursement for public transportation passes include 02, 05, 13, 14, 25, 27, 29, 41, 77, 81, 85, 86, 87, A3, A4, A6, B7, BC, C2, and C5.

Please note:

- Transportation passes may be up to 1 month in duration.
- Replacement or duplicate transportation passes are not eligible for Medicaid reimbursement.
- There shall be a continuous need for transportation to Medicaid reimbursable services consistent with the length of the purchased transportation pass.
- Providers shall determine the appropriate type/duration of public transportation pass to issue to members in accordance with the member's treatment plan and existing future appointment dates.

Billing for Transportation/Bus Passes

- Bill using code A0110 for the net cost of the transportation pass, not to exceed the cost of a 30-day pass.
- Submitted Claims must include the following documentation.
  - Copy of public transportation pass,
  - Itemized receipt specifying cost of public transportation pass,
  - Pricing that corresponds with the price of the pass in the geographic areas of issuance, and
  - Completed Public Transportation Pass form to include the following:
    - Provider's name and ID#,
    - Public Transportation pass type (daily, weekly, or monthly),
    - Price of the Public Transportation pass,
    - Date of issuance,
    - Name, title, signature, and signature date of person issuing Public Transportation pass to the member,
    - Member name, AHCCCS ID#, signature and signature date.
- Public Transportation Pass Form.

AHCCCS Prior Authorization and Concurrent Review Standards during the COVID-19 Emergency for Fee-for-Service Programs

The memo on AHCCCS Prior Authorization (PA) and Concurrent Review Standards during the COVID-19 Emergency for Fee-for-Service Programs has been updated as of January 20, 2022. Please review the PA standards.

Tribal ALTCS Digital Tool

The Tribal ALTCS Digital Tool Box can be found on the AHCCCS website.

COVID-19

AHCCCS is responding to an outbreak of respiratory illness, called COVID-19, caused by a novel (new) coronavirus. Health officials urge good hand washing hygiene, covering coughs, and staying home if you are sick.

To address Medicaid-related questions from providers and contractors about COVID-19, AHCCCS has developed a list of Frequently Asked Questions Regarding Coronavirus Disease 2019 (COVID-19), updated regularly as more information becomes available.

COVID-19 FAQs

Find out more at: azahcccs.gov/AHCCCS/AboutUs/covid19.html

Learn how to protect yourself and stop the spread of COVID-19.

Visit azdhs.gov/COVID19 and cdc.gov/COVID19.

If you are an AHCCCS member who is experiencing flu-like symptoms, please call the 24-hour Nurse Line for your health plan. Phone numbers can be found on the AHCCCS website.

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Attention All Transaction Insight (TI/TIBCO) Portal / Web Upload Attachment Users

This is an important notice for providers who log onto the Transaction Insight Portal (also known as TIBCO or the TI Portal) to upload attachments, such as medical records and the Daily Trip Report

If you select Non-Person Entity (2) and then enter in information into the Provider First Name field, this will cause an error and your attachments will not link to the claim.

This will cause your claim to be denied for missing documentation.

AHCCCS has been seeing multiple errors amongst providers who are submitting documentation as a Non-Person Entity (2). Do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.

INCORRECT
Provider Entity Type Qualifier: Person (1) Non-Person Entity (2)
Provider Last or Organization Name: Organization Name
Provider First Name: Organization Name (If you put something here, the documentation may not attach and the claim could deny.)

CORRECT (Provider First Name must be blank/empty)
Provider Entity Type Qualifier Person: (1) Non-Person Entity (2)
Provider Last or Organization Name: Organization Name
Provider First Name: The Provider First Name field must be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the portal.

Please also review Page 8 (Submitter Last or Organization Name) in the guide:
Transaction Insight Web Upload Attachment Guide
If you encounter problems logging on to the TI Portal, please contact EDI Customer Support at servicedesk@azahcccs.gov

Please click on the link below to download the latest training on the new web upload attachment layout.

- New TI Portal User Guide

Any additional questions regarding training on the TI portal, please contact:

- ProviderTrainingFFS@azahcccs.gov

Electronic Visit Verification (EVV)

For information on Electronic Visit Verification please visit the AHCCCS website.

If you are one of the provider types listed, and provide a service listed at one of the location codes listed under the information for Providers and MCOs tab (shown below), then EVV applies to you.

You must meet all three criteria (provider type, service code, and place of service) in order to meet the requirement to comply with EVV.

EVV applies to the following provider types, services rendered, and places of service:

Provider Description	Provider Type
Attendant Care Agency	PT 40
Behavioral Outpatient Clinic	PT 77
Community Service Agency	PT A3
Fiscal Intermediary	PT F1
Habilitation Provider	PT 39
HomeHealth Agency	PT 23
Integrated Clinic	PT IC
Non-Medicare Certified HomeHealth Agency	PT 95
Private Nurse	PT 46

Service	HCPCS Service Codes	DDD Focus Codes
Attendant Care	S5125	ATC
Companion Care	S5135	
Habilitation	T2017	HAH, HAI
Home Health Services (aide, therapy, and part-time/intermittent nursing services)		
Nursing	G0299 and G0300	
Home Health Aide	T1021	
Physical Therapy	G0151 and S9131	
Occupational Therapy	G0152 and S9129	
Respiratory Therapy	S5181	
Speech Therapy	G0153 and S9128	
Private Duty Nursing (continuous nursing services)	S9123 and S9124	HN1, HNR
Homemaker	S5130	HSK
Personal Care	T1019	
Respite	S5150 and S5151	RSP, RSD
Skills Training and Development	H2014	

Place of Service Description	POS Code
Home	12
Assisted Living Facility	13
Other	99

AIHP Transportation Request Process