Serious Mental Ill (SMI) Changes Effective 10/1/2022

American Indian Health Program (AIHP) Integration for Members with a Serious Mental Illness (SMI) Designation Effective October 1st, 2022 – Information for Providers

The Arizona Health Care Cost Containment System (AHCCCS) Division of Fee-for-Service Management (DFSM) serves as the health plan for Fee-for-Service (FFS) Medicaid members. The DFSM is responsible for the clinical, administrative and claims functions for the FFS population. Effective 10/1/22, American Indian/Alaskan Native (AI/AN) members with a Serious Mental Illness (SMI) designation will have the choice to be part of the integrated American Indian Health Program (AIHP) for coverage of both behavioral and physical health services.

Individuals with an SMI designation currently enrolled with the American Indian Health Program (AIHP) for physical health services and receiving behavioral health services from a Regional Behavioral Health Authority (RBHA) will have:

- Behavioral Health services transition to AIHP effective 10/1/2022, and

- Physical health services continue with AIHP.

Individuals with an SMI designation currently enrolled with an AHCCCS Complete Care (ACC) plan for physical health services and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA) will have:

- Physical health services transition to AIHP effective 10/1/2022, and

- Behavioral health services continue with the TRBHA.

Effective 10/1/22, RBHAs will be called ACC-RBHAs (AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements). SMI members' choice of enrollment remains intact; they may choose between integrated ACC-RBHA or integrated FFS (AIHP). They may also continue to receive services via IHS/638 tribal facilities, same as they can today.

This integration of AI/AN SMI designated members will not affect the ability of both physical and behavioral health providers to offer services to these members. AHCCCS encourages all providers to continue to care for members with an SMI designation. Providers currently serving AI/AN SMI designated members who continue to serve these members after 10/1/22 may be eligible for Differential Adjusted Payments (DAP).

The DFSM seeks to partner with facilities/providers for ongoing care management support and health plan technical assistance. All providers of behavioral and physical health services who are registered with AHCCCS can provide care and submit claims to DFSM for services provided to members enrolled with AIHP. No separate contract beyond the Provider Participation Agreement is required. See the AHCCCS Provider Enrollment website for more information.

For additional care management resources please contact casemanagers@azahcccs.gov.

For technical assistance with billing, claims and prior authorization please visit our website or email ProviderTrainingFFS@azahcccs.gov.

Please sign up for DFSM's "Constant Contact" E-mail notifications for providers and select the SMI Service list to receive SMI specific notifications.

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

- 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
(Remittance Advice Sign Up/835) Contact: ISDCustomerSupport@azahcccs.gov –OR- call (602) 417-4451

COVID FAQ
FAQs COVID Fact Sheet.

835/Electronic Remittance Advice (ERA)

For those providers that have signed up to receive the 835/ERA using the secure server. If a provider is missing a copy of an 835/ERA and would like to request a copy, please submit a service ticket via email at servicedesk@azahcccs.gov and request the service ticket to be assigned to ISD Finance. The service ticket must include the check/EFT number, invoice number, payment amount, and payment date in your request.

The Division of Business Finance (DBF) can only assist providers that receive Paper Remittance advice and providers may contact DBF at 602-417-5500 for assistance.

Reminders: Behavioral Health Residential Facility (BHRF) Admission

Prior Authorizations for a BHRF admission must be submitted prior to the admission to the BHRF. All prior authorization requests must be submitted timely to AHCCCS and include the required documentation to include but not limited to BHP assessment/evaluation referral associated with the BHRF admissions. BHRFs are responsible to coordinate care with the member's RHBA/TRBHA/SMI Clinic/Case Managers and other treatment team members from admission, care planning through discharge.

A referring treatment plan with BHRF as a medically necessary and least restrictive environment with clear treatment goals shall be included in the prior authorization request.

The goal of the treatment plan is to assess and re-evaluate the member's care needs. The Assessment is critical to gathering information regarding supports, strengths, goals and expectations for treatment to maximize care and the importance of discharge planning. Care coordination to include care with others to support the member after discharge and may also be included in the discharge plan.

Payment Error Rate Measurement (PERM) Audit

The Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) program recorded the Provider Education webinar conducted in April 2022. The recorded webinar is intended to educate the provider and supplier community about the PERM program and explain the responsibilities to those who are participating in the Medicaid program and/or Children's Health Insurance Program (CHIP). The PERM program is designed to measure and report improper payments in the Medicaid and CHIP programs. Improper payment rates are based on reviews of Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Reporting Year (RY) under review. The improper payment rate is not a "fraud rate" but a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. These improper payments may be overpayments or underpayments and do not necessarily represent expenses that should not have occurred.

The objectives of this recorded webinar is for those participating in the Medicaid and CHIP programs to better understand:

- The PERM program.
- The PERM medical review process.
- PERM medical record and documentation requests.
- Methods for record submission.
- Provider best practices.
- PERM resources for providers.

CMS uses a 17-state rotational approach to review the states' Medicaid program and CHIP so that the PERM program measures each state once every three years. Listening to this recorded webinar is an opportunity for the provider and supplier community to better understand their responsibilities during a PERM cycle. For additional information, please go to the CMS PERM website.

What is 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's 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 meet the appropriate billing guidelines.

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 an AHCCCS covered service for which the claim payment under review was requested, is submitted in a timely manner. Please see the webiste for more information.

Participating Provider Reporting Requirements Effective 10/1/2022

Effective for dates of service on or after October 1, 2022, Participating Provider Reporting Requirements will also apply to the following provider types and claim forms. To retain information related to the actual professional practitioner that is participating in or performing services associated with the clinic visit, this information must be reported on the claim.

 Claim Form Types:

- CMS 1500 claim form, Field 19 Field Title: Additional Claim Information

- ADA claim form, Field 35 Field Title: Remarks

Provider Types

- 05 – Clinic

- 77 - Outpatient Behavioral Health Clinic

- IC – Integrated Clinic

Denial Edit Code H482 "NPI Missing or Invalid" will append to the claim if the participating provider information is not entered or is in the incorrect format.

Provider Denial Resolution Guide

DFSM has created a denial resolution guide that includes the most common claim submission error codes and the steps a provider can take to help resolve the denial and/or how to avoid the same denial on future claim submissions. The information contained in this document is to provide general guidance only.

 Provider Denial Resolution Guide

APEP FAQs

If you're seeking quick answers to common questions regarding APEP or enrolling as an AHCCCS provider, please visit the current list of common questions regarding the provider enrollment process.

The list of FAQs can be found on our website. For all other enrollment questions, please contact Provider Assistance (602) 417-7670 option 5 or email APEPTrainingQuestions@azahcccs.gov

Reminders: Fee-for-Service Prior Authorizations

All FFS participating providers are required to request prior authorization for services identified on FFS prior authorization list before the service is rendered.

As a reminder, FFS Prior Authorizations can be requested online via the AHCCCS Online Provider Portal, which is available 24 hours a day, 7 days a week.

AHCCCS FFS recommends that providers verify a member's

enrollment prior to submitting a PA request. Did you know you could also check the status of your prior authorization case(s) on the AHCCCS Online Provider Portal in "real time". The PA team will utilize the Comments feature to communicate with providers, this will include if additional documentation or action is required by the provider in order to finalize the PA request.

Reminder: Transaction Insight Portal-
Important Information for Users

When completing the Start date field on the Transaction Insight Portal, providers should enter the begin date of service first followed by the last date of service.

Example of an incorrect date format:

Invalid Date/Time Range '20220609 - 20220602', the "Claim Service Period Start Date" field should not be later than the end date.

Example of correct date format:

06022022 - 06092022. Please also note it is not required to enter a date in the "Claim Service Period End Date" field.

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.

Division of Fee-For-Service Management: Training Resources

New TI Portal User Guide Any additional questions regarding training on the TI portal, please contact: ProviderTrainingFFS@azahcccs.gov