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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

April 2023

Alternate Care Site (ASC) Flexibility Ending for Indian Health Service (IHS) and Tribally Owned/Operated (638) Facilities

In alignment with the end of the COVID-19 PHE, the use of Alternative Care Sites (ACS) established by Indian Health Service (IHS) or tribally owned/operated 638 facilities will end on dates of service starting May 11, 2023. All services and reimbursements related to this flexibility will be discontinued in conjunction with the end of the PHE and the rollback of the CMS 1135 Blanket Waiver. This applies to all AHCCCS reimbursement of IHS and 638 facilities for services rendered at an ACS.

For more information about the ACS flexibility, please see the Centers for Medicare & Medicaid Services (CMS) Fact Sheet for State and Local Governments - CMS Programs & Payment for Care in Hospital Alternate Care Sites, as well as the Biden Administration's announcement of its intention to end the national public health emergency declarations on May 11, 2023.

Covid-19 Billing and Claims

ACS Memo

Denial Edit - L013.5 Claim Service Requires Prior Authorization, PA Not Found

Denial edit L013.5 will set on a claim when a prior authorization is required. During the initial processing of the claim the AHCCCS system could not find a prior authorization that matched the claim. Below are 3 easy steps to take for review.

1. Verify if a PA is on file using the AHCCCS Online Provider Portal. If a PA is on file, verify if the information on the PA is a match with the claim details.
2. Timing is important. If the PA was entered and approved after the initial processing of the claim and you have verified the information is a match, providers can contact the call center at (602-417-7670) to have the claim reprocessed.
    - If the claim was submitted electronically, providers can resubmit the claim to avoid wait times.
3. If the information on the claim or PA does not match, the provider must review the claim and PA to determine what action may be required.

Claim Edit Review Tips

All claims submitted to the AHCCCS Administration are extensively edited by the AHCCCS claims system. Most claim issues can be resolved easily by reviewing the denial reason code. If additional information is needed for example, medical documentation or a copy of an EOB for processing, a **replacement claim is not required**. The submitter can simply mail in or attach the necessary documentation to the existing claim via the Transaction Insight Portal (TIBCO) for review.

There are many types of denial edit reason codes. The edit reason codes include descriptions that will help you to identify key fields that may have resulted in a denial of the claim.

TRAINING AND CONTACTS

Transaction Insight Portal (TIBCO/TI):

The following TIBCO requests can be sent to servicedesk@azahcccs.gov

New user account please include your first/last name, primary provider ID number and a work email address. The service desk can also assist with adding additional users and password resets.

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

Provider Training materials for FFS Providers and upcoming Provider Training sessions can be found on the DFSM Provider Training Web Page.

For Provider Training questions, providers can contact the Provider Training Division of DFSM email at ProviderTrainingFFS@azahcccs.gov

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing, and FFS policies.

The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. Hours of Operation are Monday – Friday, 7:30am-5:00pm.

For Prior Authorization inquires and questions, please call the FFS Prior Authorization service line (602) 417-7670.

For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

Electronic Payment Sign Up (Remittance Advice Sign Up/835) Contact: servicedesk@azahcccs.gov or call (602) 417-4451

COVID Frequently Asked Questions: FAQ COVID Fact Sheet

Common Prior Authorization Submission Errors

AHCCCS has identified several common PA submission errors that include but are not limited to:

- PA request entered for CPT/HCPCS code that does not require a PA.
- Incorrect Date of Service(s).
- Incorrect Event type.
- Failure to complete the Event Tab.
- Failure to complete the Activity Tab.

PA request entered under the incorrect provider NPI number.

To learn more about procedures that may or may not require a prior authorization view the Fee for Service Prior Authorization Guide

Effective 10/14/2022 Covered Dental Services at an IHS/638 Facility Are Unlimited

As per Arizona Medicaid Section 1115 Demonstration Waiver extension, effective 10/14/2022 the $1000 dental services limits for AI/AN members over 21 years of age, and AI/AN ALTCS members, receiving services for medically necessary diagnostic, therapeutic, and preventative dental services at IHS/638 facilities are eliminated.

This expenditure authority applies only when dental services are provided to American Indian/Alaskan Native (AI/AN) beneficiaries who receive services from participating IHS facilities and/or participating Tribal 638 facilities operated under the Indian Self-Determination and Education Assistance Act (ISDEAA).

Services performed outside of the IHS/638 Tribal facilities remain limited to the $1000 Emergency Dental Benefit for members 21 years of age and over, and additional $1000 for members on ALTCS.

Additional Reimbursements of the Pharmacy All Inclusive Rate (AIR) for the Administration of COVID-19 and Influenza Immunizations are Ending

This notification communicates the ending of additional All Inclusive Rate (AIR) reimbursements that were permitted for IHS/638 pharmacies for COVID-19 and Influenza immunizations.

Initially the additional AIRs were allowed beginning on November 23, 2020. They will no longer be permitted when the Public Health Emergency (PHE) period ends effective May 11, 2023.

Additional information may be found on the AHCCCS Frequently Asked Questions (FAQs) Regarding Coronavirus Disease 2019 (COVID-19) web page, as well as the Biden Administration's announcement of its intention to end the National Public Health Emergency declaration on May 11, 2023.

As a reminder, AIRs for COVID-19 and influenza immunizations, submitted to the PBM on or after May 11, 2023, shall be reimbursed for zero dollars when it is not the first point-of-sale claim adjudicated by the pharmacy benefit manager, OptumRx, for the member on that date of service. The AIR shall be reimbursed once daily per member per facility pharmacy through the point-of-sale system.

Additional information may be found in the following manual.

IHS Provider Billing Manual Chapter 10 Pharmacy

FFS Provider Billing Manual Chapter 12 Pharmacy

Vaccine Memo: Unwinding Flu and Covid AIRs

BHRF Criteria for Continued Stay

BHRF request for a Continued Stay should be submitted to the prior authorization team at least two weeks prior to the last approved prior authorized date of the BHRF stay.

- The latest Assessment signed by the BHP (Behavioral Health Professional) or cosigned by the BHP.
- The latest Treatment Plan not older than 30 days from the submission date. Signed by both the member and the BHP.
- Group and Individual therapy notes and the seven-day schedule outlining the member day to day living.

Please note this is not an all-inclusive list, please note the PA team may request additional documentation as necessary for review.

Selecting the Correct Event Type for Medical and Behavioral Health Admissions

As a reminder, acute care hospitals that are requesting a prior authorization for an inpatient stay, the Event type must match the diagnosis code submitted on the prior authorization request.

For example, the primary admitting diagnosis code is “acute respiratory failure”. The correct Event type would be IP to indicate an inpatient medical stay.

In the same example, if the claim is submitted with a primary admitting diagnosis code that indicates a behavioral health condition, for example F10.239 for Alcoholism, and the Event type entered on the PA request is IP (inpatient) and not BI (behavioral health inpatient).

Result: The claim will deny due to mismatched Event and diagnosis billed.

Action: If the submitter determines the Event type is incorrect, please submit a Prior Authorization Correction form to correct the event type. If the claim was submitted with an incorrect primary admit diagnosis, please submit a replacement claim.

FFS Prior Authorizations Forms

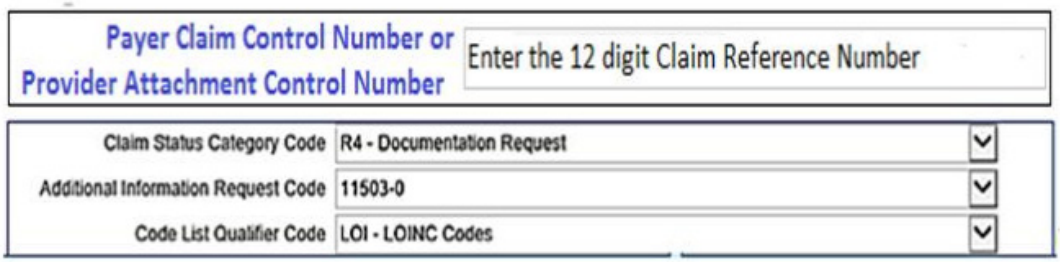
Reminders Transaction Insight Portal

As a reminder, providers using their own software application to submit claims to AHCCCS FFS may utilize the Transaction Insight Portal (TIBCO) to link any required documentation to the claim. However, please note the only way the document can be linked using TIBCO is to use the AHCCCS 12 digit claim number in the ***Payer Claim Control Number/Provider Attachment Control Number*** field as shown below.

Set Purpose Code 11 – Response (Solicited) must be selected.

Correct Example: Enter the 12 digit Claim Reference Number (230000000123).

Incorrect Example: Do not include the suffix **(000)** at the end of the CRN (230000000124**000**).



Need Help: To sign up for access to the Transaction Insight Portal, add additional users and reset passwords send your email to: servicedesk@azahcccs.gov

Prior Authorization Tips

The AHCCCS processing system will automatically search for an prior authorization based on the following elements, Member ID, Provider NPI, Date of service(s) , Event type, CPT/HCPCS codes and service units.

The AHCCCS Online Provider portal ***will not allow*** a change or modification to an existing PA when the status has been changed from Pending to **Approved, Denied or Revoked.**

If the PA has been Revoked in error or Denied due to lack of information, the provider can submit any supporting documentation for reconsideration of the PA Case.

Providers may use the Prior Authorization Correction form to request a change or update to an existing prior authorization. The PA correction form can be linked to the PA by using the ***Attachment*** feature located on the Event tab.

If the PA status shows **Pending** the submitter can make any changes to the existing PA, for example, date of service, units, CPT/HCPCS, etc.

Verifying if a Service Requires a Prior Authorization

AHCCCS requires prior authorization as a condition of payment for many services. The AHCCCS FFS Authorization Guidelines lookup tool can assist with determining if a CPT/HCPCS code has a prior authorization requirement.

Participating providers can check for CPT/HCPCS that require authorization via the FFS Authorization Guidelines tool.

We recommend that providers verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered. **Remember, prior authorization is not a guarantee of payment. Unauthorized services will not be reimbursed.**

Reminder: Referring/Ordering Provider Requirement

Many services will require the Referring/Ordering Provider's information to be included on the claim submission. Claims submitted without the ordering provider listed will be denied.

Ordering providers can only be one of the following provider types:

- Medical Doctor (MD)
- Doctor of Osteopath (DO)
- Optometrist •Physician Assistant
- Registered Nurse Practitioner
- Dentist
- Podiatrist
- Psychologist
- Certified Nurse Midwife
- Clinical Nurse Specialist (limited to DME and prescribing pharmacological agents in specific licensed health care institutions).

The referring/ordering provider qualifier code must be entered in the "**Name Of Referring Provider Or Other Source**" field on the CMS 1500/837P claim form.

- DN Referring Provider
- DK Ordering Provider*
- DQ Supervising Provider

Additional information may be found in the FFS Provider Billing Manual Chapter 05

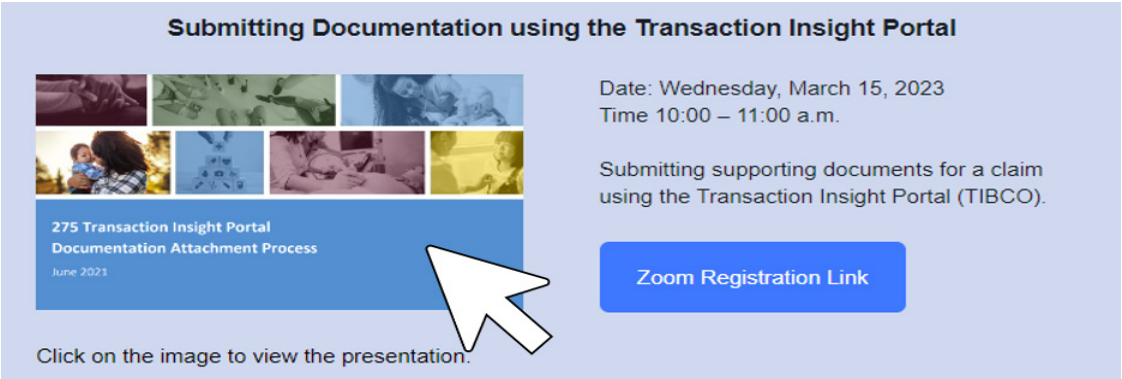
AHCCCS FFS New Vendor Notification Medicaid Travel Services Provider

The Arizona Health Care Cost Containment System (AHCCCS), Division of Fee-for-Service Management has contracted with Medical Transportation Management (MTM) to coordinate services for medically necessary lodging and meal reimbursement for AHCCCS Fee-for-Service (FFS) members. MTM will assume responsibility of providing the coordination services as of February 1, 2023.

Lodging and meal services will be arranged by MTM, however, the AHCCCS Utilization Management (UM) department will continue to provide prior authorization oversight for these services. Manual 310-BB.

Easy Access to Provider Training Presentations via Constant Contact

The Provider Training team includes links to the scheduled training sessions via the Constant Contact email notifications. Simply click the image attached in the email to view the presentation. View the entire list of training modules.



Denial Edit AD962 Referring/Ordering Provider NPI Is Not Listed

Denial edit AD962 is a manual denial edit that is appended to the claim after review. The processing team will verify if the provider's (NPI) is registered with AHCCCS FFS and second verify if the provider's NPI is active for the date of service. If this information is incorrect or invalid the claim will deny.

1. Verify if the provider's enrollment is active using the AHCCCS Online Provider Portal. The Provider Verification tab will list the enrollment date, status, and group billing affiliations by individual NPI numbers. Make sure the provider is registered with AHCCCS on the DOS (Date of Service).
2. Timing is important. If the provider's enrollment was completed after the initial date the claim was processed and now shows an active enrollment for the date of service, the claim can be reprocessed. Providers can contact the call center at (602-417-7670) to request reprocessing of the claim. If the claim was submitted electronically, providers can resubmit the claim to avoid wait times.
3. If the referring/ordering provider NPI was omitted on the original claim, the provider must submit a correction claim to include the "qualifier codes".

Tribal Self-Insurance and Required Documentation

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted, per A.R.S. §36-2946.

Per R9-22-1002, AHCCCS is not the payer of last resort (AHCCCS will be the primary payer) when the following entities are the third-party:

1. The payer is Indian Health Services contract health **(IHS/638 Tribal Plan);** or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Medical services provided through schools under the federal Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. Seq.

Once the provider has identified the member's plan is a tribal self-insurance plan, the provider must submit a letter/document from the TPL plan. The letter/document must confirm the plan is a tribal self-insurance and must identify the member by name and identification number.

A new claim is not required for processing, the provider can attach a copy of the documentation to the existing claim using the Transaction Insight Portal.

Important Note: A copy of the tribal insurance confirmation letter must be submitted with each claim submission.

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. Training Resources

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. PERM webpage