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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

February 2023

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.

Important Note: The NEMT benefit remains unchanged as outlined in the AHCCCS Medical Policy Manual 310-BB.

Attendant Care Provider Type 40 Non-Emergency Medical Transportation Services

Effective 06/01/2015, providers registering as a provider type 40 (Attendant Care Agency) will be required to be an AHCCCS registered provider for a period of twelve (12) months prior to being able to bill for non-emergency medical transportation (NEMT) services. Upon completion of the 12-month period this provider type will be able to bill for NEMT services.

However, the NEMT services should not exceed 30% of the overall services billed.

This guidance may be found in the FFS Provider Billing Manual, Chapter 3 Provider Records and Registration and Chapter 14 Transportation.

FFSChapter3ProviderRecordsandRegistration
FFSChapter14Transportation

Who Can Become an American Indian Medical Home (AIMH)

The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP). The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

Eligible Indian Health Services (IHS) and Tribally Operated 638 providers ONLY may choose whether or not to enroll as a American Indian Medical Home. Non IHS/638 providers are not eligible to enroll as a AIMH. AIMH FAQ

Prior Authorization Reminders

Providers entering authorization requests online must enter CASE, EVENT, and ACTIVITY levels for each authorization request entered. Providers should use the online ATTACHMENT feature to upload supporting documents when needed. For training on how to enter authorizations using the Web Portal please submit your training request to: ProviderTrainingFFS@azahcccs.gov

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.

Please note that these materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional

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.

REMINDER: NEMT Pick Up and Drop Off Address

Effective 11/01/2022 the pickup and drop off information must be reported for NEMT claim submissions. This change applies to paper submissions on the **CMS 1500** claim form, electronic EDI **(837P)** transaction and the **AHCCCS Provider Portal**. The pickup and drop off information can be entered in the **Additional Claim Information** field (Box 19) and please note spacing is limited.

Important Note: NEMT providers must continue to include a copy of the AHCCCS Daily Trip Report with each claim submission.

Tips:

- As spacing may be limited in the additional claim information field, use abbreviations when possible, i.e., St, Rd, Ave, Ln, Blvd., etc.
- If a house or street assignment is not available for the pickup, providers can enter the GPS coordinates for the pickup information.
- Do not enter the city and state. The Zip code is ***mandatory*** and is used to identify the city and state.

Example:

EVV Update on Hard Claims Edits

Providers, please read this entire communication for the most up-to-date information on Electronic Visit Verification (EVV) requirements and guidance.

Timeline for the Hard Claim Edits (starting January 1, 2023).

The hard claim edits will be in effect for dates of service starting January 1, 2023.

AHCCCS appreciates the efforts providers have undertaken to evaluate current compliance with EVV and develop resolutions when issues have been detected. Furthermore, AHCCCS and Sandata are working on a few change requests that will impact claims enforcement. Therefore, upon AHCCCS' request, CMS has granted a claims enforcement extension to January 1, 2023, to afford AHCCCS, Sandata and providers a little bit more time to prepare for the hard claims edit. It is strongly encouraged for providers not to consider this extension as a delay, but rather to maintain the momentum to assess and comply with the EVV requirement and use every minute of this extension to ensure their readiness for the claims enforcement.

EVV Webpage

Notice EVV Hard Claims Edit Extension 01/01/2023

Billing FAQ - October 2022

EVV Billing Check List 08/2022

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:

Tips:

- As spacing may be limited in the additional claim information field, use abbreviations when possible, i.e., St, Rd, Ave, Ln, Blvd., etc.
- If a house or street assignment is not available for the pickup, providers can enter the GPS coordinates for the pickup information.
- Do not enter the city and state. The Zip code is ***mandatory*** and is used to identify the city and state.

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.