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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

January 2024

AHCCCS Adds ID.me Security to Provider Portal

New feature will verify user identity

Beginning January 4, 2024, AHCCCS will implement another layer of security on its provider portal, AHCCCS Online, by requiring all users to register with ID.me.

ID.me is a federally-certified identity verification vendor specializing in digital identity protection. ID.me provides secure identity proofing, authentication, and group affiliation verification for government and businesses. It is a secure, online service available 24 hours a day and can be accessed on a computer, tablet, or smartphone. Many federal and state government agencies, including the Social Security Administration and the Arizona Department of Economic Security, rely on ID.me to ensure timely services while maintaining the integrity of public programs funded by taxpayers.

AHCCCS will use ID.me to verify user identity in the AHCCCS Online portal. This is one of many steps AHCCCS has taken this year to ensure program integrity and eliminate fraudulent Medicaid billing.

Upon logging in to AHCCCS Online on or after January 4, 2024, users will see an additional screen and be asked to verify identity with an ID.me account. From that screen, they can log in to their existing ID.me account, or create one if they haven't already done so.

Important Billing Code Change: Place of Service Code 56 for BHRF Provider Type (B8) Only

Effective for dates of services ***beginning*** December 01, 2023 and after, Behavioral Health Residential Facility (BHRF), provider type B8" must submit claims with **Place of Service (POS) code 56** "Psychiatric Residential Treatment". This change will impact claims billed with HCPCS code H0018 only.

This change applies to BHRF providers that are a behavioral health and or substance use disorder provider.

Please make sure your billing staff are aware of this change.

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

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

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.

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

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

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: servicedesk@azahcccs.gov

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

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

Behavioral Health Claim Denial Codes

Denial edit L237.4 will appear with any HCPCS code billed in conjunction with a per diem code. The rate for a per diem code is priced to cover the rates of other services which should be included in the per diem service.

Extension of the Provider Moratorium to June 8, 2024.

In accordance with Section 42 CFR 455.470, I, Carmen Heredia, Cabinet Executive Officer of the Arizona Health Care Cost Containment System (AHCCCS), will implement for an additional 6 months a statewide moratorium on the enrollment of Behavioral Health Outpatient Clinic, Integrated Clinic, Non-Emergency Medical Transportation, Community Service Agencies, and Behavioral Health Residential Facility providers.

This moratorium extension will **expire on June 8, 2024**. This moratorium allows provider enrollment applications to be considered for an exemption on a case by case basis, under any of the following circumstances:

1. Medically Underserved Service Area and access to care with review and approval by State Medicaid Agency,
2. Service expansion in support of a State Medicaid Agency initiative,
3. At the request of an AHCCCS contracted managed care plan to ensure that access to care standards (i.e., time and distance) are not out of compliance, or
4. Additional exemptions as appropriate and as needs are identified.

These moratoria were approved by the Centers for Medicare and Medicaid Services (CMS) and is effective on December 8, 2023. This action is necessary to safeguard AHCCCS members, public funds, and to maintain the fiscal integrity of the AHCCCS program.

End Stage Renal Disease (ESRD) NEMT Prior Authorization Submissions

AHCCCS Fee-for-Service covers NEMT transports for ESRD members to and from a AHCCCS free-standing dialysis facility. AHCCCS requires all NEMT registered providers (Provider type 28) to submit a prior authorization request before services are rendered. Prior authorization requests must be in an approved status before claims are submitted for payment.

- Prior Authorization must be submitted on the AHCCCS Online Provider Portal.
- Prior Authorization request must be submitted prior to the NEMT transport.
- A prior authorization request must be submitted for each individual day that exceeds 100 miles in total. This includes repetitive scheduled NEMT transports .
- NEMT Providers should never submit a PA request for date spans.
- Each service date must be identifiable on the claim and must be billed with actual loaded miles, as supported by odometer readings.

If the NEMT provider fails to enter the PA request correctly, this can possibly result in a denial of the PA request, delay with approval and a delay in receiving payment, pending the provider making the necessary corrections to the PA request.

Providers can correct a PA case that is in a Pend status. Once the status is changed from Pend to Denied, the provider must submit the PA Correction Request Form.

*Non-emergency medical transportation services are not covered for members that are enrolled in the Federal Emergency Services (FES) Program.

AHCCCS Provider Enrollment Portal (APEP) Adding A Provider Service Location

The APEP system allows service addresses to be updated directly in APEP. The service address(es) are updated in Step 2: Locations and require a minimum of one service address to complete the step.

Providers in an approved status requiring a service address, If the user has domain permissions to access the file, submit a modification request in APEP and add the service address(es) in **Step 2: Locations.**

If the user does not have domain permissions, email APEPTrainingQuestions@azahcccs.gov to open a service ticket, include the APEP username of the person requesting domain permissions and the provider NPI and name to obtain an APEP application code.

If you're seeking quick answers to common questions regarding APEP or enrolling as an AHCCCS provider. Please visit the (add link here current list of frequently asked questions regarding the provider enrollment process.

To view the list of Frequently Asked Questions (FAQ) can be found at: AHCCCS APEP Webpage

For all other enrollment questions, please contact Provider Assistance (602) 417-7670 or email APEPTrainingQuestions@azahcccs.gov

MCO Claim Denials – Health Plan Enrollment

We recommend that providers verify the member's enrollment prior to the service and before submitting the claim to the payer. Taking this steps the provider can avoid submitting the claim to the incorrect payer. Providers can view the Medicaid enrollment for any member enrolled in the Medicaid program using the Member Verification tab via the AHCCCS Online Provider Portal. Follow the steps listed below:

1. Click the Member Verification tab.
2. Enter the member's information (i.e., medicaid ID and DOB).
3. On this screen, providers can view the eligibility and enrollment status for the member, as well as the effective date of the enrollment with any AHCCCS FFS/ACC/MCO plan.
4. If a claim for a ACC member is submitted to AHCCCS FFS in error, providers can view the claim denial to include the denial codes which will identify which plan the member is enrolled with.

Coming January 2024! New 2024 American Dental Association Claim Form

A new version of the 2024 American Dental Association claim form and its updated completion instructions will be effective January 1, 2024.

- AHCCCS Fee-for-Service (FFS) will accept the current version ADA 2012 dental claim form until December 31, 2023.
- Beginning January 1, 2024 AHCCCS will only accept claims for dental services that are submitted on the new ADA 2024 Dental Claim Form.

Replacement claims submitted on and after 01/01/2024, must also be submitted on the new dental claim form.

Prior Authorization Lookup Tool

Providers can use the Fee-for-Service Authorization Guidelines lookup tool to easily and quickly determine if a code requires an prior authorization. Using the prior authorization guide you will be able to (1) determine if a PA is required, (2) be able to submit the PA request immediately.

What Happens When The Prior Authorization Does Not Match The Service?

What Not to Do:

Filing an appeal should never be done when the prior authorization and the claim details do not match.

What to do:

- The provider must review the claim details and prior authorization details to determine what information is inconsistent and may require correction.
- For those cases in which the prior authorization does not match the services provided, this information should be communicated to your staff to initiate the appropriate changes to the prior authorization (if applicable)
- The Prior Authorization Correction Form is used to identify what services were actually provided and the documented reasons for the change i.e. changes to the dates of service, HCPCS/CPT, the number of units.
- The PA Correction Form must be uploaded via the PA Submission tab, ***faxed copies are not accepted.***
- For those cases in which the PA details are correct, but the claim details are incorrect this information should be communicated to your billing staff to submit a correction claim *(if applicable)*.
- If a correction claim is required, the correction claim should not be billed until the PA is corrected *(if applicable)* and the updated changes are reflected on the AHCCCS Online Provider portal.
- Timely file timeframes will still apply to the initial claim and for replacement/correction claims. Submitting a correction to a prior authorization does not extend the clean claim timely filing period.

Modification Request: How to Add a Missing Provider Service Location In APEP

If you are submitting a claim using the AHCCCS Online Provider portal and do not see the specific service location in the dropdown option, you can easily verify if the location is on file. Click on the Provider Verification tab and you should see the providers pay-to-location, correspondence and service locations. If the service location is not listed providers can do an update or modification in the APEP system.

There are many training tutorials online for the APEP system. The Modification Request guide is a resource that providers can use that provides instructions for completing a modification request in APEP.

Modification Request: Steps on how to complete a modification in APEP

A “Modification” is a change or update. Some examples of a “Modification” include:

- A change in Correspondence, Pay-To, and Service location addresses.
- Group NPI/Tax ID Association
- Adding an owner or managing employee.
- Updating a license/certificate

How to Correct the Duplicate Prior Authorization Case Creation Error

The "duplicate case error" message will present when the system identifies an existing prior authorization case number is on file for the member and the same provider NPI or AHCCCS 6-digit ID number that is used for for atypical provider types only.

The PA portal is reading the **effective dates span** field on the existing authorization case number and comparing the effective date span of the exisiting PA with the dates the provider is attempting to enter for the ***New*** *PA* request.

If the date of service is within the effective date span of the first case a new Event should be created under the same PA case number.

Existing Case Example: 001234567

Note: this case is created under the same provider NPI/ID number.

Effective Date span field for this case spans **01/01/2023 - 12/31/2023.**

Next Step: Adding a New Event Under The Existing Case Number.

- Click on the PA Submission tab and search for the appropriate case number,i.e. 001234567.
- Click on the case number, this will take you to the **Event List** page.
- Click on the tab **"Create a New Event"** and enter the service begin and end date and other details for the new PA request.
- Complete the **Activity Tab** and click submit to finalize the new PA request.

Identifying Claim Problems

Prior authorization – In the event that prior authorization is not obtained prior to the service being performed, a claim may be denied.

Missing or incorrect information – This can be anything from a blank field (e.g., or incorrect plan code, to technical errors like a missing modifier.

Medical necessity requirements not met – A medically unnecessary healthcare service is not covered by the policy, and the payer disagrees with the physician about what services you need for your condition.

Duplicate claims – Claims submitted for a single encounter on the same day by the same provider for the same patient for the same service item.

Behavioral Health Services Billing and Coding H2016 and H0038 Same Day Billing Denial Edit L237.4

Claims billed with the HCPCS code H2016 (Comprehensive Community Support Services, per diem) H0038 (Self-Help/Peer Services per 15 minutes) that are billed on the same date of service will automatically deny with the denial edit **L237.4 "Service Not Allowed On The Same Day".**

Arizona Health Care Cost Containment (AHCCCS) for purposes of consideration for behavioral health services, per billing and policy may use American Medical Association Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definition purposes only and do not imply any right to reimbursement.