Claims Clues

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New Codes to Replace AHCCCS' Local Codes

Many state Medicaid programs, including AHCCCS, have adopted local codes to address specific programs.

Under the Health Insurance Portability and Accountability Act (HIPAA), all local codes must be replaced with the appropriate HCPCS, CPT-4, and revenue codes and modifiers. In addition, a number of new codes have been added to HCPCS to accommodate items that did not have codes before.

Providers may bill with the new codes for dates of service on and after October 1, 2003. Providers may continue to use the current AHCCCS-specific local codes for dates of service prior to January 1, 2004. For dates of service on and after January 1, providers must use the new codes. Claims billed with the old AHCCCS-specific codes will be denied.

This change in coding requirements applies to providers who submit claims electronically and on paper.

AHCCCS local codes include the "W," "Y," and "Z" codes, Indian Health Service-specific codes (00090 – 00099), all-inclusive revenue codes for nursing facilities, and the "VA" modifier.

Crosswalks showing the AHCCCS-specific codes that are being eliminated and the new codes which must be used are available on the AHCCCS Web site at www.ahcccs.state.az.us. At the AHCCCS home page, click on "Information for Providers." ❐

'SL' Modifier Required When Billing VFC Services

Providers who bill for administration of vaccines under the federal Vaccines for Children (VFC) program must bill the appropriate CPT code for the immunization with the "SL" (State supplied vaccine) modifier.

The Health Insurance Portability and Accountability Act (HIPAA) mandates standardization of codes by eliminating all local codes. This includes the standardization of modifiers. Providers have been billing for services under the VFC program using the AHCCCS-specific "VA" modifier.

Providers may begin using the "SL" modifier for dates of service on and after October 1, 2003.

Providers must bill with the "SL" modifier for dates of service on and after January 1, 2004. Claims billed with the "VA" modifier for dates of service on and after January 1, 2004 will be denied.

Under the VFC program, providers are paid a capped fee for administration of vaccines to recipients 18 and younger. Because the vaccine is made available to providers free of charge, they must not bill for the vaccine itself.

Providers must not use the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.

Vaccines covered under the VFC program are listed on Page 2. ❐

Nursing Facilities Must Bill with New Codes Effective Oct. 1

Effective with claims for dates of service on and after October 1, 2003, nursing facilities must bill for services using new revenue codes.

The Health Insurance Portability and Accountability Act (HIPAA) mandates standardization of codes by eliminating all local codes, including revenue codes 070, 072, 073, 074, 075, and 076.

A crosswalk showing the relationship between the local revenue codes that are being eliminated, the new revenue codes which must be used, and the allowable bill types is available on the AHCCCS Web site at www.ahcccs.state.az.us. At the AHCCCS home page, click on "Information for Providers." ❐

HIPAA Requires Standard Place of Service Codes

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of place of service (POS) codes from the national POS code set maintained by CMS.

The national POS code set is available on the AHCCCS Web site at www.ahcccs.state.az.us. Once at the AHCCCS home page, click on "Information for Providers."

The listing includes new codes authorized by CMS. These codes are indicated in boldface type with a complete description. Providers may use the new codes for dates of service on and after October 1, 2003.

The new POS codes are:

05 Indian Health Service Free-standing Facility
06 Indian Health Service Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
13 Assisted Living Facility
14 Group Home
49 Independent Clinic
57 Non-residential Substance Abuse Treatment Facility ❐

Vaccines Covered Under the VFC Program

90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule)
90646	Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule)
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule)
90657	Influenza virus vaccine, split virus, 6 - 35 months dosage (covered under VFC only for high-risk children)
90658	Influenza virus vaccine, split virus, 3 years and above (covered under VFC only for high-risk children)
90659	Influenza virus vaccine, whole virus (covered under VFC only for high-risk children)
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years
90700	Diphtheria, tetanus toxoids, and acellular pertussis (DTaP)
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)
90702	Diphtheria and tetanus toxoids (DT) adsorbed
90707	Measles, mumps and rubella virus vaccine (MMR)
90713	Poliovirus vaccine, inactivated (IPV)
90716	Varicella virus vaccine, live
90718	Tetanus and diphtheria toxoids (Td)
90720	Diphtheria, tetanus toxoids and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib)
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90732	Pneumococcal polysaccharide, 23 valent
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)
90743	Hepatitis B vaccine, adolescent (2 dose schedule)
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule)
90748	Hepatitis B and Hemophilus influenza b (HepB-Hib)

HIPAA Requires Dentists to Bill on ADA Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that dentists bill for services on the ADA form.

Dentists who submit electronic claims to the AHCCCS Administration must begin billing in the ADA format effective with dates of service on and after October 1, 2003.

Dentists who submit paper claims to the AHCCCS Administration

may begin using the ADA form effective with claims for dates of service on and after October 1, 2003. Dental claims for dates of service on and after January 1, 2004 *must* be billed on the ADA form. Dental claims billed on a CMS 1500 claim form for dates of service on and after January 1, 2004 will be denied. ❐

Behavioral Health Providers Must Use Standard Codes

The Health Insurance Portability and Accountability Act (HIPAA) requires that AHCCCS-registered masters level behavioral health providers bill for services using new codes effective October 1, 2003.

This change affects Certified Independent Social Workers (provider type 85), Certified Professional Counselors (provider type 87), and Certified Marriage and Family Therapists (provider type 86) who bill for services provided to AHCCCS Medicaid (Title XIX) and KidsCare (Title XXI) members.

HIPAA mandates standardization of codes by eliminating all local codes. In Arizona, "W", "Y," and "Z" codes will be phased out beginning October 1. Also, master's level behavioral health providers will no longer be allowed to bill using the physician CPT codes as previously allowed.

AHCCCS-registered master's level behavioral health providers will receive a letter with a crosswalk showing the new HCPCS codes. The crosswalks also will be posted on the AHCCCS Web site at www.ahcccs.state.az.us.

Providers who submit claims to the AHCCCS Administration may submit claims with the new codes effective with claims for dates of service on and after October 1. Providers must bill with the new codes effective with claims for dates of service on and after January 1, 2004.

Providers employed by or contracted with one or more AHCCCS contractors should check with those contractors to determine their conversion date and which of the services represented by the new HCPCS codes they will authorize.

Providers who have questions regarding these changes should contact Diane Somerville at (602) 417-4648. ❐

Prolonged Services Codes May Be Billed with GT Modifier

AHCCCS has been reimbursing providers for medically necessary services provided via telemedicine since January 1, 2001.

The following codes for prolonged services can also be billed to AHCCCS with the GT (Telemedicine) modifier effective for dates of service on and after October 1, 2003.

Providers may bill for telemedicine for the following CPT codes:

99354 - Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; first hour

99355 - Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service; each additional 30 minutes

99358 - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; first hour

99359 - Prolonged evaluation and management service before and/or after direct (face-to-face) patient care; each additional 30 minutes ❐

Co-pays to Increase for Some Enrolled Recipients

Effective October 1, 2003, some AHCCCS recipients enrolled with health plans will have increased co-payments for selected services.

Information regarding individual co-payment amounts and the applicable services will be available when verifying eligibility on the AHCCCS Web site, on the AHCCCS Interactive Voice Response (IVR) system, and through Medifax.

Please note that recipients with a co-payment designation of mandatory may be denied services if they do not pay their co-payment. About 10 per cent of health plan-enrolled recipients fall into this category.

Fee-for-service recipients are not affected by these changes. Additional details about co-payments and cost sharing are available on the AHCCCS Web site at www.ahcccs.state.az.us. ❐

TC and 26 Modifier Proportions Undergoing Revision

AHCCCS is revising its modifier values for the technical and professional components (modifiers TC and 26) on the fee-for-service fee schedule for consistency with Medicare proportions.

The revisions are effective for claims with dates of service on or after October 1, 2003. The technical and professional modifier values will soon be available on the AHCCCS website at www.ahcccs.state.az.us.

Questions concerning the FFS Physician Fee Schedule should be directed to Victoria Burns at (602) 417-4049. ❐

AHCCCS Approves Codes, Rate for ASC Group 9

Effective July 1, 2003, AHCCCS has approved codes and the rate for Ambulatory Surgical Center (ASC) Group 9.

The rate for group 9 is $1,331. A complete list of ASC groups and the CPT codes that are included in each group can be downloaded from the CMS Web site at www.cms.hhs.gov.

Not all CPT codes that have been approved by CMS for inclusion in an ASC group are AHCCCS-covered services.

Providers should confirm that a service is covered by AHCCCS prior to billing. ❐

Hospitals May Bill Circumcision with V50.2; Charges Must Be Reported as Non-covered

Hospitals may bill newborn circumcisions with diagnosis code of V50.2 (Routine or ritual circumcision).

However, all related charges must be reported in the Non-covered Charges field (Field 48) of the UB-92 claim form. Claims without non-covered charges will be denied.

AHCCCS ended coverage of routine circumcision for newborn male infants on October 1, 2002. AHCCCS no longer covers CPT-4 codes 54150 (Circumcision, using clamp or other device; newborn) and 54160 (Circumcision, surgical excision other than clamp, device, or dorsal slit; newborn).

To report medically necessary circumcisions on the CMS 1500 claim form, the appropriate ICD-9 diagnosis code documenting medical necessity must be used. Physicians should bill either with CPT-4 code 54152 (Circumcision, using clamp or other device; other than newborn) or 54161 (Circumcision, surgical excision other than clamp, device, or dorsal slit; other than newborn).

Prior authorization must be obtained for fee-for-service recipients. ❐

PA Unit Changes Mail Drop Number

The AHCCCS Prior Authorization Unit has changed its Mail Drop number as part of the recent reorganization.

The PA Unit's new address is:

801 E. Jefferson Street
Mail Drop 8900
Phoenix, AZ 85034

The PA Unit's telephone and Fax numbers remain unchanged. ❐