AHCCCS

ENCOUNTER KEYS

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When to use Replacement or Void Transactions

When Contractors alter or change claims data, replacement or void encounters must be submitted. Replacements are used to correct or modify adjudicated or pended encounters. Voids are utilized to remove adjudicated or pended encounters that should never have been submitted to AHCCCS. Please note that replacements and voids are linked to previous encounters for reinsurance and supplemental payment purposes.

Screens

Two new PMMIS screens have been added for information regarding AHCCCS Encounter Non-Covered Adjustment Reason Codes (EC791) and AHCCCS Encounter Non-Covered Error Code Bypass (EC792).

NCPDP Companion Document (for NCPDP Batch 1.1, Version 5.1)

The latest version of the NCPDP Companion Document (for NCPDP Batch 1.1, Version 5.1) is on the AHCCCS HIPAA webpage:
http://www.ahcccs.state.az.us/HIPAA/Documents/Default.asp#NCPDP%20Encounter%20Transaction%20Companion%20Document

Technical Assistant

Effective immediately, Dwanna Epps will be the Technical Assistant for the following plans and can be reached at the following: Dwanna Epps; 602-417-4085 or Dwanna.Epps@azahcccs.gov

APIPA	Health Choice
ADHS - BHS & CRS	Mercy Care Plan
Care 1st	Phoenix Health Plan

Jacque McElroy has the following plans and can be reached at 602-417-4004 or Jacqueline.McElroy@azahcccs.gov

Bridgeway	Cochise Health Systems
DES/DDD	Evercare
Maricopa/UPC	Pima
Pinal/Gila LTC	Scan
Yavapai County LTC	CMDP

Revised rate sheet for Mountain Vista Medical Center

While the effective CMS date for Mountain Vista Medical Center will remain August 3, 2008, their effective date for Emergency Services is July 23, 2007.

Update to OPFS Facility Peer Groups

An update to the OPFS Facility Peer Groups, for the addition of Banner Gateway Medical Center effective September 18, 2007 has been placed on the AHCCCS website for your convenience: http://www.ahcccs.state.az.us/HIPAA/Consortium/Outpatient/OutpatientKeyDocuments.asp

Bilateral Procedure Billing Policy Change

AHCCCS current policy (per the FFS Provider Billing Manual and table setups in PMMIS) requires providers (both Professional and OPFS) billing for Bilateral Procedures to bill this service in two lines one with the modifier and 1 without (see the example below).

> Line 1 of the claim – Procedure NNNNN, no modifier, 1 unit, full charges
> Line 2 of the claim – Procedure NNNNN, with a "50" (bilateral service) modifier, 1 unit, full charges.

Modifier "50" is currently loaded in PMMIS tables (RF121 and RF122) as allowing at 50% of the posted fee schedule. Valuation would then be, line 1 at the full fee schedule amount for the service and line 2 at 50% of the fee schedule amount for the service.

Medicare and commercial billing rules require the provider to bill this service as a single line with the "50" modifier and the appropriate # of units (see the example below).

> Line 1 of the claim – Procedure NNNNN, with a "50" (bilateral service) modifier, 1 unit, and full charges.

This service would then value at 150% of the fee schedule for the single unit of service.

The inconsistency between AHCCCS policy and Medicare/Commercial Insurance has caused complaints from Hospital providers under the new OPFS methodology as well as inconsistent and erroneous billings.

Effective for dates of service on and after January 1, 2008, we are modifying our current billing policy (for both Professional and OPFS) in relation to bilateral procedures to be consistent with Medicare/Commercial Insurance.

Modifications to RF121 and RE122 to reflect the new modifier % for modifier "50" will be reflected in regular bi-monthly Reference Extracts.

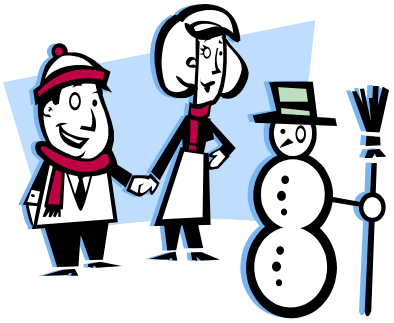
Duplicate Overrides

As previously communicated to plans, AHCCCS will be revising its duplicate logic by form type to eliminate the number of false duplicate pend errors. As an interim measure AHCCCS revised the adjudication level to allow plans to override Z305 (Date of Service Overlap) and dental Z300 (Exact Duplicate) in batch (pend file) or manually (on-line in PMMIS). As appropriate following health plan validation with the requirement that plans submit documentation for all duplicate overrides performed by the plan to the Encounter Unit monthly at the end of each month. FAILURE TO DO SO MAY RESULT IN REVOCATION OF THIS OVERRIDE CAPABILITY.

Override documentation must include:

1) CRN with Z300/Z305 duplicate error	CRN for which the Z300/Z305 error is duping against
2) member ID	member ID
3) service begin date	service begin date
4) service end date	service end date
5) service code (HCPCS)	service code (HCPCS)
6) for dental - tooth number, surface	for dental - tooth number, surface
7) paid units	paid units
8) service provider ID	service provider ID
9) AHCCCS procedure daily max units	AHCCCS procedure daily max units

Family Planning Edits



Effective January 1, 2008 the following will be changed from soft to hard edits:

- D220 (DX not covered for family planning)
- N320 (RX not covered for family planning)
- S520 (Procedure not covered for family planning)

Provider Type (PT)

- Effective with dates of service on or after December 31, 2007 the CPT code 59514 (Cesarean delivery only) can no longer be reported by provider type 09 (Certified nurse-midwife (CNM)).

- Effective with dates of service on or after January 1, 2006 the provider type 19 (Registered Nurse Practitioner) can now report the CPT code 90736 (Zoster (Shingles) vaccine, live, for subcutaneous injection)).

- Effective with dates of service on or after September 1, 2007 the provider type 19 (Registered Nurse Practitioner) can report the following CPT codes:

  76857 (Ultrasound, pelvic (nonobstetric), real time with image documentation)
  90765 (Intravenous infusion, for therapy, prophylaxis, or diagnosis

- Effective with dates of service on or after October 1, 2003 the Provider Type 40 (Attendant Care) can now report the following HCPCS codes:

  A0120 (Non-Emergency Transportation: Mini-Bus, Mountain Area Transports,)
  S0215 (Non-Emergency Transportation; Mileage, Per Mile)

Place of Service (POS)

- Effective with dates of service on or after January 1, 2006 the CPT code 88334 (Pathology consultation during surgery; cytologic examination) can be reported at the following POS:

  05 (Indian Health Service Free-Standing)
  06 (Indian Health Service Provider-Base)
  07 (Tribal 638 Free-Standing Facility)
  08 (Tribal 638 Provider-Based Facility)
  11 (Office)
  21 (Inpatient Hospital)
  22 (Outpatient Hospital)
  24 (Ambulatory Surgical Center)
  50 (Federally Qualified Health Center)
  72 (Rural Health Clinic)
  81 (Independent Laboratory)

- Effective with dates of service on or after June 1, 2007 the following CPT code 77001 (Fluoroscopic Guidance For Central Venous Access Device Placement) can be reported by POS 24 (Ambulatory Surgical Center).

Change in Limit(s)

- Effective with dates of service on or after November 8, 2007, the HCPCS code J0129 (Injection, Abatacept, 10 mg) has a procedure daily maximum of 150 the previously maximum was 4.

- Effective with dates of service on or after October 1, 2007 the CPT code 90734 (Meningococcal Conjugate Vaccine, Serogroups A, C, Y and W-135 (tetravalent), for intramuscular use) has had the limits and frequency indicators removed on the PMMIS screen RF127.

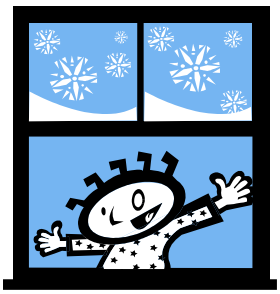
- Effective for dates of service on or after September 24, 2007 the HCPCS code H0031 (Mental health assessment, by non-physician) daily maximum limit is now three (3).

- Effective for dates of service on or after September 26, 2007 the CPT code 94150 (Vital Capacity, Total (Separate Procedure)) daily maximum limit is now two (2).

- Effective for dates of service on or after September 26, 2007 the CPT code 77300 (Basic Radiation Dosimetry Calculation, Central Axis Depth Dose Calculation) daily maximum limit is now four (4).

- Effective with dates of service on or after 10/29/2007 the following codes have a procedure daily maximum of:

Code	Description	New Units
96101	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), **per hour** of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.	6
96102	Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, **per hour** of technician time, face-to-face.	6
96119	Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test). With qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	6



"Snowy, Flowy, Blowy,
Showery, Flowery, Bowery,
Hoppy, Croppy, Droppy,
Breezy, Sneezy, Freezy."

George Ellis

Age Changes

- Effective with dates of service on or after October 11, 2007 the CPT code 99145 (Moderate Sedation Services Described by Codes) minimum age changed to 000.

- Effective for dates of service on or after September 24, 2007 the CPT code 90649 (Human Papilloma Virus (HPV) Vaccine, Types 6, 11, 16, 18) maximum age changed to 26 and limit of 3 per lifetime.

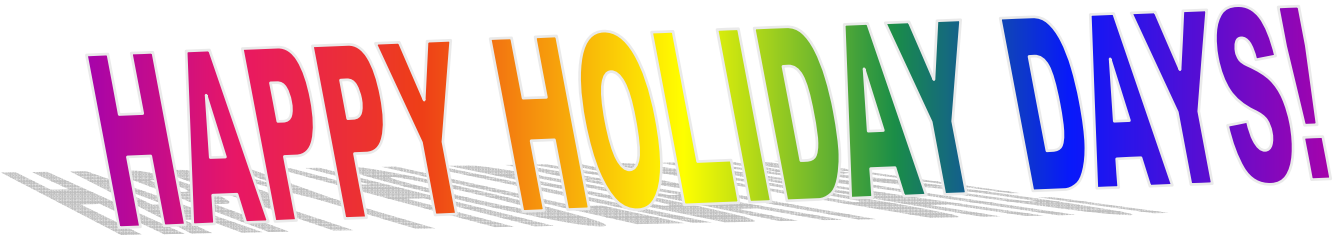
- Effective with dates of service on or after October 11, 2007 the maximum age of 11 has been removed for HCPCS code 92004 (Ophthalmological services: medical examination and evaluation).

- Effective with dates of service on or after October 11, 2007 the minimum age has been removed from HCPCS code 99145 (Moderate sedation services (other than those services described)).

Sex Indicator

Effective with dates of service on or after September 19, 2007 the sex indicator (F- Female) for the CPT Codes 77055 (Mammography; unilateral) and 77056 (Mammography; bilateral) has been removed.

Coverage Code Change(s)

- Effective with dates of service on or after September 10, 2007 the HCPCS code T2038 (Community transition, waiver; per service) has had a change of coverage to 04 (Not Covered Service/Code Not Available).

- Effective with dates of service on or after October 1, 2007 the code G0154 (Services of skilled nurse in home health setting, each 15 minutes) has a coverage code change to 01 (Covered Service/Code Available) and the procedure daily maximum of 16.