



AHCCCS

CLAIMS CLUES

A Publication of the AHCCCS Claims Department
AUGUST 2011

COMING SOON!

PHOENIX FEE FOR SERVICE PROVIDER MEETING

September 13th, 2011
10 AM - 12 NOON
701 East Jefferson, Phoenix
Gold Room

If you have topics that you would like us to address at this meeting, please send those to kyra.westlake@azahcccs.gov.
Health Plan representation will be available also.

837 CLAIMS COMPANION GUIDE

The draft Companion Guide (CG) for 837 Claims - P/I/D has been posted to our Website for our provider trading partners to use.

<http://www.azahcccs.gov/commercial/EDResources/EDITechnicalDocuments.aspx>

- 837 Fee for Service Claims Companion Guide
 - [4010a](#)
 - [5010a](#)

PERM WEBINARS COMING SOON

Want to learn more about the Payment Error Rate Measurement (PERM)? Once the Federal Contractor has selected our claims sample, CMS will be hosting webinars for providers. These webinars are designed specifically for providers to explain what PERM is, how it will affect you and to help you understand the PERM process. While these webinars are still a ways off, we want to make you aware of them so you can watch for the dates and plan to attend one. We will provide

the dates and times of the webinars as soon as they are available to us. Watch for future Claims Clues to get the latest information on PERM.

If you have questions regarding PERM you can contact:

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PRIOR AUTHORIZATION CHANGES FOR AHCCCS FEE FOR SERVICE

In an effort to reduce the unnecessary burden of prior authorizations for services which are typically determined to be medically necessary, the AHCCCS Division of Fee for Service Management will stop requiring prior authorization for the following services **effective 8/1/2011**.

-C-section delivery admissions that do not exceed 96hrs.

-Vaginal delivery admissions that do not exceed 72hrs.

- Home Health visits-up to the first 5 visits following an acute hospitalization.

- Hysteroscopy -up to 2 (one before and one after, when associated with a family planning diagnosis code, and when done within 90 days of hysteroscopic sterilization.)

In addition to the above changes: pursuant to ARS R9-22-217 **effective 9/1/11** AHCCCS DFSM will no longer require concurrent review for inpatient FES member admissions. DFSM may only reimburse for emergencies and complete retrospective review will be necessary to determine whether assessment and treatment meet federal criteria for emergency status.

For purposes of this rule, an emergency medical or behavioral health condition for a FES member means:

A medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

"Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition.

Clinical documentation for FES members should be submitted directly to the FFS Claims Department, along with the FES claim.

AHCCCS RESPITE BENEFIT CHANGE EFFECTIVE OCTOBER 1, 2011

BACKGROUND

On March 15, 2011, Governor Brewer presented her plan to preserve Arizona's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State's General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget. The Medicaid Reform Package includes changes to the AHCCCS member benefit package and can be found on the AHCCCS website at the following Address:

<http://www.azahcccs.gov/shared/news.aspx#GovernorBrewersMedicaidReformPackage>

BENEFIT CHANGE

Beginning October 1, 2011, the annual limit of covered respite hours will be 600 hours during each October 1 through September 30 time period. (Prior to October 1, 2011, the annual limit is 720 hours per benefit year.) The respite benefit change will impact adults and children who are:

- Enrolled in the Arizona Long Term Care System (ALTCS). ALTCS members include individuals who are elderly and/or physically disabled as well as individuals with developmental disabilities, or
- Receiving respite services through the behavioral health system.

If 1) respite services were prior authorized before October 1, 2011, and 2) the authorized respite services will be provided on or after October 1, 2011, the authorization and the amount of services may need to be adjusted to ensure that the annual limit is not exceeded. For additional information providers are encouraged to contact the appropriate Contractor or, for questions concerning FFS members, the AHCCCS Administration.

The proposed AHCCCS Rule may be found at:

<http://www.azahcccs.gov/reporting/state/proposedrules.aspx#Respite> .

NON-COVERED SERVICES & MEMBER BILLING

Providers may charge AHCCCS members for services which are excluded or provided in excess of AHCCCS limits if the provider obtains the member's written agreement to pay for the services in advance of providing the service. However, providers are still prohibited from charging members for non-excluded services provided within the limit when a claim is denied or payment is reduced due to the provider's failure to comply with billing requirements such as timely claim filing, lack of authorization, or lack of clean claim status. AHCCCS rule R9-22-702 has been revised to clarify the

circumstances when registered providers may bill AHCCCS members. The Final AHCCCS Rule may be found at:

<http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx> .

Additional information about the benefit changes can be found at <http://www.azahcccs.gov/shared/news.aspx#Benefits>. Questions regarding the benefit changes can be e-mailed to LegislativeBenefitChange@azahcccs.gov.

AHCCCS BENEFIT CHANGES EFFECTIVE OCTOBER 1, 2011: ANNUAL LIMITS FOR INPATIENT DAYS AND RESPITE SERVICES

BACKGROUND

On March 15, 2011, Governor Brewer presented her plan to preserve Arizona's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State's General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget. The Medicaid Reform Package includes changes to the AHCCCS member benefit package and can be found on our website at the following address:

<http://www.azahcccs.gov/shared/news.aspx?ID=reporting#GovernorBrewersMedicaidReformPackage>

The benefit changes addressed in this memo are the annual limits on the number of hospital inpatient days and the number of hours of respite services available. The inpatient hospital limit will not impact AHCCCS members under 21 years of age¹. The change in annual respite hours impacts both adults and children. Benefit changes are effective October 1, 2011.

BENEFIT CHANGES

Inpatient Day Hospital Limit (Adults Only)

The annual inpatient hospital limit impacts individuals 21 years and older and only applies to facility (not professional) services. Members in the acute and long term care programs are subject to the limits, regardless of whether they receive services through managed care or fee for service.² No inpatient limits are placed on persons under 21 years of age.

For persons age 21 and older, AHCCCS will pay hospitals a maximum of 25 days of hospital inpatient care per benefit year (October 1 of each year through September 30 of the following year). Each 24 hours of paid observation services also counts as 1 inpatient day. There are certain exceptions to the annual 25 day inpatient hospital limit such as: inpatient days for behavioral services, transplant services which are reimbursed under component pricing, or certain Medicare

¹ AHCCCS is awaiting final approval from CMS.

² At this time, these limits also apply to American Indians regardless of where they receive services. AHCCCS will provide notice if there are any changes.

beneficiaries for whom AHCCCS is responsible for co-pays and deductibles. Physician services provided to inpatients beyond the 25-day limit will continue to be covered as an AHCCCS benefit.

Refer to Attachment A regarding coordination of benefits.

Respite (Adults and Children)

The decrease in the number of hours of annual respite services available to AHCCCS members will impact both adults and children receiving respite services through the Arizona Long Term Care System (ALTCs) or through the Behavioral Health System. Effective October 1, 2011, the number of respite hours paid for by AHCCCS or its Contractors will be reduced to a maximum of 600 hours per benefit year. The benefit year time period is from October 1 through September 30 of the following year. Since respite is not a Medicare covered service, AHCCCS is not responsible for co-pays and deductibles. (Prior to October 1, the annual limit for respite services is 720 hours per benefit year.)

NON-COVERED SERVICES & MEMBER BILLING

Providers may charge AHCCCS members for services which are excluded from AHCCCS coverage or which exceed AHCCCS limits if the provider obtains the member's written agreement to pay for the services in advance of providing the service.

Providers are still prohibited from charging members for non-excluded services provided within the limits when a claim is denied or reduced due to the provider's failure to comply with billing requirements such as timely claim filing, lack of authorization, or lack of clean claim status. For more information, please review AHCCCS rule R9-22-702 which has been revised to clarify the circumstances when registered providers may bill AHCCCS members. As previously mentioned, medically necessary professional services will continue to be covered even when payments to hospitals for inpatient admissions are not paid by AHCCCS or its Contractors after the limits have been met.

Additional information about the benefit changes can be found at <http://www.azahcccs.gov/reporting/legislation/2011/BenefitChanges.aspx> and

<http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx>

Questions regarding the benefit changes can be e-mailed to LegislativeBenefitChange@azahcccs.gov.

**IN-PATIENT LIMIT: MEMBER & CONTRACTOR RESPONSIBILITY
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
(MEDICAID ONLY, QMB DUAL AND NON-QMB DUAL STATUS)**

CONDITION	CONTRACTOR IMPLEMENTATION (Fiscal Implications)
Member is Medicaid only and is not Medicare eligible. (Also known as non-dual)	Contractor is responsible for payment limited to the first 25 inpatient days per contract year. Contractor is not responsible for payment of inpatient days beginning with the 26 th inpatient day in a contract year. The first 25 inpatient days are the first 25 inpatient days (with dates of service during the contract year) that are paid by the Administration or the member's Contractor-irrespective of whether the date of payment was during or after the contract year. For more information about counting the 25 day inpatient limit and exclusions, refer to the "Adult Inpatient limits and member billing rule: http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx
Member is Dual Eligible (Also known as Medicare Primary, non-QMB dual)	Contractor is responsible for Medicare cost sharing (co-pay, coinsurance, and deductible) associated with all admissions through the admission in which the 25 th inpatient day of the contract year occurs. (Example: a non-QMB dual with 23 prior inpatient days during the contract year is admitted and remains in the hospital for 10 days. Since the admission occurs before the 25-day limit is reached, Contractor is responsible for Medicare cost sharing associated with the 10 days even though the member exceeds the 25-day annual limit during that admission.) Contractor is not responsible for Medicare cost sharing (co-pay, coinsurance and deductible) related to admissions occurring after the first 25 inpatient days per contract year.
Member is QMB Dual	Contractor is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year.
Member is QMB Only	AHCCCS FFS program is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year.

DEFINITIONS:

- **Inpatient Setting** – Acute Care hospital including Specialty Care Hospital and Rehabilitation Hospital (in-state and out of state)
- **Dual Eligible (Non-QMB Dual)** - An individual who is Medicare and Medicaid eligible with income above 100% FPL. The individual does not qualify for QMB.
- **QMB Dual** - An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL.
- **QMB Only** – An individual who is Medicare only who qualifies to have Medicare premiums, co-payments, and deductibles paid by the AHCCCS program.

EXCLUSION

The following inpatient days are not included in the inpatient hospital limitation:

- a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract³;
- b. Days related to Behavioral Health:
 - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
- c. Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmentally-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to 10/1/2011;
- d. Same Day Admit Discharge services are excluded from the 25 day limit; and
- e. Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

¹ Examples include the following:

- **Evaluation** (Limited to inpatient days directly associated with the evaluation)
- **Harvest** (Tissue harvesting for autologous bone marrow transplants; The related costs/in-pt days for live donors; Note: if the donor is a Medicaid member this will not be included as part of their 25 day limit)
- **Total Body Irradiation** (Limited to the inpatient days associated with the series of conditioning regimens prior to bone marrow or peripheral blood stem cell transplantation)
- **Preparation and transplant** (10 days post transplant care for kidney transplants)
- **Post transplant care** (Up to 60 days for other covered transplants)
- **Placement of Circulatory Assist Devices (CADs)** also known as Ventricular Assistive Devices (VADs) and Total Artificial hearts (TAHs) (Limited to day of surgery; Inpatient days before and after the placement of the CADs are to be counted towards the 25 day limit)

Note: Inpatient days while “wait listed” are to be counted towards the 25 day limit. This is the period of time after a member has been determined to be a candidate for transplant, by the transplant facility, and is waiting for an available organ.