



AHCCCS

CLAIMS CLUES

A Publication of the AHCCCS Claims Department
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AHCCCS ADMINISTRATION OFFICES TO CLOSE FOR FURLOUGH DAYS

Recently the Arizona State Legislature, in the seventh special session, passed HB2003 which requires mandatory furlough days for many State offices and agencies. AHCCCS Administration will be closed on the following furlough days in FY2011 & FY2012:

June 10, 2011
July 22, 2011
August 19, 2011
September 16, 2011
November 25, 2011
December 23, 2011
June 15, 2012

All web site services will still be available during this time.

PERM UPDATE

(Payment Error Rate Measurement)

We are still in a holding pattern with PERM. The appeal regarding the contract awarded to the statistical contractor, by CMS, is still pending so we have not been able to submit our claims universe. Once we have submitted our universe and the sample has been selected, the review contractor will be requesting medical records for the claims selected. We will be providing the contractor with the providers service address and phone number listed in our system. Please ensure that this information is correct. The contractor will first try to make contact at the phone number provided to confirm the address for requesting the medical records. They will then send a medical record request to that address. Please alert your staff, who would most likely receive and open the mail, as to the importance of compliance with the PERM requirements. If you should have any questions regarding the PERM process please contact one of the following:

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PRIOR AUTHORIZATION CHANGES IN 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 1/1/11**:

1. Apnea management and training for premature babies up to one year of life
2. Professional and facility component for dialysis shunt placement (including FESP members on Extended Services for ESRD)
3. Professional and facility component for outpatient arteriovenous graft placement for dialysis (including FESP members on Extended Services for ESRD)
4. Professional and facility component for outpatient thrombectomies of dialysis shunts (including FESP members on Extended Services for ESRD)

5. Professional and facility component for outpatient thrombectomies of arteriovenous grafts for dialysis (including FESP members on Extended Services for ESRD)
6. Professional and facility component for outpatient angioplasties of dialysis shunts or grafts (including FESP members on Extended Services for ESRD)
7. Professional and facility component for outpatient eye surgery for the treatment of diabetic retinopathy CPT codes 67028, 67210, 67220, and 67228
8. Professional and facility component for outpatient eye surgery for the treatment of glaucoma CPT codes 65855 and 66761
9. Professional and facility component for outpatient eye surgery for the treatment of macular degeneration CPT codes 67028 and 67210
10. Outpatient wound debridement prior authorizations by the facility
11. Physical therapy outpatient visits for adult acute members
12. Physical therapy visits for adult acute care members in subacute SNFs with up to 90 day stays
13. Family stay at provider types 55 and 56 which includes Ronald McDonald House, Ronald McDonald House-SA, Casa Esperanza, Hospital Traveler, Banner Good Samaritan-Hotel, and University Medical Center when associated with a medical service
14. Oral Supplements for ALTCS members will need to be entered on the member's service plan by the case manager but will no longer require medical oversight by the FFS prior authorization department.

These changes apply to all FFS members excluding the FES population except where specifically delineated above. Stay tuned for future additions to this list.

ASSOCIATED CLAIMS RECOUPMENT PROJECT

Beginning October 1, 2010 the AHCCCS Office of the Inspector General (OIG) began recouping incorrectly paid Federal Emergency Services Program (FESP) claims. These claims are associated with either a facility claim and/or an ER physician claim that was denied as non-emergent.

The claims currently being recouped are for dates of service during the period 2008 and 2009. These claims will appear on remittance advices as "AV025-

Denial Initiated by OIG". This will be an ongoing process. As soon as 2008 and 2009 have been recouped, 2010 and forward will be reviewed.

Providers can contact Claims Customer Service at 602-417-7670 with any questions.

CLAIMS TIPS & REMINDER

- **Billing for multiple transports on the same day?**

To avoid denials for duplicate services, bill the trips as follows:

- ✓ 2 units of base should be billed on line #1 of the claim
- ✓ Total mileage for both trips should be billed on line #2

- **Billing with a 59 modifier?**

All claims billed with a 59 modifier are subject to medical review. To avoid denials for additional information:

- ✓ Explain why the 59 modifier is being used
- ✓ Send supporting documentation that substantiates the use of the modifier
- ✓

UNSPECIFIED DENTAL PROCEDURE CODES TO REQUIRE PA

Dental codes ending in the digits either 99 or 999 are described in the CDT 2011- 2012 as unspecified procedures, by report. The CDT goes on to say that these codes are used for procedures that are not adequately described by another code. In order to be consistent, [effective 04/01/2011](#), **D0999, unspecified diagnostic code, by report; D2999 unspecified restorative code, by report; and D3999, unspecified endodontic procedure, by report** will require prior authorization (PA). The prior authorization request should describe the procedure and include chart notes and radiographs as indicated. Currently all other similar codes require PA.

If you have any questions regarding this, please contact Dr. Robert Birdwell, Dental Director at 602-417-4198.

MEDICAL DOCUMENTATION

When.... Why.... What.... How.....

AHCCCS is often asked for guidelines regarding submitting medical documentation. This article is intended to offer some insight into why AHCCCS requires medical documentation; what & when to submit; and the various options available for submitting these records.

When does AHCCCS require medical documentation & why are we asking?

AHCCCS requires medical documentation in several different circumstances. The following are just a few of the most common:

1. *FESP Claims*- AHCCCS requires medical documentation with all but a few FESP claims. Under federal law we are required to review all FESP claims to determine if the services meet the federal definition of an emergency.
2. *Outliers*- Outlier claims are a line by line review of the itemized statement. Anything billed on the IZ must be able to be substantiated in the medical documentation.
3. *Modifier 59*- Modifier 59 indicates that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Normally these services are not reported together, but the servicing provider feels that they are appropriate under the circumstances. The 59 modifier has an impact on reimbursement, so it is the provider's responsibility to submit substantiating documentation to show that the 59 modifier is appropriate.
4. *Abortion*- All services for abortions (i.e. spontaneous, missed, septic, inevitable etc) and elective terminations require medical documentation.

What does AHCCCS require for documentation?

The best "rule of thumb" is to determine what you are billing and ask yourself what documents would prove that the services were performed. The following are just a few examples of the most common circumstances:

1. *FESP Claims*- Documentation should show that the services provided were for an emergency medical condition. Although services may be

medically necessary & appropriate, they may not meet the federal definition of an emergency. If you are billing for emergency room services, send the emergency room records/dictated summary done by the billing provider. Surgical services require the operative report & may require the H&P to support the emergent nature of the surgery.

- 2. Outliers-** These claims require the most extensive amount of documentation. Each charge on the claims itemized statement must be substantiated in the medical records sent. For example, if 14 doses of a particular antibiotic are billed, then the Medication Administration records must be submitted. If laboratory services are billed, the laboratory test results should be submitted etc. Be sure to submit an itemized statement with all outlier claims.
- 3. Modifier 59-** As described above, the use of a 59 modifier indicates that a procedure or service was distinct or independent from other services performed on the same day and are not normally reported together. Documentation must support a different session, different procedure or surgery.
- 4. Unlisted/Unspecified Services-** All claims with unlisted or unspecified procedures (identified by CPT codes ending in "99") must be submitted with documentation that describes the service rendered and identifies the service in the procedure or operative report.

How can medical documents be submitted to AHCCCS?

AHCCCS has furnished providers several different ways to submit medical documents to us:

- 1. Electronically-** AHCCCS has developed a web upload portal for claim attachment submissions and is accepting 275 EDI transactions from individual providers and clearinghouses. This is quickest, most efficient way to submit documentation.

http://www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSTechnicalAssistance.aspx#Uploading_275_Claim_Attachments_Technical_Assistance_Document

PWK Segment (837 loop 2300) -Providers who indicate on the PWK segment of electronic claims that electronic documents are to follow, have **5 days** to submit these documents. Otherwise claims will be denied for "no documentation received."

2. FAX- documentation submitted to AHCCCS via fax should be sent to (602) 253-5472. Please be sure to also include a medical documentation submission form with each document submitted.