



# ENCOUNTER KEYS

## AHCCCS

### 2010 Encounter Manual

The 2010 Encounter Manual has been posted on AHCCCS' Encounter Web Page. Chapters 3 and 4 have been revised.

In Chapter 3 the Encounter Submission and Tracking Report was replaced with the Encounter Submission and Revision Tracking Reports. **Effective April 2011 these four reports must be submitted monthly to the Encounter Unit.** The first set of reports for the month of April 2011 will be due on May 2011.

Corrective Action Plans and Sanctions are also found in Chapter 3, and as a result the Pended Encounter Sanction Policy was removed from Chapter 4.

Please refer to the 2010 Encounter Manual for additional information.

<http://www.azahcccs.gov/commercial/ContractorResources/encounters/EncounterManual.aspx>

Inside this issue:	
<i>2010 Encounter Manual; Encounter Processing Schedule; OPFS; ASC Fee Schedule Rates, Sage Memorial Hospital</i>	1
<i>Outpatient Hosp. Fee Schedule; Physician Fee Schedules; Coverage Code &amp; Provider Types</i>	2-4
<i>Modifiers</i>	4-5
<i>Procedure Daily Maximum</i>	5
<i>Edits</i>	6-8

### Encounter Processing Schedule

The Encounter Processing Schedule for April 2011 to September 2011 has been posted to the AHCCCS website: [http://www.azahcccs.gov/commercial/ContractorResources/encounters/encounters.aspx#Encounter Processing Schedules](http://www.azahcccs.gov/commercial/ContractorResources/encounters/encounters.aspx#Encounter_Processing_Schedules)

### OPFS Facility Peer Groups

The most current Out Patient Fee Schedule Facility Peer Groups Document has been posted to the AHCCCS OPFS web-page. Any questions please let us know.

### Ambulatory Surgery Center Fee Schedule Rates

Effective January 1, 2011, Ambulatory Surgery Center fee schedule rates for implant-related surgeries will revert to their pre-October 2010 rates. During the last update, these rates were changed which resulted in a misalignment with the AHCCCS Hospital Outpatient Fee Schedule (OPFS) rates for the same services. In order to re-align the two fee schedules, AHCCCS will revert the codes back to their previous rates. Again, these changes will have an effective date of January 1, 2011. For any questions, contact Jean Ellen Schulik-Rates & Reimbursement Manager at 602-417-4335.

### Sage Memorial Hospital

Information pertaining to the October 1, 2010 rates for Sage Memorial Hospital (Provider Id. 021353) has been distributed. Although, Sage Memorial Hospital qualifies as a 638 facility they have not yet chosen to claim the OMB rate for their inpatient services. Therefore, the rate sheet should be used for this hospital for all services from October 1, 2010 for further information contact, Cynthia C. Barker at 602-417-4708 or Fax 602-417-4725.

**Outpatient Hospital Fee Schedule**

The outpatient fee schedule for new codes effective 01/01/2011 can be obtained by contacting Jean Xia at (602) 417-4233, or if outside Maricopa County (800) 654-8713 ext. 7-4233., or the AHCCCS website:  
<http://www.azahcccs.gov/commercial/ProviderBilling/rates/hospitals.aspx>

**Physician Fee Schedules**

The AHCCCS Physician Fee Schedules have been updated to incorporate new codes and the quarterly drug schedule update. Questions concerning AHCCCS Physician reimbursement rates may be directed to Victoria Burns at (602) 417-4049, or if outside Maricopa County (800) 654-8713 ext. 7-4049.

**Coverage Code & Provider Type(s) Updates:**

- Effective for dates of service on or after January 1, 2010 the coverage code of 01 (Covered Service/Code Available) 32998 (Ablation Therapy For Reduction Or Eradication Of 1 Or More Pulmonary Tumor(s) Including Pleura Or Chest Wall When Involved By Tumor Extension, Percutaneous, Radiofrequency, Unilateral) is now available, and can now be reported by the following provider types:

08	MD-Physician	18	Physicians Assistant
19	Registered Nurse Practitioner	31	Do-Physician Osteopath
43	Ambulatory Surgical Center		

- Effective for the dates of service on or after June 1, 2009 the coverage code has been changed to 01 (Covered Service/Code Available) for the following codes:

- S5520 - Home Infusion Therapy, All Supplies (Including Catheter) Necessary for a Peripherally Inserted Central Venous Catheter (PICC) Line Insertion
- S5521 - Home Infusion Therapy, All Supplies (Including Catheter) Necessary for a Midline Catheter Insertion
- S5523 - Home Infusion Therapy, Insertion of Midline Venous Catheter, Nursing Services Only (No Supplies or Catheter Included).

“The moments of happiness we enjoy take us by surprise. It is not that we seize them, but that they seize us.”

Ashley Montagu

- 
- Effective for dates of service on or after October 1, 2010 the coverage code has been changed to 04 (Not Covered Service/Code Not Available) for the following codes:
    - 90663 - Influenza Virus Vaccine, Pandemic Formulation, H1N1
    - 90470 - H1N1 Immunization Administration (Intramuscular, Intranasal), Including Counseling When Performed
  - Effective for the dates of service on or after February 1, 2011 the coverage code has been changed to 01 (Covered Service/Code Available) for the following code:
    - T2038 - Community Transition, Waiver; Per Service
  - Effective for dates of service on or after January 1, 2011 the following HCPCS codes now have a coverage code of 09 (Medicare Only):
    - Q2035 - Influenza Virus Vaccine, Split Virus, When Administered To Individuals 3 Years of Age and Older, For Intramuscular Use (Afluria)
    - Q2036 – Influenza Virus Vaccine, Split Virus, When Administered To Individuals 3 Years of Age and Older, For Intramuscular Use (Flulaval)
    - Q2037 – Influenza Virus Vaccine, Split Virus, When Administered To Individuals 3 Years of Age and Older, For Intramuscular Use (Fluvirin)
    - Q2038 - Influenza Virus Vaccine, Split Virus, When Administered To Individuals 3 Years of Age and Older, For Intramuscular Use (Fluzone)
    - Q2039 - Influenza Virus Vaccine, Split Virus, When Administered To Individuals 3 Years of Age and Older, For Intramuscular Use (Not Otherwise Specified)
  - Effective for dates of service on or after January 1, 2011 the following CPT codes now have a coverage code of 04 (Not Covered Service/Code Not Available):
    - 90460 - Immunization Administration Through 18 Years Of Age Via Any Route Of Administration, With Counseling By Physician Or Other Qualified Health Care Professional; First Vaccine/Toxoid Component
    - 90461 - Immunization Administration Through 18 Years Of Age Via Any Route Of Administration, With Counseling By Physician Or Other Qualified Health Care Professional; Each Additional Vaccine/Toxoid Component (List Separately In Addition To Code For Primary Procedure)

- Effective for dates of service on or after April 1, 2008 the following HCPCS Codes have had a coverage code change to 01 (Covered Service/Code Available):

J7612 - Levalbuterol, Inhalation Solution, FDA-Approved Final Product, Non-Compounded, Administered Through DME, Concentrated Form, 0.5 Mg

J7613 - Albuterol, Inhalation Solution, FDA-Approved Final Product, Non-Compounded, Administered Through DME, Unit Dose, 1 Mg

J7614 - Levalbuterol, Inhalation Solution, FDA-Approved Final Product, Non-Compounded, Administered Through DME, Unit Dose, 0.5 Mg

### **Place of Service (POS)**

Effective for dates of service on or after January 1, 2010 the Place of Service (POS) 11 (Office); 20 (Urgent Care Facility); 49 (Independent Clinic); 50 (Federally Qualified Health Center); 71 (State or Local Public Health Clinic) and 72 (Rural Health Clinic) have been added to the following HCPCS Codes:

81050 Volume Measurement for Timed Collection, Each  
 82075 Alcohol (Ethanol); Breath  
 86485 Skin Test; Candida  
 86486 Skin Test; Unlisted Antigen, Each  
 86490 Skin Test; Coccidioidomycosis  
 86510 Skin Test; Histoplasmosis  
 86580 Skin Test; Tuberculosis, Intradermal  
 88720 Bilirubin, Total, Transcutaneous  
 88738 Hemoglobin (HGB), Quantitative, Transcutaneous  
 88740 Hemoglobin, Quantitative, Transcutaneous, Per Day; Carboxyhemoglobin  
 88741 Hemoglobin, Quantitative, Transcutaneous, Per Day; Methemoglobin  
 89220 Sputum, Obtaining Specimen, Aerosol Induced Technique

### **Modifier(s)**

Modifiers added to the system:

<b>Modifier</b>	<b>Modifier Description</b>	<b>Code</b>	<b>Code Description</b>	<b>Effective Date</b>
AZ	Phy Prov A Serv In A Dental Hlth Prof Sh			01/01/2011
CS	Item Or Serv Related In Whole Or In Part			01/01/2011
DA	Oral Hlth Assessment By A Lic Hlth Prof			01/01/2011
GU	Proc Performed In Non Fee Sch Pos			01/01/2011
NB	Nebulizer Sys, Any Type, FDA-Cleared For			01/01/2011
NU	New Equipment	V2626	Reduction Of Ocular Prosthe- sis	12/31/2009
PT	Colorectal Cancer Screening Test; Conver			01/01/2011

Listed below are modifiers that have been added to specific codes:

<b>Modifier</b>	<b>Modifier Description</b>	<b>Code</b>	<b>Code Description</b>	<b>Effective Date</b>
50	Bilateral Procedure (Pay 50%)	73701	Computed Tomography, Lower Extremity; With Contrast Material(s)	01/01/2010
80 81 82	Assistant Surgeon; Minimum Assistant Surgeon Assist Surg/Qual Resident Surg Not Avail	11045	Debridement, Subcutaneous Tissue (Includes Epidermis And Dermis, If Performed); Each Additional 20 Sq Cm, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	01/01/2011
80 81 82	Assistant Surgeon; Minimum Assistant Surgeon Assist Surg/Qual Resident Surg Not Avail	11046	Debridement, Muscle And/Or Fascia (Includes Epidermis, Dermis, And Subcutaneous Tissue, If Performed); Each Additional 20 Sq Cm, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	01/01/2011
80 81 82	Assistant Surgeon; Minimum Assistant Surgeon Assist Surg/Qual Resident Surg Not Avail	11047	Debridement, Bone (Includes Epidermis, Dermis, Subcutaneous Tissue, Muscle And/Or Fascia, If Performed); Each Additional 20 Sq Cm, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)	01/01/2011
CD CE CF	AMMC Test Ordered By ESRD FAC/MCP PHYS AMCC Test Ordered By ESRD FAC/MCP PHYS AMCC Test Ordered By ESRD FAC/MCP PHYS	82330	Calcium; Ionized	01/01/2010

### **Procedure Daily Maximum**

- The limits have been removed from the CPT code 14302 (Adjacent Tissue Transfer or Rearrangement, Any Area; Each Additional 30.0 Sq., Cm, Or Part Thereof (List Separately In Addition To Code For Primary Procedure)).

**Edits**

- On December 13, 2010 we communicated that the co-pay related edits A621 (Co-Pay Amount Required But Not Reported) and A622 (Co-Pay Amt Different From Amt Assigned To Service) were to remain soft for an additional 30 to 60 days beyond the previously stated 90 day period which began 10/1/2010. Due to unforeseen delays related to system changes we are looking at no earlier than May 1, 2011 as the date to turn these edits on hard.
- Beginning with the first encounter cycle of June 2010 five edits were changed from pend to denial edit status. Another twenty-four edits, were changed to a denial edit status with the first encounter cycle of September 2010. **Effective with the first May 2011 encounter cycle the additional ninety-one edits, listed below, will be changed from pend to denial edit status.**

<b>Edit</b>	<b>Description</b>
C010	NDC missing or invalid
C300	Dispense date is prior to prescribe date
H193	Other payer dispensing fee paid is not numeric
H194	Other payer ingredient cost paid is not numeric
H195	Other payer copayment amount is not numeric
H196	Ingredient cost submitted by pharmacy is not numeric
H197	Dispensing fee submitted by pharmacy is not numeric
H290	Adjustment/void code invalid
H340	Medicare deductible must be numeric
H345	Medicare coinsurance not numeric
H350	Other pay amount 1 not numeric
H355	Other pay amount 2 not numeric or invalid
H360	Plan paid amount is invalid
H366	Medicare deductible and coinsurance exceeds bill charges
H370	Previous claim reference number (CRN) is invalid
H425	Date of service after claim receipt date

H430	From date of service is after thru date of service
H440	Date of service is prior to 10/01/82
H470	Date of service is prior to date of birth
H610	Previous CRN and adjustment/void code not both present
H641	Medicare deductible and coinsurance exceeds bill charges
H643	Medicare deductible and coinsurance exceeds bill charges
H644	Medicare Paid, deductible and coinsurance exceed approved amount
H680	Must have plan payment
H690	Encounters and RI claims must have plan ID
N004	NDC code not on file
N010	NDC is invalid; not on file (for date of service)
N020	NDC not covered on date of service
N022	Procedure is Medicare only
N025	Drug not available on date of service
N033	Drug obsolete on date of service

Edit	Description
N035	Replacement NDC available on date of service
N037	Replacement NDC not in effect on date of service
N040	Drug cancelled by manufacturer
N050	Drug cancelled by Federal Regulation
N060	Drug cancelled by State Regulation
N070	Drug cancelled; now OTC
N080	Drug cancelled; NDC changed by manufacturer
N090	Drug cancelled; invalid NDC
N100	Drug cancelled for unspecified reason
P285	Split bill for provider ID change
P290	Service provider inactive during service date span
P291	Header service provider inactive during service date span
P301	Header service provider enrollment inactive during service date span
P305	Service provider enrollment denied during date of service
P306	Header service provider enrollment denied during date of service
P310	Service provider enrollment suspended during date of service
P311	Header service provider enrollment suspended during date of service
P378	Billing provider not enrolled on date of service
R466	Recipient ineligible for LTC services on date of service
R470	Recipient enrolled in fee for service network on service dates
R480	Recipient not enrolled on service dates
R481	Recipient not enrolled on date of service - split bill
R582	Other insurance reported in invalid

Edit	Description
S200	Only dental procedures can be submitted on the dental form
S334	Procedure code not on file
S340	Procedure code is missing or not on file for date of service
S345	Procedure not available on date of service
S350	Procedure not covered by AHCCCS on date of service
S510	Medicare deductible and coinsurance exceeds allowed amount
U030	Bill type missing or invalid
U033	Outpatient late charge bill type 135 not allowed
U210	Non-covered charge not numeric or invalid
U230	Non-covered charge exceeds line charge
U265	Service units exceed date span
U600	Detail service begin date is invalid
U605	Detail service end date is invalid
U610	Detail service end date is prior to detail service begin date
U615	Header service dates must encompass detail service dates
U920	Bill type not on file
V190	Total non-covered charges exceed billed amount
V398	Procedure code must be valid HCPC format of XNNNN
V400	Procedure code not on file
V402	Procedure code is missing or not on file for date of service
V403	Procedure not available on date of service
V404	Procedure not covered by AHCCCS on date of service
V672	Service not covered by AHCCCS, non cover the line charge

Edit	Description
Z040	Health Plan ID is invalid
Z100	Billing provider ID is invalid
Z120	Service provider ID missing or invalid
Z121	Header service provider ID missing or invalid
Z125	Service provider NPI field is missing or invalid
Z126	Detail service provider NPI field is missing or invalid
Z165	Service provider ID not on file

Edit	Description
Z166	Header service provider ID not on file
Z176	Detail service provider NPI not on file
Z180	From date of service missing or invalid
Z185	Date must be greater than or equal to 10/01/2000
Z200	Thru date of service missing or invalid
Z260	Recipient not on file and no alternate ID found
Z400	Original claim not found on history; adj/void invalid

Please note that encounters denied by AHCCCS are not considered for purposes of plan performance measures, supplemental payments such as reinsurance and reconciliations, or for future plan capitation rates.

Encounters denied by AHCCCS must be replaced using the replacement process in order to retain timely filing of the prior encounter submission. Encounter new day resubmissions will be considered originals and not linked to prior encounters denied by AHCCCS as a result of edit denials. Plans must diligently monitor/track these denials and replace/resubmit them. AHCCCS will monitor plan performance around these denials and, when necessary, may require corrective action plans, other activities to improve performance, or levy sanctions.

**Edits**

The following new encounter form type C (retail pharmacy) edits have been added to PMMIS:

H207 Members Must Be Age 21 or Over to Receive Flu Vaccine Begin DOS 01/01/10 & Receipt Date: 01/01/11 Mode 1: Set to: "Y" Pend Adj lvl: 80	H208 Vaccine Administration Fee Submitted Incorrectly Begin DOS 01/01/10 & Receipt Date: 01/01/11 Mode 1: Set to: "Y" Pend Adj lvl: 80
H209 Vaccine Administration Fee Exceeds Contracted Amount Begin DOS 01/01/10 & Receipt Date: 01/01/11 Mode 1: Set to: "Y" Pend Adj lvl: 80	

*“Some cause happiness wherever they go; others whenever they go.”*

Oscar Wilde