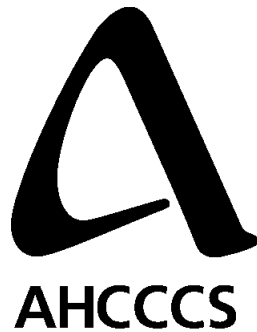


Chapter 8

IHS/Tribal Providers Individual Practitioner Services



**This Page
Intentionally
Left Blank**



GENERAL INFORMATION

Within limitations, AHCCCS covers medically necessary medical and surgical services performed by licensed physicians and other individual practitioners employed by Indian Health Service (IHS) and tribes (638 facilities). (See Chapter 3, Provider Records and Registration for information about IHS and tribal providers)

Cosmetic surgery, experimental procedures, and unproven procedures are not covered.

Physicians and mid-level practitioners must bill for services on the CMS 1500 claim form. Services must be billed using appropriate CPT and HCPCS codes and procedure modifiers, if applicable. Dentists must bill for services provided to KidsCare recipients on the ADA 2006 form using CDT-4 codes.

CORRECT CODING INITIATIVE

AHCCCS follows Medicare's Correct Coding Initiative (CCI) policy and performs CCI edits and audits on fee-for-service claims for the same provider, same recipient, and same date of service.

Correct coding means billing for a group of procedures with the appropriate comprehensive code. "Unbundling" is the billing of multiple procedure codes for services that are covered by a single comprehensive code.

Some examples of **incorrect** coding include:

- Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Downcoding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.



Modifier 59 must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Claims submitted to AHCCCS utilizing modifier 59 will be subject to Medical Review. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with evaluation and management codes (99201-99499) or radiation therapy codes (77261 -77499).

If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. Separate services during the post-operative period may be billed with modifier 58 or 78. Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

Other modifiers may be appropriately attached to comprehensive codes (e.g., professional component (26), assistant surgeon (80), etc.).

CCI edits and audits are run on a prepayment basis, and claims that fail the CCI edits are denied. The CCI edit results are:

- L140.1 - Invalid Coding Combination; Mutually Exclusive Code Paid (Deny)
- L140.2 - Invalid Coding Combination; Component Previously Paid (Deny)
- L140.3 - Invalid Coding Combination; Comprehensive Previously Paid (Deny)
- L140.4 - Invalid Coding Combination; Multiple Component Codes (Approve. Possible post payment review and recoupment)
- L140.5 – Invalid Coding Combination; Ventilator Management with E/M Code (Deny)
- L140.6 - Invalid Coding Combination; Discharge Management with E/M Code (Deny)

To meet CCI requirements, you should follow these steps:

1. Determine if the code to be billed is a mutually exclusive code.

Mutually exclusive procedures are those that cannot reasonably be performed in the same session (e.g., codes for “initial” and “subsequent” services).

If a mutually exclusive code and its “partner” are billed on the same claim, the system will allow the code with the lowest capped fee. If the “partner” code has been paid, the system will deny the billed code.

2. Determine if the code to be billed is a component of a comprehensive code that also will be billed or that has been billed.

You must bill the comprehensive code, if applicable. Claims for component codes that describe services distinct or separate from the services described by the comprehensive code may be reimbursed when billed with one of the following modifiers, if appropriate:

24, 25, 50, 57, 58, 59, 78, E1-E4, F1-F9, FA, LC, LD, RC, T1-T9, TA, RT, or LT.



3. Determine if the code to be billed is a comprehensive code.

If it is a comprehensive code and one of its components has been billed and paid, that claim for the component code must be voided before the comprehensive code can be billed.

Component codes cannot be billed if the comprehensive code is the most appropriate code.

INDIVIDUAL PRACTITIONER SERVICES

NOTE: The covered services, limitations, and exclusions described in this chapter offer general guidance to providers. Specific information regarding covered services, limitations, and exclusions can be found in the AHCCCS Medical Policy Manual and AHCCCS Administrative Rules A.A.C. R9-22-201 et.seq. Please direct questions to the AHCCCS Office of Medical Policy and Programs at (602) 417-4627. The *AHCCCS Medical Policy Manual (AMPM)* is available on the AHCCCS web site at www.azahcccs.gov.

Pregnancy Terminations

- AHCCCS does not cover abortion counseling and pregnancy terminations unless:
 - ✓ The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated, or
 - ✓ The pregnancy is a result of rape or incest, or
 - ✓ The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
 - Creating a serious physical or mental health problem for the pregnant member, or
 - Seriously impairing a bodily function of the pregnant member, or
 - Causing dysfunction of a bodily organ or part of the pregnant member, or
 - Exacerbating a health problem of the pregnant member, or
 - Preventing the pregnant member from obtaining treatment for a health problem.
- All medically necessary abortions require prior authorization (PA) except in cases of medical emergency.
 - ✓ In the event of a medical emergency, all documentation of medical necessity must accompany the claim when submitted for reimbursement.



- The request for PA must be accompanied by a completed Certificate of Medical Necessity for Pregnancy Termination (See the *AHCCCS Medical Policy Manual (AMPM)*, Exhibit 410-1).
- ✓ If the pregnancy is a result of rape or incest and the recipient is under 18 years of age, a parent or legal guardian must sign the Certificate of Necessity.
- The AHCCCS PA Unit will review the request and the certification and may authorize the procedure if medically necessary.



Anesthesia Services

- ☑ Anesthesia services (except epidurals) require the *continuous physical presence* of the anesthesiologist or certified registered nurse anesthetist (CRNA).
 - ✓ Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of MINUTES in Field 24G of the CMS 1500 claim form.
 - ✓ The begin and end time of the anesthesia administration must be entered on the claim on the line following the ASA code.
 - ✓ The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim.
 - ✓ AHCCCS uses the limits and guidelines as established by ASA for base and time units (AHCCCS system will calculate units based on minutes billed) for most anesthesia procedures. Every 15 minutes or any portion thereof is equal to one unit of time.
 - ✓ The AHCCCS system adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established Fee For Service Rate to obtain the allowed amount.

Billing for Labor and Delivery

- ☑ Providers should bill ASA code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes the repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)) for labor and delivery when epidural is used.
 - Providers may bill for a maximum of 180 minutes (three hours).
- ✓ If labor results in a Cesarean section, add-on code +01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia) should be added.
 - Providers should bill for the time of the Cesarean section portion of the service only.
 - A base of 5 units is added for the ASA code 01967, and a base of 3 units is added for +01968.
- ✓ For all other labor and delivery, ASA codes 01960 (Anesthesia for vaginal delivery only) and code 01961 (Anesthesia for Cesarean delivery only) should be used.



- ✓ Providers who bill other CPT codes for additional procedures performed during anesthesia administration must use the units field to indicate the number of times the procedure was performed.
- ✓ Providers should not include the Basic Unit Value listed in the ASA Manual as part of the units billed.

☑ Example:

A provider who bills 36556 (Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) should bill one unit.

Billing the Basic Unit Value of four would indicate placement of four catheters.
Reimbursement is based on capped fee schedule.

The following anesthesia services are not covered:

- ☑ 00938 (Insertion of penile prosthesis)
- ☑ Qualifying circumstances codes
- ☑ Physical status codes

- ☑ AHCCCS will reimburse only one provider for anesthesia administration when a CRNA administers the anesthesia, AHCCCS will not reimburse the anesthesiologist for oversight services.
 - ✓ Only the CRNA will be reimbursed by AHCCCS

- ☑ When one provider begins the anesthesia administration and another provider takes over, only the first provider may bill for the service. If both providers bill for the service, one claim will be denied as a near duplicate.

Dental services

- ☑ In accordance with AHCCCS Administrative Rule A.A.C. R9-22-207, AHCCCS covers limited dental services for members age 21 years age and older.

- ☑ For members age 21 years old and older, AHCCCS covers medical and surgical services furnished by a dentist only to the extent that such services:..
 - ✓ May be performed under state law by either a physician or by a dentist and
 - ✓ The services would be considered physician services if furnished by a physician



- ✓ Services furnished by dentists must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw.

A. Covered services include examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate level of anesthesia and the prescription of pain medication and antibiotics.

B. The services do NOT include: dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures.

Diagnosis and treatment of TMJ is not covered except for reduction of trauma.

AHCCCS covers limited dental services for covered transplantation and for covered radiation treatment for cancer of the jaw, neck, or head.

- ✓ Prophylactic extraction of teeth in preparation for radiation treatment or cancer of the jaw, neck or head is covered

- ✓ As a prerequisite to covered transplantation, AHCCCS covers dental services necessary for the elimination of oral infections and the treatment of oral disease, which include:

Dental cleanings

Treatment of periodontal disease

Medically necessary extractions, and

Provision of simple restorations (limited to silver amalgam or composite resin fillings, stainless steel crowns or preformed crowns)

- ✓ AHCCCS covers these services only after a transplant evaluation determines that the member is an appropriate candidate for covered organ or tissue transplantation.

Dental Services for Individuals under Age 21: EPSDT Services

AHCCCS covers comprehensive health care for recipients under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT covers all medically necessary services described in federal law 42 USC 1396d to treat or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening, whether or not the service is described in the State Plan. .

- Covered EPSDT dental services for recipients under age 21 and KidsCare recipients include, but are not limited to:
 - ✓ Screening and preventive services specified in periodicity schedule
 - ✓ Emergency dental services
 - ✓ All medically necessary therapeutic dental services

Prior authorization requirements

- PA is not required for emergency dental services nor for preventive/ therapeutic dental services for EPSDT and KidsCare recipients.
- Dental surgery services for EPSDT and KidsCare recipients require PA.
- Pre-transplant dental services that are medically necessary in order for the recipient to receive the major organ or tissue transplant require prior authorization from the AHCCCS transplant case manager.

Billing requirements

- Dentists must bill on the ADA 2006 claim form using CDT-4 codes.
- Only oral surgeons registered as Provider Type 07 (Dentists) may use CPT Evaluation and Management (E/M) codes on the CMS 1500 claim form to bill AHCCCS for office visits.
- Dentists who are not oral surgeons must use one of the following codes to bill for office visits and evaluation services:
 - D0120 - Periodic oral exam
 - D0140 - Limited oral evaluation -- problem focused
 - D0150 - Comprehensive oral evaluation
 - D0160 - Detailed and extensive oral exam -- problem focused
 - D9430 - Office visit for observation (during regularly scheduled hours) – no other services performed
 - D9440 - Office visit -- after regularly scheduled hours
- Dentists may use appropriate E/M codes for hospital consultation, emergency room services, and hospital visits.



Discharge Management

- Physicians and mid-level practitioners who bill Evaluation and Management (E/M) codes 99238 and 99239 for discharge management should not bill any other evaluation and management code for the same date when submitting claims to AHCCCS.
- E/M codes for hospital discharge day management are used to report all services provided to a patient on the date of discharge, including final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.
- If you submit a claim for discharge management and another E/M code for the same date, the E/M code will be paid, but the discharge management claim will be denied.

EPSDT Services

- AHCCCS covers comprehensive health care for recipients under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
- EPSDT also covers all medically necessary services to treat or ameliorate defects and physical and mental illnesses and conditions, identified in an EPSDT screening whether or not the service is covered under the State Plan.
- KidsCare (Title XXI) recipients are eligible for nearly the same services as ESPDT recipients eligible under Title XIX.
 - ✓ KidsCare recipients are not eligible for licensed midwife services and home births.
- EPSDT screening services are to be provided in compliance with AHCCCS medical policy including the periodicity schedule which meet reasonable standards of medical practice and specified screening services at each stage of a child's life.
- The EPSDT screening requirements are:
 - ✓ Comprehensive health, nutritional and developmental history
 - ✓ Comprehensive unclothed physical examination
 - ✓ Screening for immunizations appropriate to age and health history.
 - ✓ Laboratory tests
 - ✓ Health education
 - ✓ Vision, speech and hearing assessment
 - ✓ Age appropriate dental screening
 - ✓ Behavioral health services
- Under the federal Vaccines for Children (VFC) program, providers are paid a capped fee for administration of vaccines to recipients 18 and younger.

- ✓ You must bill the appropriate CPT code for the immunization with the “SL” (State supplied vaccine) modifier that identifies the immunization as part of the VFC program.
- ✓ Do **not** use the immunization administration CPT codes 90471, 90472, 90473, and 90474 when billing under the VFC program.
- ✓ Because the vaccine is made available free of charge, do not bill for the vaccine itself.
- ✓ Vaccines covered under the VFC program:

- 90371 Hepatitis B immune globulin (HBIG), human, for intramuscular use
- 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
- 90472 Each additional vaccine (single or combination vaccine/toxoid)
- 90473 Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
- 90474 Each additional vaccine (single or combination vaccine/toxoid)
- 90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use
- 90647 Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use
- 90648 Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use
- 90649 Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use
- 90650 Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use
- 90655 Influenza virus vaccine, split virus, preservative free, for children 6-35 months of age, for intramuscular use (covered under VFC only for high-risk children)
- 90656 Influenza virus vaccine, split virus, preservative free, for individuals 3 years of age and above, for intramuscular use (covered under VFC only for high-risk children)
- 90657 Influenza virus vaccine, split virus, for children 6-35 months of age, for intramuscular use (covered under VFC only for high-risk children)



- 90658 Influenza virus vaccine, split virus, for individuals 3 years of age and above, for intramuscular use (covered under VFC only for high-risk children)
- 90660 Influenza virus vaccine, live, for intranasal use
- 90669 Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use
- 90670 Pneumococcal conjugate vaccine, 13 valent, for intramuscular use
- 90680 Rotavirus vaccine, pentavalent, 3 dose schedule, live, for oral use
- 90681 Rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use
- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and poliovirus vaccine, inactivated (DtaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use
- 90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP-Hib-IPV), for intramuscular use
- 90700 Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to younger than 7 years, for intramuscular use
- 90702 Diphtheria and tetanus toxoids (DT) adsorbed when administered to younger than 7 years, for intramuscular use
- 90707 Measles, mumps and rubella virus vaccine (MMR)
- 90710 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use
- 90713 Poliovirus vaccine, inactivated, (IPV), for subcutaneous or intramuscular use
- 90714 Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to 7 years or older, for intramuscular use
- 90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to 7 years or older, for intramuscular use
- 90716 Varicella virus vaccine, live, for subcutaneous use
- 90723 Diphtheria, tetanus toxoids, acellular pertussis vaccine, hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
- 90732 Pneumococcal polysaccharide vaccine, 23 valent, adult or immunosuppressed patient dosage, when administered to 2 years or older, for subcutaneous or intramuscular use

- 90734 Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetraivalent), for intramuscular use
- 90743 Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use
- 90744 Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use
- 90748 Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use

Family Planning Services

- Family planning services are provided to eligible recipients who voluntarily choose to delay or prevent pregnancy and include covered medical, surgical, pharmacological and laboratory benefits.
- Family planning services includes the provision of accurate information and counseling to allow recipients to make informed decisions about the specific family planning methods available.
- Covered services include:
 - ✓ Contraceptive counseling, medications, supplies and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories
 - ✓ Voluntary sterilization (male and female)
 - ✓ Natural family planning education or referral to qualified health professionals
- Limitations and exclusions
 - ✓ Services for the diagnosis or treatment of infertility are not covered.
 - ✓ Abortion counseling is not covered.
 - ✓ Pregnancy terminations are not covered unless 1) the pregnancy termination is necessary to protect the life of the mother, 2) the pregnancy termination is medically necessary to prevent a serious physical or mental health problem for the pregnant mother, or 3) the pregnancy is the result of a rape or incest. (see Page 8-3 to 8-4)
- A Federal Consent Form must be submitted with all claims for voluntary sterilization procedures.
- Federal consent requirements for voluntary sterilization require:



- ✓ The recipient to be at least 21 years of age at the time consent is signed.
- ✓ The recipient to be mentally competent.
- ✓ Consent to be voluntary and obtained without duress.
- ✓ Thirty days, but not more than 180 days, to have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- ✓ At least 72 hours to have passed since the recipient gave informed consent for the sterilization if the recipient is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
- ✓ The informed consent to have been given at least 30 days before the expected date of delivery in the case of premature delivery.
- ✓ The person securing the informed consent and the physician performing the sterilization procedure to sign and date the consent form.
- ✓ A copy of the signed Federal Consent Form to be submitted by each provider involved with the hospitalization and/or the sterilization procedure.
 - ✓ Sterilization consents may not be obtained when an eligible recipient:
 - ☒ Is in labor or childbirth.
 - ☒ Is seeking to obtain or obtaining an abortion.
 - ☒ Is under the influence of alcohol or other substances that affect that recipient's state of awareness.
- ☒ Providers must bill for IUDs on the CMS 1500 claim form using the following codes:
 - J7300 Intrauterine copper contraceptive (Paraguard)
 - J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg (Mirena)
 - S4989 Contraceptive intrauterine device (e.g. progesterone IUD), including implants and supplies
- ☒ Providers must bill for Depo-provera injections on the CMS 1500 claim form using HCPCS code J1055 - Depo-provera (150mg)
- ☒ Norplant insertion is no longer an AHCCCS-covered service because the manufacturer, Wyeth, is no longer distributing Norplant in the United States.
 - ✓ Do not bill for CPT codes 11975 - Insertion, implantable contraceptive capsules and 11977 - Removal with reinsertion, implantable contraceptive capsules
 - ✓ Essure insertion must be billed on a CMS 1500 claim form using CPT code 58565.

Foot and Ankle Care

In accordance with AHCCCS Administrative Rule A.A.C. R9-22-215,

- AHCCCS covers medically necessary foot and ankle care, including reconstructive surgeries, when ordered by a member's primary care provider, attending physician or practitioner, within certain limits, for eligible members.
- Foot and ankle services are not covered for persons age 21 and older when provided by a podiatrist or podiatric surgeon.
- Routine foot care is designated as those services performed in the absence of localized illness, injury or symptoms involving the foot. Routine foot care is considered medically necessary in very limited circumstances as described below. These services include:
 - ✓ The cutting or removal of corns or calluses
 - ✓ The trimming of nails (including mycotic nails)
 - ✓ Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the fee, and the use of skin creams to maintain skin tone or both ambulatory and bedfast patients).
- Coverage includes medically necessary foot and ankle care such as wound care and treatment of pressure ulcers.
- Foot and ankle care also includes fracture care, reconstructive surgeries, and limited bunionectomy services.
- Routine foot care is considered medically necessary when the member has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional person would be hazardous. Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include but are not limited to:
 - ✓ Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
 - ✓ Buerger's disease (thromboangiitis obliterans)
 - ✓ Chronic thrombophlebitis
 - ✓ Diabetes mellitus
 - ✓ Peripheral neuropathies involving the feet
 - ✓ Member receiving chemotherapy
 - ✓ Pernicious anemia
 - ✓ Hereditary disorder, i.e. hereditary sensory radicular neuropathy, Fabry's disease
 - ✓ Hansen's disease or neurosyphilis
 - ✓ Malabsorption syndrome
 - ✓ Multiple sclerosis
 - ✓ Traumatic injury



- ✓ Uremia (chronic renal disease)
- ✓ Anticoagulant therapy

- ☑ Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered in the following circumstances:
 - ✓ A systemic condition, and
 - ✓ Clinical evidence of mycosis of the toenail, and
 - ✓ Compelling medical evidence documenting the member either:
 - ☑ Has a marked limitation of ambulation due to the mycosis which requires active treatment of the foot, or

 - ☑ In the case of a nonambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.

Limitations:

- ☑ Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to early and periodic screening, diagnosis and treatment (EPSDT) members).
 - ✓ Contract year is defined as October 1-September 30

- ☑ Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT members).

- ☑ Neither general diagnoses such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitation injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnosis under which routine foot care is covered.

- ☑ Bunionectomies are covered only when the bunion is present with:
 - ✓ Overlying skin ulceration, or

 - ✓ Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report)

- ☑ Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Prior Authorization requirements:

- All foot and ankle services not covered by Medicare require Prior Authorization

Health risk assessment and screening tests

For persons 21 years old and older, AHCCCS covers health risk assessment and screening tests pursuant to AHCCCS Rule R9-22-205 provided by a physician, primary care provider or other licensed practitioner within the scope of his/ her practice under State law for all members.

These services include appropriate clinical health risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status. For individuals age 21 years and older, well exams are not covered. Well exams are physical examinations in the absence of any known disease or symptom or any specific medical complaint by the patient precipitating the examination. Certain preventive services such as immunizations, PAP smears, colonoscopies, and mammograms are covered for persons age 21 and older.

Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program and KidsCare Program.

- Preventive health risk assessment and screening tests services for non-hospitalized adults include, but are not limited to:
- ✓ Hypertension screening (annually)
 - ✓ Cholesterol screening (once; additional tests based on history)
 - ✓ Mammography (annually after age 40; recommended annually for younger females who are at high risk due to immediate family history)
 - ✓ Cervical cytology (annually for a sexually active woman; after three successive normal exams the test may be less frequent)
 - ✓ Colon cancer screening (digital rectal exam and stool blood test, annually after age 50 as well as baseline colonoscopy after age 50)
 - ✓ Sexually transmitted disease screening (at least once during pregnancy; other, based on history)
 - ✓ Tuberculosis screening (once; additional testing based on history or for AHCCCS members residing in a facility, as necessary per health care institution licensing requirements)
 - ✓ HIV-screening
 - ✓ Immunizations
 - ✓ Prostate screening (annually after age 50; recommended annually for males 40 and older who are at high risk due to immediate family history)



- ✓ Physical examinations, periodic health examinations or assessments, diagnostic work ups or health protection packages designed to: provide early detection of disease; detect the presence of injury or disease; establish a treatment plan; evaluate the results or progress of treatment plan or the disease; or to establish the presence and characteristics of a physical disability which may be the result of disease or injury.
Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.
- ☑ Physical examinations performed to satisfy the demands of outside public or private agencies such as the following are not covered services:
 - ✓ Qualification for insurance
 - ✓ Pre-employment physical examination
 - ✓ Qualification for sports or physical exercise activities (does not apply to EPSDT recipients)
 - ✓ Pilots examinations (FAA)
 - ✓ Disability certification to establish any kind of periodic payments
 - ✓ Evaluation for establishing third party liability
 - ✓ In accordance with AHCCCS Administrative Rule A.A. C. R9-22-205 preventive examination in the absence of any known disease or symptom for members 21 years of age or older

Prior Authorization requirements:

- ☑ Prior Authorization for medically necessary health risk assessment and screening services is not required

Hysterectomy Services

- ☑ AHCCCS covers medically necessary hysterectomy services.
- ☑ AHCCCS does not cover a hysterectomy service if it is performed solely to render the individual permanently incapable of reproducing.

- Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis, and, except for treatment of carcinoma and management of life-threatening hemorrhage, has been preceded by a trial of therapy (medical or surgical) which was proven unsatisfactory.
- Hysterectomy services may be considered medically necessary without trial of therapy in the following cases:
 - ✓ Invasive carcinoma of the cervix
 - ✓ Ovarian carcinoma
 - ✓ Endometrial carcinoma
 - ✓ Carcinoma of the fallopian tube
 - ✓ Malignant gestational trophoblastic disease
 - ✓ Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
 - ✓ Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruptio
- All claims for hysterectomy services are subject to medical review.
- A hysterectomy consent form (See Exhibit 8-1) or a hospital consent form that contains the same information as the hysterectomy consent form must be submitted with the claim.
 - ✓ The form must state that the patient will be permanently incapable of having children.
 - ✓ The form must be signed by the recipient, the physician who performs the hysterectomy, the person who obtains the recipient's consent and, if applicable, an interpreter.

Licensed Midwife Services

- A licensed midwife is an individual licensed by the Arizona Department of Health Services to provide maternity care pursuant to ARS §36-751 and AAC Title 9, Chapter 16, Article 1.
 - ✓ This provider type does not include certified nurse midwives licensed by the Arizona Board of Nursing as nurse practitioners or physician assistants licensed by the Arizona Board of Medical Examiners.



- Labor and delivery services provided by licensed midwives generally are provided in the recipient's home.
 - ✓ Licensed midwife services cannot be provided to AHCCCS recipients in a hospital, free-standing birthing center, or other licensed health care institution.
- Licensed midwives must obtain prior authorization from the AHCCCS Prior Authorization Unit.
 - ✓ Documentation certifying risk status of the recipient's pregnancy must be submitted to the PA Unit prior to providing licensed midwife services.
- Licensed midwife services may be provided only to pregnant AHCCCS recipients for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated.
 - ✓ The age of the recipient must be a consideration in the risk status evaluation.
 - ✓ Risk status must be determined at the time of the first visit and each trimester thereafter.
 - ✓ Recipients initially determined to have a high-risk pregnancy or recipients whose physical condition changes to high risk during the course of the pregnancy must immediately be referred to an AHCCCS-registered physician or practitioner.
- Upon delivery of the newborn, the licensed midwife is responsible for conducting the newborn examination and for referring the mother and newborn to a physician for follow-up care of any assessed problematic conditions.
- The licensed midwife also must notify the AHCCCS Administration's Newborn Reporting Line no later than three days after the birth in order to enroll the newborn with a health plan.
- Licensed midwives must bill on the CMS 1500 claim form
 - ✓ Licensed midwives must bill for delivery using CPT-4 code 59400 -- Routine obstetrical care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care.
 - ✓ Reimbursement is the lesser of billed charges or the AHCCCS capped fee.
 - Prenatal and postpartum care is bundled into one service, and all services related to the care of the pregnant woman are included in this reimbursement rate.
 - ✓ If complications arise during the pregnancy and the woman must be referred to a physician, the licensed midwife may bill for prenatal care only using CPT code 99212 -- Office or other outpatient visit for the evaluation and management of an established patient.
 - Each visit should be billed on a separate line.

Obstetrical Services

- Information about obstetrical visits and services normally provided in uncomplicated maternity cases (and included in AHCCCS' reimbursement for the global CPT codes) can be found in the current issue of the *Physician's Current Procedural Terminology* (CPT) code book.

- ✓ The CPT code book also provides information on the circumstances under which it is appropriate to bill separately for services not included in the global CPT codes, such as additional services required by medical complications of pregnancy.
- ☑ The global obstetrical (OB) package includes *all* OB visits prior to the delivery, the delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.
 - ✓ Only services not included in the global OB care CPT code may be billed separately.
 - ✓ Evaluation and management (E/M) codes for office and/or hospital visits may not be unbundled from the global OB code and billed separately.
 - ☑ Claims for these services will be denied when billed in addition to the global code.
- ☑ Physicians and certified nurse practitioners in midwifery (CNMs) may not bill the global OB package if the recipient has been seen for less than 5 visits prior to delivery.
- ☑ Providers *must* bill the global OB code if the recipient is seen five or more times prior to delivery.
- ☑ If a CNM refers a recipient to a physician for consultation, the physician may bill for the consult visit.
- ☑ If a CNM refers a recipient to a physician for on-going OB care, that physician may bill for the visits plus the delivery, unless the requirements for billing the global OB code are met.
 - ✓ The CNM who referred the recipient may bill for the visits that occurred prior to referring the patient to the physician for on-going OB care.
 - ✓ The CNM may not bill for the delivery or global OB code if the delivery is billed by another provider.
- ☑ Billing for other than total care
 - ✓ A provider may not bill the global OB code or codes for postpartum care if the delivery is the only service provided.
 - ✓ A provider who performs a *delivery and subsequent postpartum care only* should consult the CPT code book for the appropriate CPT codes.
 - ✓ A provider billing for *postpartum care only* should use CPT code 59430.
 - ✓ A provider billing for *antepartum care only* should use CPT codes 59425 (4 - 6 visits and services) or 59426 (7 or more visits and services).
 - ✓ For 1 - 3 antepartum care visits, a provider should use the appropriate E/M Codes.
- ☑ When billing delivery services for twin births, providers should bill only one global obstetric care code and one code for delivery only.
 - ✓ Global obstetric codes include all antepartum and postpartum services and therefore encompass all services rendered to the mother, including instances of multiple gestation.



- ✓ The global code also includes delivery services for one baby.
- ✓ Delivery of the second baby should be billed using the appropriate code for delivery only.

Ordering Provider (Effective 1/1/2012- Fee for Service only)

The following services require the submission of an ordering provider:

- ✓ Laboratory
- ✓ Radiology
- ✓ Medical and Surgical Supplies
- ✓ Respiratory DME
- ✓ Enteral and Parenteral Therapy
- ✓ Durable Medical Equipment
- ✓ Drugs (J-Codes)
- ✓ Temporary K codes
- ✓ Orthotics
- ✓ Prosthetics
- ✓ Temporary Q codes
- ✓ Vision codes (V-codes)
- ✓ 97001-97546

Ordering providers can only be one of the following provider types:

- ✓ M.D.
- ✓ D.O.
- ✓ Optometrist
- ✓ Physician Assistant
- ✓ Registered Nurse Practitioner
- ✓ Dentist
- ✓ Podiatrist
- ✓ Psychologist
- ✓ Certified Nurse Midwife

Claims submitted without the ordering provider will be denied.

Pathology and Laboratory Services

- Diagnostic testing and screening are covered services.
- Pass-through billing by which the physician pays the laboratory for tests and then bills AHCCCS for the lab services is not allowed.

- AHCCCS follows Medicare guidelines that specify which codes providers may bill using the professional (26) and/or technical component (TC) modifiers.
 - ✓ The laboratory portion of the claim must be billed with modifier TC.
 - ✓ The professional component of the laboratory service must be billed with modifier 26.
 - ✓ When the procedure code for the test is for the technical component only or the professional component only, the procedure should be billed without a modifier.
 - ✓ Laboratory tests with automated results do not have a professional component, and claims for the professional component should not be billed for those laboratory services.
- Laboratory services for hospitalized recipients must be included on the UB-04 inpatient claim.
 - ✓ These services may not be unbundled and billed separately from the inpatient claim.
- In accordance with Medicare guidelines, physicians may bill only a limited number of CPT codes for pathology services performed in a hospital setting.
 - ✓ AHCCCS follows Medicare guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital.
 - ✓ AHCCCS does not reimburse physicians for the technical portion of tests performed at hospitals or for any indirect costs, such as supervising the laboratory.
 - The hospital is reimbursed for the technical component of the test performed in its facility.
 - The hospital is also responsible for compensating employees supervising the lab.

Radiology and Medical Imaging Services

- Diagnostic testing and imaging and MRI are covered services.
- Positron emission tomography (PET) scans are covered only at PET imaging centers with PET scanners that have been approved by the FDA.
- No PA is required for medically necessary radiology and medical imaging services.
- Radiology services provided to hospitalized recipients must be included on the UB-04 claim.
 - ✓ These services may not be unbundled and billed separately from the inpatient claim.
 - ✓ The professional services of a radiologist may be billed separately with a 26 modifier.

Rehabilitative services

- AHCCCS covers physical, occupational, speech and respiratory therapy services that are:
 - ✓ Ordered by a physician, and
 - ✓ Provided by or under the direct supervision of a licensed therapist.



Occupational Therapists must be licensed by the Arizona Board of Occupational Therapy Examiners, or governing Board of the State where the therapist practices or a certified OT assistant (under the supervision of the occupational therapist) licensed by the Arizona Board of Occupational Therapy Examiners.

- ✓ AHCCCS covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP/attending physician. Inpatient occupational therapy consists of evaluation and therapy.
- ✓ Outpatient speech and occupational therapy services are covered only for EPSDT and ALTCS recipients.

Therapy services may include, but are not limited to:

- ✓ Cognitive training
- ✓ Exercise modalities
- ✓ Hand dexterity
- ✓ Hydrotherapy
- ✓ Joint protection
- ✓ Manual exercise
- ✓ Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device or splint
- ✓ Perceptual motor testing and training
- ✓ Reality orientation
- ✓ Restoration of activities of daily living
- ✓ Sensory reeducation, and
- ✓ Work simplification and/or energy conservation.

Physical Therapists must be licensed by the Arizona Board of Physical Therapy or the governing Board of the State where the therapist practices or a Physical Therapy Assistant (under the supervision of the PT) certified by the Arizona Physical Therapy Board of Examiners.

- ✓ Physical therapy (PT) is an AHCCCS covered treatment service to restore, maintain or improve muscle tone, joint mobility or physical function.
- ✓ AHCCCS covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's PCP/Attending physician as follows:

1. Inpatient

- a. Inpatient PT services are covered for all members who are receiving inpatient care at a hospital (or a nursing facility)
- 2. Outpatient
 - a. Outpatient PT services are covered for EPSDT and KidsCare members when medically necessary.
- In accordance with AHCCCS Administrative Rule A.A. C. R9-22-215 outpatient PT services are covered for adult members, 21 years of age and older (ACUTE and ALTCS) as follows:
 - ✓ AHCCCS members who are not Medicare eligible are limited to 15 outpatient visits per contract year regardless of whether or not the member changes Contractors. (contract year is defined as October 1-September 30).
 - ✓ Outpatient settings include, but are not limited to, physical therapy clinics, outpatient hospital units, FQHCS, home health agencies and physician offices.
 - ✓ Service limits will be applied to physical therapy CPT codes 97001-97546
 - ✓ A physical therapy visit is defined as:
 - An occurrence of CPT codes 97001-97546
 - Billed on form types 1500 and UB-04 outpatient
 - Any provider type except:
 - 13- Occupational therapist
 - 22- Nursing home
 - Any place of service excluding:
 - 31- Nursing home
 - 32- Nursing facility
 - 33- Custodial facility
 - ✓ Outpatient service limits will be calculated in the following manner:
 - AHCCCS enrolled recipients:
 - Services occurring on the same day with either the same or different providers will count as a single visit.
 - Multiple services provided on the same day will be counted as a single visit.
 - Member is Medicaid only and is not Medicare eligible. (Also known as non dual)
 - ✓ Contractor is responsible for the visit up to 15 PT visits per contract year.



Member is Dual Eligible (Also known as Medicare Primary, non QMB dual)

✓ Contractor is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to 15 PT visits.

In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will pay the Medicare cost sharing up to the 15 visit limit per contract year.

As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; **however** the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the members' responsibility.

In the event that the member exhausts the Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.

Member is QMB Dual

✓ Contractor is responsible for Medicare cost sharing up to Medicare maximum dollar amount.

In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached.

In the event that member exhausts the Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.

Definitions:

✓ **Visit** - a visit equals PT services received in one day per provider. The 15 visit limit applies regardless that the member has the same contractor or changes contractors during the contract year.



- ✓ **Setting** - Any out patient place of service. (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).
- ✓ **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.

✓ Physical therapy prescribed only as a maintenance regimen is excluded

✓ Authorized treatment services include, but are not limited to:

- The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment
- The administration, evaluation and modification of treatment methodologies and instruction, and
- The provision of instruction or education, consultation and other advisory services.

A qualified Speech-Language Pathologist (SLP) must be licensed by the Arizona Department of Health Services (ADHS) or a Speech-Language Pathologist who has a temporary license from ADHS and is completing a clinical fellowship year. He/she must be under the direct supervision of an ASHA certified Speech-Language Pathologist. AHCCCS registration will be terminated at the end of two years if the fellowship is not completed.

A qualified Speech-Language Pathology Assistant (SLPA) must be licensed by the Arizona Department of Health Services (ADHS). The SLPA must be identified as the servicing provider and bill for services under his or her individual NPI number. (A group ID number can be utilized to direct payment) SPLA's may only perform services under the supervision of a SLP and within their scope of service as defined by regulations.

- ✓ AHCCCS covers medically necessary speech therapy services provided to all members who are receiving inpatient care at a hospital (or a nursing facility) when services are ordered by the member's PCP or attending physician for FFS members. Speech therapy provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members.



- ✓ Speech therapy by qualified professionals may include the list below:

- Articulation training
- Auditory training
- Cognitive training
- Esophageal speech training
- Fluency training
- Language treatment
- Lip reading
- Non-oral language training
- Oral-motor development, and
- Swallowing training.

- ✓ Respiratory therapists must be billed with the following code:
 - S5180 Home health respiratory therapy, initial evaluation
- ✓ Respiratory therapists may not use CPT codes 94010 - 94799.
- ✓ Physicians and hospitals may use CPT codes 94010 - 94799.
- ✓ No outpatient rehabilitation services are covered for ESP recipients.

Prior authorization requirements:

- The following written documentation must be received by the AHCCCS/DFSM/PA Unit prior to the issuance of a PA number:
 - ✓ Nature, date, extent of injury/illness and initial therapy evaluation
 - ✓ Treatment plan, including specific services/modalities of each therapy, and
 - ✓ Expected duration and outcome of each therapy provided.
- Upon concurrent review and/or receipt of above documentation, which substantiates AHCCCS rehabilitation requirements, authorization will be given.
- Progress notes may be requested by the AHCCCS/DFSM/PA Unit every 10 days, as evidence of member progress for continued authorization (when there is no concurrent review).



Residents, Interns, and Teaching Physicians

- A hospital may not submit a claim for professional services rendered unsupervised by a resident or intern using the hospital's provider ID, the attending/teaching physician's provider ID, or the chief of staff's provider ID number.
- Patient services rendered by the attending/teaching physician solely in the capacity of teaching are excluded from reimbursement.
- The attending/teaching physician may submit a claim for professional services if:
 - ✓ The attending/teaching physician is present for a key portion of the time the service being billed was performed.
 - For deliveries, the attending/teaching physician must be present for the requisite number of prenatal visits and the delivery in order to bill the global OB code.
 - If the attending/teaching physician is present only for the delivery, he/she must bill the "delivery only" code. (See obstetrical services, Pages 10-19 to 10-20)
 - ✓ For surgery or dangerous/complex procedures, the attending/teaching physician is present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.
 - ✓ For inpatient and outpatient evaluation and management services, the attending/teaching physician is present during the key portion of the visit.
 - Documentation substantiating the above criteria must be available for audit purposes.
 - All claims are subject to postpayment review and recovery.

Supplies, Materials, Injectable Drugs

- AHCCCS does not reimburse providers on a fee-for-service basis for services billed using procedure code 99070 (Supplies and materials, except spectacles, provided by the physician over and above those usually included with the office visit or other services rendered).
- Providers must use the following codes rather than procedure code 99070:
 - ✓ J Codes for injectable drugs.
 - ✓ HCPCS codes for durable medical equipment and supplies.

Surgeon Billing

- Multiple surgical procedures performed on the same recipient on the same day must be billed using modifier 51.



- ✓ Providers should list the principal procedure on the first line of the CMS 1500 claim form and list the secondary surgeries on subsequent lines with modifier 51.
 - ☒ The principal procedure is reimbursed at the lesser of 100 percent of the capped fee or billed charges.
 - ☒ Each secondary surgical procedure is reimbursed at 50 percent of the capped fee or billed charges, whichever is less.
- ✓ If a claim is received without modifiers to indicate secondary procedures, the AHCCCS system identifies the first procedure on the claim as the principal procedure and prices it accordingly.
 - ☒ All other surgical procedures are identified as secondary and priced at 50 percent of the capped fee or billed charges, whichever is less.
- ✓ Claims with more than four secondary surgical procedures are subject to medical review.
- ☒ Certain modifiers indicate less than comprehensive surgical care.
 - 54 Surgical care only
 - 55 Post-operative management
 - 56 Pre-operative management
- ☒ If multiple surgeons participate in a surgery, the appropriate modifier is necessary to ensure proper payment of claims.
 - 80 Assistant surgeon (reimbursed at 20 percent of the capped fee or billed charges, whichever is less)
 - 62 Two surgeons
 - 66 Surgical team
- ✓ If multiple providers bill for the same procedure without modifiers, all but the first claim received will be denied as duplicates.
- ✓ Certain modifiers indicate less than comprehensive surgical care.
 - 54 Surgical care only
 - 55 Post-operative management only
 - 56 Pre-operative management only
- ☒ AHCCCS accepts modifiers 22 – Increased procedural services or 52 - Reduced services.
 - ✓ These modifiers do not impact reimbursement.
- ☒ Bilateral procedures performed during the same session are identified by using modifier 50 with the CPT code for the second (bilateral) procedure.



- When a procedure is repeated, use of the appropriate modifier reduces the likelihood that the claim will be denied as a duplicate.
 - 76 Repeat procedure or service by same physician
 - 77 Repeat procedure or service by another physician

- Modifier 78 indicates an unplanned return to the operating/procedure room by the same physician following the initial procedure for a related procedure during the postoperative period.

- Assistant surgeons, including RNFAs and physician assistants, must bill with modifier 80.
 - ✓ When billing multiple surgical procedures, secondary procedures should be billed with modifier 80 and modifier 51.
 - ✓ Assistant surgeons must use codes for delivery only when billing for Cesarean deliveries.

Telemedicine

- AHCCCS covers medically necessary services provided via telemedicine.
- Service delivery via telemedicine can be in one of two modes:
 - ✓ *Real time* means the interactive, two-way transfer of information and medical data, which occurs at two sites simultaneously: the hub site and the spoke site.
 - Hub site means the location of the telemedicine consulting provider, which is considered the place of service.
 - Spoke site means the location where the recipient is receiving the telemedicine service.
 - Diagnostic, consultation, and treatment services are delivered through interactive audio, video, and/or data communication.
 - ✓ *Store-and-forward* means transferring medical data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.
- The following medical services are covered, both real time and store-and-forward:
 - ✓ Cardiology
 - ✓ Dermatology
 - ✓ Endocrinology
 - ✓ Hematology/oncology



- ✓ Home health
- ✓ Infectious diseases
- ✓ Neurology
- ✓ Obstetrics/gynecology
- ✓ Oncology/radiation

- ✓ Ophthalmology
- ✓ Orthopedics
- ✓ Pain clinic
- ✓ Pathology
- ✓ Pediatrics and pediatric subspecialties
- ✓ Radiology
- ✓ Rheumatology
- ✓ Surgery follow-up and consultations
- Behavioral health services are covered for Title XIX (Medicaid) and Title XXI (KidsCare) recipients.
- Covered behavioral health services include (real time only):
 - ✓ Diagnostic consultation and evaluation
 - ✓ Psychotropic medication adjustment and monitoring
 - ✓ Individual and family counseling
 - ✓ Case management
- Non-emergency transportation to and from the spoke site to receive a medically necessary consultation or treatment is covered for Title XIX recipients only.
- Conditions and limitations
 - ✓ At the time of service delivery via real time telemedicine, the recipient's PCP, attending physician, or other medical professional employed by the PCP or attending physician who is familiar with the recipient's condition must be present with the recipient.
 - Other medical professionals include registered nurses; licensed practical nurses; clinical nurse specialists; registered nurse midwives; registered nurse practitioners; physician assistants; physical, occupational, speech, and respiratory therapists; and a trained telepresenter familiar with the recipient's medical condition.

- ✓ For real time behavioral health services, the recipient's physician, case manager, behavioral health professional, or telepresenter must be present with the recipient during the consultation.
 - ✓ All services provided via telemedicine must be reasonable, cost effective and medically necessary for the diagnosis or treatment of a recipient's medical or behavioral health condition.
- Services must be billed on a CMS 1500 claim form using the "GT" modifier to designate the service being billed as a telemedicine service.
- ✓ Services are billed by the consulting provider.

Unlisted or Unspecified Services

- Procedure codes for unspecified or unlisted procedures (identified by CPT codes ending in "99") should only be billed in situations where no other code adequately describes the service performed.
- Providers who bill procedure codes for unspecified or unlisted procedures must include documentation that describes the service rendered.
- Claims with such procedure codes are subject to Medical Review.

Ventilator Management

- Providers should not bill AHCCCS for any E/M service when submitting claims for ventilator management services.
- CPT Codes 94002 (Ventilation assist and management, first day); 94003 (Ventilation assist and management, subsequent days) and 94004 (Ventilation assist and management, nursing facility, per day) are global procedure codes.
- Claims with an E/M code in addition to a ventilator management code are subject to denial during Medical Review.

Exhibit 8-1

HYSTERECTOMY CONSENT FORM

Arizona Health Care Cost Containment System
(AHCCCS)
Hysterectomy Consent Form

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be undone and it will permanently prevent you from having children. A hysterectomy should only be done when there is a disease of the woman's uterus or some other problem that can only be treated by removing the uterus. It is a serious operation and there are discomforts and a chance of serious health problems.

AHCCCS does not cover hysterectomy procedures when performed only for the purpose of rendering an individual sterile.

By signing below, I hereby consent of my own free will to be sterilized by a hysterectomy which will render me permanently incapable of reproducing. My signature also acknowledges that I have read and understood the above information.

Patient Signature

Date

Patient AHCCCS Identification Number

Patient Social Security Number

In accordance with Federal Regulation, 42CFR §441.258, the signatures and dates below are required in order for reimbursement to be made.

Physician who performed the hysterectomy

Date

Person who obtained the patient's consent
to the hysterectomy

Date

Interpreter, if provided

Date

**This Page
Intentionally
Left Blank**