ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

PROFESSIONAL/1500 ENCOUNTER RECEIVED – DETERMINE IF CONSIDERATION FOR PCP ENHANCED RATE CRITERIA IS MET:

1. Begin date of service must be > or = to 1/1/2013 and End date of service must be < or = to 12/31/2014;
2. Service/Rendering Provider Type must be = 08, 18, 19 or 31;
3. PCP Specialty Code must appear on PR030 and the PCP Indicator must = B – attested Board Certified, 6 – attested 60 %; or 7 – new provider attested 60%. *If the indicator is "blank" or N – provider is not eligible enhanced rates.* The C – verified board certified indicator may also appear but will be associated with the specific specialty code for which the provider is Board certified and is for informational purposes only;
4. Dates of service on the encounter must fall within the Begin and End dates for Provider "PCP" Specialty Code; (*Included in weekly Provider Extracts to Contractors.*
5. The Provider Tax Id submitted on the Encounter must not be defined as belonging or related to an FQHC or FQHC look alike*;* and/or Place of Service must not be = 50 FQHC or 72 RHC. *(List will be provided to Contractors)*
6. CN1 Code is <u>not</u> equal to 09 and recipient <u>does not</u> have a 25 exception code for the date of service.

Yes, above criteria is met.

If all criteria are met, go to New Rate Schedule RF144 and check for applicable rate for the procedure on the encounter for the reported dates of service. *Only those procedures eligible for enhanced rates will be on this table.* Modifier related amounts/%;'s with exception of the SL Modifier are not impacted by this initiative. If a SL modifier is reported, go to New Modifier table RF147 to obtain the applicable rate for the modifier

Rate Not Found on RF144

No, above criteria is not met.

If all criteria not met, or rate or procedure not found on RF144, continue to use current Fee Schedule (RF142/RF112 as applicable).

Rate Found on RF144/RF147

Use Rate from RF144 for the encounter date of service to calculate the AHCCCS Allowed for the encounter. If applicable to the provider type 18 and 19 (per RF618) apply Provider Type %'s reduction to the calculated AHCCCS Allowed Amount. Apply applicable Medicare calculations, Other Insurance Payments, etc.);
Set Pay1 code to PCP, and update subcap code on the encounter to the appropriate value as outlined on page 8 of this document, UNLESS <u>CN1</u> code on the Encounter is 05, <u>and</u> Plan Allowed is greater than > or equal to = Plan Paid; or the Plan Paid is greater than the calculated AHCCCS Allowed plus interest or minus Other Insurance Paid.

NEW EDITING – (applying <u>all</u> criteria – 1500 Form type, dates of service, provider type etc… as noted in box 1)
Edit A650 – AHCCCS valuation logic indicates that PCP enhanced rates should apply to the encounter, but based upon Plan Paid Amount was not applied. (AHCCCS Pay1 code = PCP; check plan paid if not equal to or greater than AHCCCS Allowed (plus interest if applicable, minus Other Insurance Paid if applicable or minus AHCCCS copay if applicable) or the Billed Charge whichever is less).
Edit A655 – AHCCCS valuation logic indicates that PCP enhanced rates should not apply to the encounter, but based upon Plan Paid Amount was applied. (AHCCCS Pay 1 code not equal to PCP; check plan paid if not equal AHCCCS allowed (plus interest if applicable) but equal rate applicable from RF144).

OTHER EDIT CONSIDERATIONS – Existing editing must accommodate Plan Allowed Amounts which are less than Plan Paid Amounts.

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

REPORTING OF ENCOUNTERS:

Contractors must include indication of payment of enhanced rates versus non-enhanced rates within submitted encounters for trending, analysis, and reimbursement for Contractors is as outlined by each of the following scenarios. Contractors must continue to build appropriate CAS segments for all scenarios. (Examples assume scenarios meet all basic criteria for consideration - 1500 Form type, dates of service, provider type etc… as outlined in the flowchart). Formula – (Enhanced minus COB) minus (Allowed minus COB).

1. No Subcap arrangement with provider: "Pay Parity Rate" –
   Health Plan Allowed = Non-enhanced payment rate
   Health Plan Paid = Enhanced payment rate (or Billed Charge if less)

   a. EXAMPLE:
      Billed Charge = $175.00
      Non-enhanced payment rate = $100.00 (= Health Plan Allowed)
      Enhanced payment rate = $113.00 (= Health Plan Paid)
      Payment to MCO will be $13.00

2. No Subcap arrangement with Provider/Other Insurance Payment on claim; Other Insurance Allowed less than Health Plan Allowed: "Pay Parity Rate less Other Insurance Payment" -
   Health Plan Allowed = Non-enhanced payment rate
   Health Plan Paid = Enhanced payment rate (or Billed Charge if less) minus Other Insurance Payment

   a. EXAMPLE:
      Billed Charge = $175.00
      Other Insurance allowed = $90.00
      Other Insurance payment = $40.00
      Non-enhanced payment rate = $100.00 (Health Plan Allowed)
      Enhanced payment rate = $113.00 (Health Plan Paid = $63.00)
   Payment to MCO will be $13.00- AHCCCS will consider Other Insurance payment in calculation using the lessor or Other Insurance Allowed or Health Plan Allowed.

   Other Insurance Allowed greater than Health Plan Allowed: "Pay Parity Rate less Other Insurance Payment" -
   b. EXAMPLE:
      Billed Charge = $175.00
      Other Insurance allowed = $120.00
      Other Insurance payment = $40.00
      Non-enhanced payment rate = $100.00 (Health Plan Allowed)
      Enhanced payment rate = $113.00 (Health Plan Paid = $73.00)
      Payment to MCO will be $13.00- AHCCCS will consider Other Insurance payment in calculation

1. Subcap arrangement with provider is < Parity Rate: "Pay Parity Rate" -
   Health Plan Allowed = Non-enhanced subcap payment rate would have paid
   Health Plan Paid = Difference between subcap payment rate would have paid and the Enhanced payment rate (or Billed Charge if less) plus Interest paid (if applicable)

   a. EXAMPLE:
      Billed Charge = $175.00
      Non-enhanced subcap arrangement = $90.00 (= Health Plan Allowed)
      Enhanced payment rate = $113.00 (Health Plan Paid = $23.00)
      Payment to MCO will be $23.00

   b. EXAMPLE WITH INTEREST:
      Billed Charge = $175.00
      Interest Amount = $10.00

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

Non-enhanced subcap arrangement = $90.00 (= Health Plan Allowed)
Enhanced payment rate = $113.00 (Health Plan Paid = $33.00)
Payment to MCO will be $23.00-AHCCCS will deduct Interest Paid

2. Subcap arrangement with provider is < Parity Rate/Other Insurance Payment on claim:
"Pay Parity Rate less Other Insurance Payment" - (Health Plan Allowed <= Other Insurance Allowed)
Health Plan Allowed = Non-enhanced subcap payment rate would have paid
Health Plan Paid = Difference between subcap payment rate would have paid and the Enhanced payment rate (or Billed Charge if less) minus Other Insurance Payment

a. EXAMPLE:
Billed Charge = $175.00
Other Insurance allowed = 100.00
Other Insurance payment = $40.00
Non-enhanced subcap arrangement = $90.00 (Health Plan Allowed)
Enhanced payment rate = $113.00 *($73.00 = enhanced payment - OTI*) (Health Plan Pd = $23.00)
Payment to MCO will be $23.00- AHCCCS will consider Other Insurance payment in calculation

3. Subcap arrangement with provider is > or = Parity Rate:
"Pay Subcap Rate" – no additional reimbursement to the Contractor.
Health Plan Allowed = No change to current process
Health Plan Paid = No change to current process

a. EXAMPLE:
Billed Charge = $175.00
Non-enhanced payment rate = $115.00 (= Health Plan Allowed)
Enhanced payment rate = $113.00 (Health Plan Paid = $0.00)
No additional payment to MCO

b. EXAMPLE: ADD – Plan Paid > Parity Rate

4. Medicare Primary No Subcap arrangement with provider: "Pay Lessor of Patient Responsibility, or Parity Rate minus Medicare Paid"-
Health Plan Allowed = Lessor of Patient Responsibility, or Non-enhanced payment rate minus Medicare Paid
Health Plan Paid = Lessor of Patient Responsibility, or Enhanced payment rate minus Medicare Paid (or Billed Charge if less)

a. EXAMPLE:
Billed Charge = $175.00
Medicare Allowed/Approved = $140.00
Medicare Paid = $80.00
Patient Responsibility = $60.00
Non-enhanced payment rate = $100.00 (Health Plan Allowed = $100.00)
Calculated Lessor of Amount = $20.00
Enhanced payment rate = $113.00 (Health Plan Paid = $33.00)
Payment to MCO will be $13.00

b. EXAMPLE:
Billed Charge = $175.00
Medicare Allowed/Approved = $140.00
Medicare Paid = $80.00
Patient Responsibility = $15.00
Non-enhanced payment rate = $100.00 (Health Plan Allowed = $100.00)
Calculated Lessor of Amount = $15.00
Enhanced payment rate = $113.00 (Health Plan Paid = $15.00)
No additional payment to MCO

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

5. Medicare Primary Subcap arrangement with provider < Rate Parity: "Pay Lessor of Patient Responsibility or Parity Rate minus Medicare Paid"-
   Health Plan Allowed = Lessor of Patient Responsibility, or Non-enhanced payment rate minus Medicare Paid
   Health Plan Paid = Lessor of Patient Responsibility, or Enhanced payment rate minus Medicare Paid (or Billed Charge if less)

   a. EXAMPLE:
      Billed Charge = $175.00
      Medicare Allowed/Approved = $140.00
      Medicare Paid = $80.00
      Patient Responsibility = $60.00
      Non-enhanced subcap arrangement = $90.00 (Health Plan Allowed = $90.00)
      Calculated Lessor of Amount = $10.00
      Enhanced payment rate = $113.00 (Health Plan Paid = $33.00)
      Payment to MCO will be $23.00

   b. EXAMPLE:
      Billed Charge = $175.00
      Medicare Allowed/Approved = $140.00
      Medicare Paid = $80.00
      Patient Responsibility = $15.00
      Non-enhanced payment rate = $100.00 (Health Plan Allowed = $100.00)
      Calculated Lessor of Amount = $15.00
      Enhanced payment rate = $113.00 (Health Plan Paid = $15.00)
      No additional payment to MCO

6. Billed Charge < Rate Parity: "Pay Billed Charges" –
   Health Plan Allowed = No change to current process
   Health Plan Paid = No change to current process

   a. EXAMPLE:
      Billed Charge = $105.00
      Non-enhanced payment rate = $115.00 (= Health Plan Allowed)
      Enhanced payment rate = $113.00 (Health Plan Paid = $105.00)
      No additional payment to MCO

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

MCO COST SETTLEMENT PAYMENTS:

Payments to Contractors will be based upon adjudicated /approved encounter data, flagged by an AHCCCS subcap code 10 or 11 as eligible for PCP Enhanced Payment.

On a quarterly basis Contractors will be sent a report with all Encounter CRNs (and other key identifying data) that have been reported, and validated as correctly paid, by Contractors using enhanced rates since the last quarter (based upon the Encounter adjudication status date). Layout of this Reporting is included below.

Contractors will be given a two-week review period to review and tie their payments to the report. Contractor will agree or comment on the reported CRNs and amounts, and cost settlement payment will be made based upon the finalized list of CRNs.

Contractors will be required to include all reprocessed claims in their reported encounters and refund payments to AHCCCS for any reduced claim payments in the event that a provider is subsequently "decertified" for enhanced payments due to audit.

AHCCCS will provide a reasonable timeline or window of opportunity for Contractors to comply with this requirement, and will work with the Contractor to help identify impacted Encounter CRNs for the Contractor.

RETROACTIVE REPROCESSING OF IMPACTED CLAIMS:

In the event that a provider is retroactively flagged as Board Certified or Attested (60%, New Provider or Board certified) or loses this designation as noted above, Contractors will be afforded a maximum of 4 months during which it is expected that impacted claims will be identified and automatically reprocessed for enhanced payment or the recoupment of enhanced payments. It is expected that this reprocessing will be conducted by the Contractor without requirement of further action by the provider.

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

CN1 CODE TO SUBCAP CODE CROSSWALK:

CN1 CODE	CN1 DESC	TRANSPLANT RCP (MEMBER EXCEPTION CODE '25' TRANSPLANT)	ELIGIBLE FOR PCP RATE	SUBCAP CODE	ELIGIBLE FOR PCP ENHANCED RATE	
01	Diagnosis Related Group (DRG)	N	N	00 (FFS)	*Y*	*10 (FFS) (PCP Rate Parity)*
02	Per Diem	N	N	00 (FFS)	*Y*	*10 (FFS) (PCP Rate Parity)*
03	Variable Per Diem	N	N	00 (FFS)	*Y*	*10 (FFS) (PCP Rate Parity)*
04	Flat	N	N	00 (FFS)	*Y*	*10 (FFS) (PCP Rate Parity)*
05	Capitated	N	N	01 (SUBCAPITATED)	*Y*	*12 (SUBCAPITATED) (PCP Rate Parity)*
06	Percent	N	N	00 (FFS)	*Y*	*10 (FFS) (PCP Rate Parity)*
09	Other	N	N	08 (Negotiated Settlement)	*Y*	*13 (Negoitated Settlement) (PCP Rate Parity)*
01	Diagnosis Related Group (DRG)	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	*Y*	*11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
02	Per Diem	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	*Y*	*11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
03	Variable Per Diem	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	*Y*	*11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
04	Flat	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	*Y*	*11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
05	Capitated	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	*Y*	*11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
06	Percent	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	*Y*	*11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
09	Other	Y	N	04 (Transplant Svc for Transplant Rcp)	*Y*	*14 (Transplant Svc for Transplant Rcp) (PCP Rate Parity)*
			NA	06 (Denied, per File type .deny)	NA	

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

FIELD DEFINITION	FIELD NAME	TYPE	LENGTH	COMMENTS	
Submitting Health Plan ID	CLM-HP-ID	X	6		1-6
Submitting Health Plan County	CLM-HP-LOC-CD	X	2		7-8
Submitting Health Plan TSN	TP-SUPL-ID	X	2		9-10
Adjudication Status	ADJU-STA-O	X	2	*31 – Approved, 32 – Voided Original, 33 – Replaced Original*	11-12
Adjudication Date	STA-EFF-DAT	X	8		13-20
HCPCS/CPT Code	HCPCS-PROC-CD	X	5		21-25
Service Begin Date	SRV-BEG-DAT-O	X	8		26-33
Service End Date	SRV-END-DAT-O	X	8		34-41
Service Provider NPI	SER-PR-NPI	X	10		42-51
Service AHCCCS Provider ID	SER-PR-ID	X	6		52-57
Service Provider Type	SER-PR-TYP	X	2		58-59
Tax ID Number	BIL-PR-TAX-ID	X	9	As reported on the Encounter	60-68
Claim/Encounter Reference Number	CRN	X	14		69-82
Prior CRN	PRR-CRN	X	14	*If Applicable*	83-96
Health Plan CRN	HP-CLM-NO	X	30		97-126
Recipient AHCCCS ID	PRI-AHCCCS-ID	X	9		127-135
Sub-capitated Code	SUBCAPITATED-CD	X	2		136-137
CN1 Code	CN1-CODE	X	2		138-139
Billed Charge		D	9		140-148
Health Plan Allowed Amount	HP-ALLOW-AMT	D	9		149-157
Health Plan Paid Amount	HP-PAID-AMT	D	9		158-166
Other Insurance Allowed		D	9		167-175
Other Insurance Paid		D	9		176-184
Medicare Approved		D	9		185-193
Medicare Paid		D	9		194-202
Interest Paid		D	9		203-211
Co-Pay Amount	From Co-Pay Table	D	9		212-220

ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW

FIELD DEFINITION	FIELD NAME	TYPE	LENGTH	COMMENTS	
PCP Parity Payment Rate		D	9	*From Fee Schedule (RF144) – minus Provider Type Discount (Equal AHCCCS Allowed Amount)*	221-229
Calculated PCP Rate Parity Amount		D	9	*AHCCCS calculated*	230-238
Provider Attestation Type		X	1	*C- Board Certified; B-Board Certified Attested;6-60% Attested; 7-New Provider 60% Attested;N-Not Qualified*	239-239
PCP Indicator Begin		X	8		240-247
PCP Indicator End		X	8		248-255
PCP Indicator Last Modified Date		X	8		256-263
Vaccine Indicator		X	1	Blank - For Future Use	264-264
Total Encounter Count		D	8	Blank - For Future Use	265-272
Total Calculated PCP Rate Parity Amount		D	9	Blank - For Future Use	273-281