



Welcome!

# IHS/638 Quarterly Forum

October 18, 2017  
1:30 – 3:00 PM



# Submitting Medicare Part B Claims



# Medicare Part B Only Inpatient Claim

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Medicare pays under Part B for physician services and for non-physician medical and other health services listed in section 240 when furnished by a participating hospital to an inpatient of the hospital when patients are not eligible or entitled to Part A benefits or the patient has exhausted their Medicare Part A benefits and have **Part B benefits only**.

# Crossover

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Medicare will automatically forward any inpatient Medicare approved claims to AHCCCS for secondary payment. This process includes any inpatient facility claims for Medicare recipients that have PART B coverage only.

Note: Denied Medicare claims are *never forwarded to AHCCCS by Medicare.*

# Process

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1. If the crossover claim is in an approved status – the provider should initiate a void and replacement. The Medicare cross-over CRN (**12 digits only**) must be referenced in Box 64 on the UB-04 form.
2. The provider must include a copy of the Medicare Part B Explanation of Benefits (all pages) with the replacement claim. AHCCCS will not use the payment information from the Medicare cross-over claim.
3. If the provider has submitted a replacement claim, but failed to indicate the “original CRN”, the provider must resubmit the replacement claim following AHCCCS guidelines.

# Summary

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- To properly bill AHCCCS the provider must replace or void the paid Medicare crossover claim and re-bill the claim with the appropriate revenue for payment of the all-inclusive rate. Failure to do so will cause a denial.
- Note: this only applies to IHS/638 facilities.
- The Part B EOB must also be submitted.

# Questions?

Please email

[ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)



# Thank You.







# Face to Face Requirements

Home Health Services  
Medical Equipment and  
Supplies



# Face to Face Requirements

Effective 10/1/17 for  
Fee-For-Service (FFS)



# Face to Face Requirements 10/1/17

Face to Face Requirements (42 CFR §440.70) apply to initiation of services provided under the Home Health Benefit to FFS members:

- Home Health Services under 42 CFR §440.70 provided by a Home Health Agency, and including,
- Medical supplies, equipment, and appliances (medical equipment/supplies) provided under the Home Health Benefit.

# Face to Face Requirements (cont.)

Home health services are provided to a member:

- At his (or her) place of residence.
- On his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except:
- Medical equipment/supplies must reviewed by a physician annually.

# Face to Face Requirements (cont.)

- A Face-to-face encounter related to the primary reason the member requires the services must occur:
  - Home Health Services - within 90 days prior to or 30 days following the start of services.
  - Medical equipment/supplies: no more than 6 months prior to the start of services.

# Face to Face Requirements (cont.)

The face-to-face encounter must be conducted by one of the following:

- The ordering physician,
- A nurse practitioner, clinical nurse specialist, or certified nurse midwife (CNM excluded for medical equipment/supplies),
- A physician assistant under the supervision of the ordering physician, or
- For members admitted to home health immediately after an acute or post acute stay, the attending acute or post acute physician.

# Face to Face Requirements (cont.)

- Non-physician must communicate the clinical findings of the encounter to the ordering physician.
- Ordering physician must incorporate the clinical findings into the member's record, document who conducted encounter, date & within timeframes.
- Ordering physician include encounter/date/dx information on prescription order.
- Encounter may occur through telehealth.

# Face to Face Requirements (cont.)

Medical equipment/supplies:

- An additional face-to-face encounter is only required if a new medical equipment or supply is needed.
- Renewals, repairs, and the need for ancillary equipment do not require a face-to-face encounter.
- Renewal requires annual physician review.



# Questions?



# Thank You.



# AHCCCS, Inmates and the Department of Corrections



# Medicaid and Corrections Systems

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- Medicaid cannot pay for medical services provided in prisons or jails.
- People who are arrested and incarcerated can enroll in Medicaid and become eligible for benefits in the community after they are released from incarceration.
- Incarcerated persons are not covered by AHCCCS if they are brought to the IHS/638 facility by any jail, prison or detention center.



# Enrollment Suspense IGA

- AHCCCS suspends enrollment upon incarceration, instead of terminating coverage.
- This allows the department of corrections and counties to send discharge dates for AHCCCS members and coverage can be reinstated.
- Care can be coordinated by county jails or prisons upon discharge for over 95% of members involved in Arizona's criminal justice system.

# Pre-Release Applications

- Individuals who are at risk of an institutional level of care upon their release, receive a pre-admission screening while incarcerated and have a Medicaid application completed.
- When eligible, the member is connected to the Arizona Long Term Care System (ALTCS) program and placed into a long-term care setting immediately upon their release.



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# Pre-Release Applications (cont)

- In Maricopa County, jail staff, DES staff and Community Assistors partner to assist detainees with substance use disorders to complete and submit applications for AHCCCS Health Insurance 30 days prior to their release.
- Approval of applications are held until release from incarceration is confirmed.
- This pre-release application process targets persons who are in critical need of treatment for substance use disorder and enables enrollment in AHCCCS immediately upon release.



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# Care Coordination

- All AHCCCS Managed Care Organizations (MCOs) are contractually required to provide “reach-in” care coordination to identify members with complex health needs prior to their release from incarceration.
- MCOs (including Regional Behavioral Health Authorities (RBHAs)) connect case managers to members pre-release to provide information and schedule appointments with primary care physicians and behavioral health providers, as appropriate.



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# Transition out of the Criminal Justice System

- <https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/justiceinitiatives.html>



# Hospital Inpatient IGA

- When a detainee is released from custody temporarily to an inpatient hospital setting, designated staff assist the detainee with completing an application for AHCCCS Health Insurance.
- The application is submitted to a special unit that determines AHCCCS eligibility for the specific period of the hospital stay.
- When the detainee is determined eligible, the hospital will submit a bill to AHCCCS to pay for the brief hospital stay.

# Department of Corrections

- AHCCCS is contract with over 9 State and County Department of Correction (DOC) agencies.
- AHCCCS Role
  - Process claims on behalf of the contracted DOC agencies.
    - Each County Contract has it own unique branding (criteria code and recipient exception code)
    - DOC agencies are responsible for state share of the costs.
    - Claims follow AHCCCS guidelines



# Thank You.





# Dental Updates

Effective 10/1/17



# Introduction

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Senate Bill 1527 established a \$1,000 emergency dental benefit for emergency dental care and extractions, for all members 21 years of age and older. This benefit is \$1,000 per member per contract year (October 1<sup>st</sup> to September 30<sup>th</sup>).

- This affects our Fee-For-Service Acute members 21 years of age and older, and our ALTCS and Tribal ALTCS members 21 years of age and older.

# What is a Dental Emergency?

- As defined in AMPM 310-D1 a dental emergency is “an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.”



# Examples of Covered Services in a Dental Emergency

- Emergency oral diagnostic examination (limited oral examination – problem focused),
- Radiographs and laboratory services, limited to the symptomatic teeth,
- Composite resin due to recent tooth fracture for anterior teeth,
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only,
- Re-cementation of clinically sound inlays, onlays, crowns, and fixed bridges,
- Pulp cap, direct or indirect plus filling,
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain,
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis,
- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition,
- Tooth re-implantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis,
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment),
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods,
- Preoperative procedures and anesthesia appropriate for optimal patient management, and
- Cast crowns limited to the restoration of root canal treated teeth only.

# What Does This Change for FFS Acute Members 21 Years of Age and Older?

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- These members previously had no dental benefit. They only had medical and surgical services furnished by a dentist covered, only to the extent that such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician (A.A.C. R9-22-207), per AMPM 310-D1.
- Now members 21 years of age and older have a \$1,000 dental benefit per member, per contract year to cover emergency dental care and extractions.

# What does this change for ALTCS and Tribal ALTCS members?

- Previously ALTCS and Tribal ALTCS members had a \$1,000 benefit per member, per contract year to cover medically necessary diagnostic, therapeutic, and preventative care services (this included dentures).
- Now ALTCS and Tribal ALTCS members also have a \$1,000 benefit per member, per contract year to cover emergency dental care and extractions.
- \*\*\*Overall they now have \$2,000 per year, but the allotments are separated out into the two categories: 1) \$1,000 for diagnostic, therapeutic and preventative care and 2) \$1,000 for emergency dental care and extractions.

# Important Note

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- Any unused benefits by Fee-For-Service members, 21 years of age and older, ALTCS members, or Tribal ALTCS members will not be permitted to “carry-over” into the next contract year.

# Informed Consent

## What is an informed consent?

Informed consent is a process by which the provider advises the member/guardian/designated representative of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

## Informed consents for oral health treatment include:

- A written consent for examination and/or any treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six month follow-up appointment.
- A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/guardian/designated representative receiving a copy of the complete treatment plan.

# Informed Consent

**All providers** shall complete the appropriate informed consents and treatment plans for AHCCCS members as listed previously, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member/guardian/designated representative.

This requirement extends to all Contractor mobile unit providers. Consents and treatment plans shall be in writing and signed/dated by both the provider and the patient, or patient's representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. §14-5101).

Completed consents and treatment plans must be maintained in the members' chart and are subject to audit.

# Charges to Members

- Emergency dental services of **\$1000** per contract year are covered for AHCCCS members age 21 years and older. Billing of AHCCCS members for emergency dental services in **excess** of the \$1000 annual limit is permitted **ONLY** when the provider meets the requirements of A.A.C R9-22-702 (for acute members) and A.A.C. R9-28-701.10 (for ALTCS members).
- In order to bill the member for emergency dental services exceeding the \$1000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the \$1000 limit and is not covered by AHCCCS.
- Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by AHCCCS and that the member agrees to pay for the amount exceeding the \$1000 emergency dental services limit, as well as services not covered by AHCCCS.
- The member **MUST** sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contain information describing the type of service to be provided and the charge for the service.

# For ALTCS Members

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## Notification Requirements for Charges to Members

Providers shall provide medically necessary services within the ALTCS \$1,000 dental benefit allowable amount. In the event that medically necessary services are greater than \$1,000, the provider may perform the services as set forth in A.A.C. R9-28-701.10 and R9-22-702, after the following notifications take place.

In accordance with A.A.C. R9-28-701.10 and R9-22-702 (Charges to Members), the provider must inform/explain to the member both verbally and in writing, in the member's primary language, that the dental service requested is not covered and exceeds the ALTCS \$1,000 limit. If the member agrees to pursue the receipt of services:

The provider must supply the member a document describing the service and the anticipated cost of the service.

Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeds the ALTCS \$1,000 limit.



# Questions?



# Thank You.





# Sara Salek

Chief Medical Officer

[AHCCCS Covered Behavioral Health Services Guide](#)



# Thank you!

