

**Q: Who determines the provider type? Does this happen during provider Registration?**

**A:** The Provider Registration production staff determined the provider type based on the licenses and the information provided by the provider on the application.

**Q: Can you verify that the timely filing limit is 1 year for IHS/638 facilities where 100% FFP is available?**

**A:** *In accordance with A.A.C. R9-22-703 (B)4 "Unless a shorter time is specified in the contract, the Administration shall not pay a claim submitted by an IHS or tribal facility for a covered service, unless the claim is initially submitted within 12 months from the date of service, date of discharge, or eligibility posting, whichever is later." A clean claim must be submitted within 12 months from the date of service or discharge date or eligibility posting. AHCCCS Billing Manual for IHS/Tribal Providers General Billing rules, Chapter 4, page 4-2.*

<http://www.azahcccs.gov/commercial/Downloads/IHS-TribalManual/IHS-Chap04GenBillRules.pdf>

**Q: Where is MedImpact formulary on AHCCCS website?**

**A:** On the right side of the menu, under section "Common Resources", select "Pharmacy Information", then select one of the three ADLs listed as appropriate:

- the AHCCCS Fee-For-Service Drug List (ADL)
- the AHCCCS Fee-For-Service Drug List (ADL) – Duals
- the AHCCCS Fee-For-Service Drug List (ADL) – TRBHA Behavioral Health

<http://www.azahcccs.gov/commercial/pharmacyupdates.aspx>

For more information regarding the formulary, contact MedImpact at (800)788-2949.

**Q: When a KidsCare member is seen at an IHS/638 facility who should be billed?**

**A:** When a KidsCare (Title XXI) recipient is enrolled in a managed care plan, and receives services at an IHS/638 facility, the managed care plan should be billed.

**Q: Which claim form is utilized when billing inpatient laboratory and radiology services billed on a 1500 or a UB claim form?**

**A:** Inpatient laboratory services are included in the inpatient AIR and cannot be billed separately. Inpatient radiology technical component services are included in the inpatient AIR (billed on a UB claim form).

Inpatient radiology reading services can be billed on a 1500 claim form with the appropriate code and modifier.

**Q: Can IHS/638 facilities bill for outpatient laboratory and radiology services on the same day as a doctor visit?**

**A:** Note: xray/imaging has 2 parts or components:

- Taking the xray/image using the facilities equipment is the technical component or TC.
- Physician reading and interpreting the xray/image is the professional component)

Reading services modifier 26, can be billed on a 1500 claim form for codes where the professional and technical split is appropriate.

When a covered radiology service is completed in a facility the technical portion of the service is billable by the facility on a UB04.

**Laboratory Stand Alone/Orphan visits:**

- If during a billable provider visit, a lab test is ordered for that day's assessment and the patient decides to get the lab work on another day, this should be billed as ONE All Inclusive Rate on a UB04.
- If, during a billable provider visit, the provider makes a care plan that includes laboratory tests for another time, i.e. a new medicine is started and a laboratory assessment is required after initiation of therapy, the patient would then return again for the planned laboratory assessment. This can be billed separately as an All Inclusive Rate claim on a UB04.

**Examples:**Outpatient doctor visit with labs ordered (regardless of when the labs were performed)

- Bill 1 clinic AIR on a UB claim form.

Outpatient doctor visit with xray/imaging ordered (regardless of when the xray/imaging was performed)

- Bill 1 clinic AIR on a UB claim form (the xray/imaging TC (technical component) is included in the AIR).
- Bill on CMS 1500 for the radiologist's professional service with appropriate CPT codes and modifier -26. The radiologist must be an active AHCCCS registered provider.

**Q: How should a same day admit and discharge claim be billed?**

A: Same day admit/discharge should be billed as inpatient. AHCCCS will reimburse the IHS/638 facility at the outpatient All Inclusive Rate (AIR)

**Q: How do IHS/638 facilities submit claims for case managers? What if our RN's are not registered AHCCCS providers?**

A: Case management is only billable as a claim for behavioral health services. Case management services must be billed on a 1500 claim form using the appropriate HCPCS code, place of service, modifier, and diagnosis. Only an AHCCCS registered provider that has this service in their provider profile can bill for this service. AHCCCS does not register RN's.

**Q: If a behavioral health provider has a one on one session with a member in the morning and then also treats the member in the afternoon in a group session can two (2) outpatient AIR claims be billed?**

A: Yes, two AIR claims can be billed for that member. For example:

The member comes in for a 10:00AM group therapy session, then immediately after the group therapy session, the member has an individual therapy session with a different attending provider. This would be billed as two (2) separate clinic visits.

If the member is a "walk-in", is triaged, then has an individual therapy session (or a group therapy session) this is 1 clinic visit. The "triage" service is not billable separately.

The key distinctions to determine would be:

- Is the attending (servicing) provider AHCCCS registered?
- Is the service covered by AHCCCS?
- Were the services completed at different times, and
- Are the services separate and distinct?

**Q: Can the same provider perform 5 different outpatient AIR services in the same day?**

A: Refer to the previous answer above.

**Q: Are physical therapy services covered?**

- A: AHCCCS covers medically necessary PT services for recipients, in an inpatient or outpatient setting, when services are ordered by the recipient's PCP/Attending physician as follows:
- PT is covered for Inpatient Title XIX (Medicaid) and Title XXI (Kids Care) for members under and over the age of 21.
  - PT is covered for Outpatient EPSDT and Title XXI (Kids Care) recipients (under age 21)
  - PT services are covered for adult recipients, 21 years of age and older (ACUTE and ALTCS)
- See Policy Regarding Visit Limitations, AHCCCS Billing Manual for IHS/Tribal Providers, Chapter 8 Individual Practitioner Services and Chapter 14 ALTCS Services.

**Q: Can IHS/638 facilities bill AHCCCS for patients who are treated at a Tribal fitness center that has the appropriate equipment and the service is completed by an AHCCCS registered provider and is a covered service?**

- A: Outpatient settings include, but are not limited to: physical therapy clinics, outpatient hospital units, FQHCS, home health settings and physician offices.

**Q: Are orthotic services restricted by age?**

- A: AHCCCS covers limited orthotics, for members 21 years of age and older, as specified in HB2010 Laws 2013 Chapter 10 §40. Prosthetics are covered when medically necessary for rehabilitation. Refer to AMPM Chapter 300, Policy 310-P for specific details.

**Q: Are occupational therapy services covered for recipient's over age 21?**

- A: Outpatient OT services are covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, KidsCare members and ALTCS members (under age 21).

**Q: Can multiple All Inclusive Rate claims be billed on the same date of service?**

- A: The All-inclusive rate (AIR) is paid for up to five encounters/visits per recipient per day. Encounters/visits are limited to the AHCCCS-registered facilities that provides covered services to Medicaid members in an IHS or tribal 638 health facility.
- Each encounter/visit must be a separate distinctive service completed by an AHCCCS registered provider.
- The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit by the facility.
- Only one pharmacy AIR is allowable per recipient per day.

For example: a recipient has a scheduled visit with the PCP. After the PCP visit, the recipient walks over to the pulmonary clinic. The pulmonary provider examines the recipient and orders an albuterol treatment which is performed by the respiratory therapist. The recipient then goes to the pharmacy to pick up refill medications, as well as the new medication ordered by the pulmonary provider. There would be 4 billable clinic visits: PCP visit, pulmonary provider visit, the respiratory therapist visit (all 3 providers are eligible AHCCCS registered providers) and the pharmacy visit. All 4 are separate and distinct services.

**Q: Would Anti-Coagulation therapy be billable under a clinic pharmacist or the MD?**

A: Anti-coagulation therapy for IHS/638 facilities would be considered a pharmacy service if the pharmacist is completing the service and would be considered in the one (1) pharmacy claim billable per recipient per day.

If the anti-coagulation therapy is performed during the clinic visit with the physician, then it would be included in the clinic AIR.

**Q: Can RN's bill for their services to AHCCCS as a provider?**

A: AHCCCS does not register RNs or LPNs so these cannot be billed.

If RN/LPN services are done during a clinic visit (with an eligible AHCCCS registered provider), then the RN/LPN services are included in the clinic AIR.

**Q: How are prenatal visits billed?**

A: For more detail information on when and how to bill for prenatal visits, please refer to the AHCCCS Billing Manual for IHS/Tribal Providers, Chapter 8 Individual Practitioner Services.

**Q: Is diabetic education a covered service?**

A: Diabetic Education services are Not an AHCCCS covered service.

**Q: Are home care visits a billable service? If so, define claim requirements.**

A: Home health services must be provided by a Medicare certified Home Health Agency (HHA). For more information on home health, refer to the AMPM chapter 1200 (1240-G). AHCCCS covers medically necessary home health services provided in the recipient's place of residence in lieu of hospitalization. AHCCCS also covers home health services for elderly and physically disabled and developmentally disabled ALTCS recipients under Home and Community Based Services. Prior authorization from the AHCCCS Administration is required for home health services rendered by tribal providers to acute fee-for-service members. However, no authorization is required for home health services rendered by Indian Health Service (IHS). For more detail information please refer to the AHCCCS Billing Manual for IHS/Tribal Providers, Chapter 13 Home Health Care Services.

**Q: Can immunizations be performed in a pharmacy for members under age 18?**

A: AHCCCS does not cover pharmacists giving immunizations to members under 21 years of age.

**Q: Are licensed counselors a billable provider type?**

A: Behavioral Health Professional: (R9-20-101)

Arizona Licensed: A social worker, counselor, marriage and family therapist or substance abuse counselor licensed according to A.R.S. Title 32, Chapter 33. Please refer to AHCCCS Behavioral Health Services Guide

<http://www.azahcccs.gov/commercial/Downloads/BehavioralHealthServicesGuide.pdf>.

**Q: Are optometry services for members age 21 and older covered?**

A: Emergency eye care which meets the definition of an emergency medical condition is covered for all members. For members who are 21 years of age or older, treatment of medical conditions of the eye are covered (excludes eye examinations for prescriptive lenses and the provision of prescriptive lenses). For member under age 21 vision examinations and the provision of prescriptive lenses are covered and for adults when medically necessary following cataract removal.

**Q: Are podiatry services covered by AHCCCS?**

A: Services are not covered for members 21 years of age or older, when provided by a podiatrist or podiatric surgeon. Services are covered if performed by a physician or mid-level practitioner that is an active AHCCCS registered provider.

**Q: Is diabetes a covered medical condition?**

A: Diabetes is a covered medical condition. However, diabetic education is not a covered service.

**Q: Is a prior authorization required 72 hours after a patient is admitted to an inpatient facility?**

A: Prior authorization is required *before* all non-emergency and elective admissions including all organ and tissue transplantation for FFS members.

Notification to the UM/CM Unit *must* be provided within 72 hours of an emergency hospitalization.\*

\*This does not apply to FES inpatient admissions.

*\*This does not apply to IHS/638 providers since no Prior Authorization is required for these facilities.*

**Q: If Medicare denies a service as non-covered, will AHCCCS pay as secondary?**

A: Not always - this would depend on the eligibility of the member:

QMB Only

QMB Dual

Non QMB Dual (also known as Dual Eligible)

Always look up the member's AHCCCS eligibility when Medicare is involved.

Refer to the IHS/Tribal Billing Manual, Chapter 4, Section A. Medicare, for full details of these 3 types of eligibility.

**Q: Who is the AHCCCS Tribal Liaison?**

A: Bonnie Talakte, Tribal Liaison – 602-417-4610 or [bonnie.talakte@azahcccs.gov](mailto:bonnie.talakte@azahcccs.gov).

**Q: What is the process online for recouping overpayments for one line vs. the whole claim?**

A: If recouping certain lines you would do a replacement claim submission; if recouping the entire claim a void would be submitted.

**Q: Is medication covered for an adult dental visit?**

A: Prescription medication ordered/written by a dentist would not automatically disqualify the prescribed medication from payment. However, the prescribed medication may be subject to prior

authorization to determine whether it is covered (if billing the PBM). Medications billed must be covered by AHCCCS, this information can be found at:

<http://www.azahcccs.gov/commercial/pharmacyupdates.aspx>

Note: if the member is eligible for Medicare Part D, then billable medications are limited to only those medications listed in the AHCCCS Fee-For-Service Dual Eligible Members Drug List available on the AHCCCS website, under Pharmacy Information, at

<http://www.azahcccs.gov/commercial/Downloads/PharmacyUpdates/FFSAHCCCSDUALSFORMULARY.pdf>

**Q: Are adult emergency dental visits covered if the service is performed by an M.D. or D.O.?**

A: AHCCCS Medical Policy Manual (AMPM) Chapter 300 Section 310-D advises:

“As described in this Policy, AHCCCS covers medical and surgical services furnished by a dentist only to the extent that such services:

1. May be performed under State law by either a physician or by a dentist, and
2. The services would be considered physician services if furnished by a physician.”

the policy continues: “...covered services furnished by dentists to members 21 years of age and older do not include services that physicians are not generally competent to perform such as dental cleanings, routine dental examinations, dental restorations including crown 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.”

AMPM Exhibit 300-3 has a list of dental HCPC codes that are reimbursable for member’s age 21 years of age and older.

**Q: Are ordering provider’s required on CMS 1500 claim forms?**

A: 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.*

**Q: If the patient is seen by a registered provider, and is given an injection (penicillin), how should that be billed?**

A: The visit, and the injection are included in the visit; only one AIR should be billed.

**Q: Is it a requirement that a registered provider (MD) has to give an injection not a nurse or MSA?**

**A:** If given during a clinic visit with a physician or mid-level practitioner, the injection would be included in the clinic AIR.

AHCCCS does not register RNs, LPNs or MSAs, so their services cannot be billed as a clinic visit.

**Q: How do IHS/638 facilities bill for labor and delivery services?**

**A:** The hospital bills inpatient AIR, on a UB, for all inpatient services.

The AHCCCS global obstetrical (OB) codes are billed on a CMS 1500 claim form.

Evaluation and management (E/M) codes for office and/or hospital/clinic 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. For more information on how to bill the OB code please refer to the AHCCCS Billing Manual for IHS/Tribal Providers Chapter 8 Individual Practitioner Services.

Outpatient clinic/AIR is not billable for pre-natal or post-natal visits.

**Q: If a patient comes in and has a UTI, back pain, or other injuries not related to pregnancy, can the service be billed to AHCCCS?**

**A:** Please refer to previous guidance regarding billing for laboratory, radiology and prenatal services.

For example – patient comes in for an OB visit and also complains about a sore throat so the OB/G provider examines/treats the sore throat during the OB visit. This is NOT billable as an AIR clinic visit.

If the OB/G prescribes a medication for the sore throat, AND/OR for the pregnancy, and the patient picks up the medication at the pharmacy on the same day, then this pharmacy encounter is billable as one (1) AIR.

However, if the patient comes in for an OB visit, then goes to the walk-in clinic and is seen by another AHCCCS registered provider who examines/treats for the sore throat, then this clinic visit is billable as a visit. If the patient then goes to the pharmacy window and picks up medications prescribed by both the OB/G and walk-in clinic, then this pharmacy encounter visit is billable as one (1) AIR.