Prior Quarter FAQ's
As of 9/20/13

Q1: What is Prior Quarter coverage?
A1: In accordance with 42 CFR 435.914 (re-designated as 435.915 effective October 1, 2013) prior quarter means:

The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—

> (1) Received Medicaid services, at any time during that period, of a type covered under the plan; and
> (2) Would have been eligible for Medicaid at the time they received the services if they had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

Q2: When does Prior Quarter coverage begin?
A2: January 1, 2014

Q3: What is the earliest date that individuals applying for AHCCCS can be eligible for Prior Quarter coverage?
A3: Individuals applying for AHCCCS in February 2014 may be determined to qualify for prior quarter coverage during the month of January 2014.

Q4: Why is AHCCCS required to implement Prior Quarter coverage?
A4: Prior Quarter coverage is a federal requirement AHCCCS is currently waived from. This waiver authority expires December 31, 2013.

Q5: Who is eligible for Prior Quarter coverage?
A5: Beginning with coverage dates after January 1, 2014, a member who had a Medicaid covered service in any one of the three months prior to submitting an application for AHCCCS, if the applicant would have qualified for AHCCCS at the time services were received.

Q6: Are providers responsible to return payment to members who are Medicaid eligible for services received during the prior quarter?
A6: Yes, if a member paid for a service during the prior quarter, R9-22-703 states that providers MUST promptly reimburse members if payment was previously made by the member during the prior quarter. Providers must accept payment by the Administration as payment in full.

Q7: What if providers fail to reimburse members?
A7: Providers failing to reimburse a member for any payments members made during the prior quarter period will be referred to the AHCCCS Office of Inspector General for investigation and action.

Q8: What if a member hasn't paid for a service?
A8: All providers, including RHBAs and TRBHAs must submit a claim (except for pharmacy claims) directly to the AHCCCS Administration. Pharmacy claims must be submitted to Med Impact per Q10.AHCCCS Managed Care Contractors are not responsible for payment for covered services received during the prior quarter.

Claims can be submitted to AHCCCS either through an 837 transaction, through the on-line claims submission application or via a paper claim.

Q9: Who is responsible to pay for behavioral health services in the Prior Quarter period?
A9: Claims for eligible behavioral health services for the Prior Quarter period will be reimbursed by the AHCCCS Administration.

Q10: Who will pharmacy claims be submitted to?
A10: All pharmacy point of sale claims should be submitted to Med Impact.

Q11: Where can I find information on how to submit a claim to the Administration?
A11: http://www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSProviderManual.aspx