

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

September 2016

<updated ALTCS Dental article with eff date per CMS approval>

**Reminder: AHCCCS will be closed Monday, October 10, 2016
To observe Columbus Day**

The claims payment schedule for the week of October 10, 2016 will have a one day delay due to the holiday.

Long Acting Reversible Contraceptive (LARC)

Effective dates of discharge on and after 10/01/2016, Long Acting Reversible Contraceptive (LARC) devices are permitted to be separately reimbursed outside of the APR-DRG payment when billed by the Hospital on a CMS 1500 claim form with the appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code. AHCCCS has identified LARC procedure codes as follows:

- J7297 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg, 3 Year Duration
- J7298 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg, 5 Year Duration
- J7300 Intrauterine Copper Contraceptive
- J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg
- J7307 Etonogestrel (Contraceptive) Implant System, Including Implant and Supplies

This does not apply to individuals on the Federal Emergency Services Program (FESP).

Refer to the Fee-For-Service (FFS) Provider Billing Manual, Chapter 11 Addendum – APR-DRG on the AHCCCS website at

https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap11_Addendum.pdf

Reinstatement: Coverage of Podiatry Services Performed by a Licensed Podiatrist

Effective service dates on and after October 1, 2016 AHCCCS covers medically necessary podiatry services for adults age 21 and older, when provided by a licensed podiatrist and ordered by a recipient's primary care provider, attending physician or primary care practitioner.

Billing requirements will be included in the FFS and the IHS/Tribal Provider Billing Manual chapter updates in October.

ALTCS Dental Benefit

Restoration of the ALTCS dental benefit was approved (HB 2704) in the 2016 Legislative Session. [AHCCCS has received CMS approval. The effective date for ALTCS Dental coverage is date of service 10/01/2016.](#)

Highlights of the proposed ALTCS Dental Benefit are:

- For ALTCS members age 21 years and older and at risk for institutional level of care
- Benefit limit up to \$1,000.00 per contract year
- Contract year is defined as 10/1 through 9/30
- Benefit coverage is member-specific and remains with the member if transferring between MCO's or between FFS and managed care
- Unused benefits will not roll over into the next contract year
- Reimbursement is subject to the Dental FFS Rates and Codes

The AHCCCS Medical Policy Manual (AMPM), the FFS and the IHS/Tribal Provider Billing Manuals [will be updated to reflect the coverage restoration.](#)

Refer to the AHCCCS website at:

<https://www.azahcccs.gov/shared/Downloads/ALTCSDentalFactSheet.pdf>

Referrals for NEMT Trips Beyond "nearest facility"

NEMT Coverage Policy and Medical Necessity Documentation Information for Facilities/Providers Referring American Indian Health Plan (AIHP) (Health Plan ID number 999998) FFS Members beyond the nearest facility for AHCCCS Covered Services

AHCCCS policy limits NEMT transportation to the cost of transporting the member to the nearest appropriate IHS/Tribal 638 medical facility or nearest appropriate AHCCCS registered provider capable of meeting the member's medical needs (FFS Provider Manual Chapter 14; IHS/Tribal Provider Billing Manual Chapter 11; AMPM Chapter 800 Policy 820 W).

Transportation service must only be provided to transport the member to and from the required covered medical service (AMPM Chapter 300 policy 310 BB; Chapter 800 Policy 820 W).

When NEMT prior authorization is requested beyond what appears to be the nearest appropriate facility or provider, the PA Unit may request medical necessity justification from the

referring facility/provider to ensure that AHCCCS NEMT coverage policy is being followed appropriately (AMPM Chapter 800 Policy 820 W).

The referring facility or provider should submit the medical necessity documentation via fax directly to Division of Fee for Service Management (DFSM), not to the transportation provider. If the medical necessity documentation is not received, AHCCCS may not have the information necessary to approve the authorization request, e.g., such as in cases where the service is not available at the referring facility and/or the wait list at the nearest facility is too long to meet the member's medical needs.

Medical necessity documentation must be submitted to DFSM using a Prior Authorization Medical Documentation Form as a cover sheet, which can be found on our website under <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html>. The form with the attached medical necessity documentation should be faxed to the Transportation fax number, 602-254-2431.

Dental Review Process for Deep Sedation/General Anesthesia

AHCCCS Fee-For-Service (FFS) transitioned from prospective review to retrospective review of dental services performed under deep sedation/general anesthesia **beginning August 1st 2016**. This process change was implemented to improve the timeliness of service delivery to AHCCCS Fee-For-Service (FFS) plan members, and help reduce the administrative burden associated with an increased volume of service requests.

Dental providers performing services under deep sedation/general anesthesia submit their claims electronically to the FFS Claims area with the following documentation:

- Dentist's Substantiation of Necessity of Services Through Depiction of Dental Condition
- Dentist's Treatment Plan and Schedule
- Radiographic Images Fully Depicting Existing Teeth and Associated Structures by Standard Illumination When Appropriate.

**Please note that Fee-For-Service claims found to have been reimbursed incorrectly are subject to recoupment.*

Continue to submit dental prior authorization requests using the completed FFS Authorization Request form as the coversheet to your documents for the following dental services *at least 7 days in advance of the date of service*:

- Removable Dental Prosthetics (including complete and removable partial dentures)
- Cast Crowns
- Orthodontia Services
- Pre Transplant Dental Services

Services requiring Prior Authorization should be mailed to the AHCCCS FFS Prior Authorization area with the following documentation:

- Completed Fee-For-Service Authorization Request form
- Dentist's Substantiation of Necessity of Services Through Depiction of Dental Condition
- Dentist's Treatment Plan and Schedule
- Radiographic Images Fully Depicting Existing Teeth and Associated Structures by Standard Illumination When Appropriate. If radiographs are unavailable please document why.

Dental authorization requests should be mailed to:
AHCCCS DFSSM – Prior Authorization: Dental
Mail Drop # 8900
701 E. Jefferson Street
Phoenix, AZ 85034

Fee-For-Service Authorization Request Forms Can be Found at:
<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html>

Please direct Prior Authorization or Claims/Billing inquiries to:
Fee-For-Service Prior Authorization Line: 602-417-4400
Fee-For-Service Claims Customer Service: 602-417-7670

Prior Authorization Request Timeframes

AHCCCS endeavors to review all authorization requests as expeditiously as possible, but may take up to 14 calendar days to make a determination on an authorization request per A.A.C R9-34-306.

For requests that meet the criteria for an expedited decision per A.A.C R9-34-306, the decision will be issued not later than 3 working days after receipt of the request. AHCCCS will review requests for expedited decisions in order to determine whether following the 14 calendar day review timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. Expedited requests that do not meet the criteria for an expedited decision will be processed in accordance with the 14 calendar day time frame.

When an extension is requested by the member, or if AHCCCS requires additional information to make a determination, AHCCCS may extend the timeframes for both expedited and non-expedited requests up to an additional 14 calendar days.

For authorization requests in which service delivery has already occurred, the above timeframes are not applicable.

To submit a request for an expedited decision, use AHCCCS Online to enter a pended authorization request and fax the FFS PA request or medical documentation form with the pended PA number and supporting clinical documentation to the appropriate AHCCCS fax line. Call the FFS PA line at 602-417-4400 to notify PA staff of the pended authorization and faxed clinical documentation.

Provider Registration Required for Licensed Board Certified Behavior Analysts (BCBA)

AHCCCS is accepting applications from licensed Board Certified Behavior Analysts. This new AHCCCS provider type will be effective October 1, 2016 and will be designated as “BC” in the AHCCCS Provider Registration system.

Provider Registration and Other Requirements

1. BCBAs currently providing services through AHCCCS-registered providers

Licensed and credentialed BCBAs who are currently working under an AHCCCS-registered provider through a contract with an AHCCCS Managed Care Organization (MCO) need to submit a provider registration packet no later than **August 15, 2016** to AHCCCS Provider Registration. The Provider Registration application can be found at:

www.azahcccs.gov/PlansProviders/CurrentProviders/packet.html.

Providers will not be able to submit claims beginning with date of service October 1, 2016 for BCBA services unless there is an active AHCCCS-registered BCBA provider submitted as the rendering/service provider.

Licensed BCBAs who are currently working under an AHCCCS-registered provider and providing services through AHCCCS Fee for Service need to submit a provider registration packet no later than August 15, 2016 to AHCCCS Provider Registration. Providers will not be able to submit claims beginning with date of service October 1, 2016 for BCBA services unless there is an active AHCCCS-registered BCBA provider submitted as the rendering/service provider.

2. BCBAs not currently employed by an AHCCCS-registered provider who wish to practice independently starting on October 1, 2016

Licensed BCBAs who wish to practice independently starting on October 1, 2016 need to submit a provider registration packet no later than **August 15, 2016** to AHCCCS Provider Registration. The Provider Registration application can be found at www.azahcccs.gov/PlansProviders/CurrentProviders/packet.html. In order to submit claims for AHCCCS Fee for Service programs, an active unrestricted license in the state of Arizona and an active AHCCCS provider registration number is required. In order to submit claims for AHCCCS managed

care programs, BCBA's will need to be credentialed and contracted with AHCCCS MCOs in addition to being registered through AHCCCS provider registration. Credentialing requirements for BCBA's are outlined in AHCCCS Medical Policy Manual (AMPM) Chapter 900.

For additional questions regarding the provider registration process please contact Angelica Quezada, Health Program Manager II within the Provider Registration section at (602)417-4098 or Angelica.Quezada@azahcccs.gov. Applications can be faxed to Angelica Quezada's attention at (602)256-1474.

For additional information regarding this provider type refer to the AHCCCS webpage at: <https://www.azahcccs.gov/shared/asd.html>