

September 2018

## NEW: Open House

Unfortunately, at this time we no longer have any availability for the proposed dates. Open Houses are an option that was newly incorporated by provider training and due to the high requests, we do hope to expand our training availability. If this option becomes available, providers will be notified through our Constant Contact or Claims Clues communications.

Confirmation from Provider Training is required. At this time, Provider Training is unable to accommodate walk-ins for one-on-one training.

We thank you for your patience and understanding!

## Direct Care Workers

In August 2019, the AHCCCS Division of Fee-for-Service Management (DFSM) will conduct annual monitoring of Direct Care Service Agencies serving Tribal ALTCS members who live in their own homes. The monitoring is to ensure the provision of the following: 1) service delivery in accordance with authorizations and members' needs; 2) quality of care for members; and 3) training and supervision of direct care workers.

From October 2018 to July 2019, AHCCCS DFSM will provide informational sessions to direct care worker agencies to explain the monitoring process/ standards, monitoring tool, and provide assistance on how to meet the requirements. These informational sessions will be held via webinar or at the AHCCCS Office.

The monitoring will be a desk level audit, meaning direct care worker agencies will be responsible for faxing/emailing/mailing files and documents to DFSM. The audit will be consistent with Chapters 900 and 1200 of the AHCCCS Medical Policy Manual. There will be an administrative review and a review of member files. The administrative review will consist of service utilization, employee screening, policies and procedures of each agency. The review of member files will consist of customer satisfaction, service provision, quarterly and supervisor visits, and contingency plans.

General information about direct care worker agencies can be found on the [AHCCCS website](#).

If there are questions about the upcoming audit on direct care worker agencies on tribal lands, please email the following: [DCWAgenies@azahcccs.gov](mailto:DCWAgenies@azahcccs.gov)

### PROVIDER EDUCATION DATES

- AHCCCS Complete Care  
9/12/2018  
9:30 – 10:30 AM
- NEW: Open House  
9/26/2018  
9:30 – 11:30 AM

### ELECTRONIC PAYMENT SIGN UP

Contact:

ISDCustomerSupport@azahcccs.gov

-OR-

Call 602-417-4451

### CONTACTS

- Prior Authorization Questions FFS  
PA Line (602) 417-4400
- Claims Customer Service  
Billing Questions  
(602) 417-7670
- Provider Registration Process  
Questions - (602) 417-7670  
Fax Applications (602) 256-1474
- Technical Assistance with Online  
Web Portal Please email  
[ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov)

## Reminder

The Fee-For-Service and IHS/Tribal Provider Billing manuals provide guidance for **Fee-For-Service claims only** and it is **not** intended as a substitute or a replacement for a health plan's or a program contractor's billing manual.

- If you contract with and/or provide services to members enrolled with an AHCCCS health plan or program contractor, please continue to follow their instructions when providing and billing for services rendered to a member enrolled with that health plan or program contractor.

## Fee for Service Authorization Reminders

### General Reminders

- To improve the efficiency of the ongoing review process FFS providers should include the latest Rx or Certificate of Medical Necessity along with the latest clinical notes, CPT codes, quantities, and by report prices with each request submitted.
- Providers and facilities may have separate authorization requirements. Each FFS provider is responsible for obtaining authorization for the services they intend to bill for.
- Providers requesting authorization must verify they are using the correct identifier (NPI or AHCCCS ID#) on their authorization requests.

### Web Portal Use Reminders

AHCCCS registered providers, including behavioral health providers, are now able to submit prior authorization requests for acute services\* via the AHCCCS Online Provider Portal.

- Multiple clinical documents should be uploaded as a *single* file.
- All hospital admission notifications and/or authorization requests for hospital admissions must be accompanied by the facility's face sheet, and the history and physical document for the admission.
- Hospital authorizations pending for a discharge date should be updated online by the facility.

Facility providers must attach the discharge summary using the web portal attachment feature.

- The status of all prior authorization requests can be viewed using the Web Portal. Prior authorization staff will no longer provide authorization status or issue standard authorizations to callers over the phone.
- \*Urgent/Expedited medical requests should be submitted online with supporting documentation, **AND** a call must be made to the FFS Prior Authorization line to notify PA staff that a request requiring *expedited* review has been submitted.

**\*Note:** *Submission of requests on short notice does not constitute an urgent request. An urgent/expedited request can take up to three days to review. Requests submitted as urgent that are determined to be routine in nature will be processed in accordance with standard review timeframes.*

- **Effective August 1, 2018** Providers with access must use the online system to submit requests and to verify the status of authorizations. The FFS prior authorization area will no longer fax determinations to providers\*.
- Authorization requests submitted online automatically generate a pending authorization number that also serves as verification of receipt of the request, while allowing providers to check

## Fee for Service Authorization Reminders Continued

the status of their request via the online portal. Clinical documentation can be uploaded with the online request, so faxing of supporting documents is no longer necessary.

- Providers who continue to submit PA requests via fax after 7/1/18 will receive a notification on their return fax indicating that their request should be submitted online.
- Providers should use AHCCCS Online to verify FFS member eligibility prior to submitting authorization requests. Requests entered for non-FFS members will be revoked.
- Federal Emergency Services Plan (FESP) members: Online authorization submission does not apply. Do not submit online authorization requests. Please refer to the information in the FESP section at the end of this article for instructions and requirements.

### \*Exceptions:

- Authorization requests for acute services (e.g. hospital stays, surgeries, lodging) rendered to Tribal ALTCS members must continue to be faxed, however, the status of these authorizations must be checked using the online web portal.  
**Note:** *Authorization requests for long term care (non-acute) services for Tribal ALTCS plan members must be submitted to the member's Tribal Case Manager.*
- Providers that do not have access to use the FFS web portal can fax in time sensitive requests after online access has been requested from AHCCCS' ISD area at <https://azweb.statemedicaid.us/Account/Register.aspx>. Faxed authorization requests must include confirmation that online access is pending.

- If submission of a Prior Authorization request or documentation *is not possible* due to internet outage or other unforeseen events, then it can be done through the fax method. The Prior Authorization Request Form must be utilized with all faxed documents.

### Face to Face (F2F) Requirements

The following providers satisfy the F2F ordering provider requirement: MD, DO and DPM.

F2F documentation elements must include information specifically documenting the practitioner who conducted the F2F encounter, and that the encounter findings were communicated to the ordering provider.

F2F requirements apply to service initiation, not to renewals for continuation of the same service.

### Physical Health vs. Behavioral Health Authorization Requests

- Hospitals submitting authorization requests for inpatient admissions involving the provision of both physical and behavioral health services during the same admission must bill a single claim for the entire admission using either a behavioral health principle diagnosis **OR** a physical health principle diagnosis. The authorization type entered online must be submitted with diagnosis and billing codes that are appropriate for the admission type that will be billed on the claim. The claim billed must match the services authorized

Medical inpatient hospital admissions are authorized for diagnosis related grouping (DRG) reimbursement and behavioral health inpatient hospital admissions are authorized for per diem reimbursement using revenue codes.

## Fee for Service Authorization Reminders Continued

See below for a brief description of the code types used to enter authorization requests for inpatient hospital admissions online.

| Acute Hospital Inpatient Admission Types                                   | Authorization Event Type         | Corresponding Activity Type | Corresponding Activity Codes                          |
|--|----------------------------------|-----------------------------|---|
| <b>Physical Health/Medical</b><br>ALL FFS Members (including Tribal ALTCS) | <b>IP</b><br>(Medical Inpatient) | <b>D</b>                    | <b>DRG</b>  |
| <b>Behavioral Health</b><br>FFS members, excluding Tribal ALTCS members    | <b>BI</b><br>(BH Inpatient)      | <b>R</b>                    | <b>0114, 0116, 0124, 0126, 0134, 0136, 0154, 0156</b> |
| <b>Behavioral Health</b><br>Tribal ALTCS members                           | <b>PI</b><br>(BH Inpatient)      | <b>R</b>                    | <b>0124</b>   |

NOTE: All acute hospitals (provider type 02 or 71) located in Arizona must enter Activity information on their authorization requests for inpatient admissions.

### Training

- Providers requiring assistance with the online authorization entry process are encouraged to review training resource materials [on our website](#).
- For general questions about the PA process please contact the Prior Authorization line at 602-417-4400 or 800-433-0425 (In-state-outside the Phoenix area). PA staff will direct providers requiring in-depth instruction related to authorization entry to the FFS Training area.

## Reminder

- When submitting 1500 paper claim forms, providers must remember to enter a “0” in box 21 as this will indicate the provider intends to submit ICD-10 codes. Claims that are left blank under box 21 will be rejected and sent back to the provider.

|   |                |            |            |              |
|---|----------------|------------|------------|--------------|
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) |                |            |            | ICD Ind.   0 |
| A.   DX1 _____  | B.   DX2 _____ | C.   _____ | D.   _____ |              |
| E.   _____  | F.   _____     | G.   _____ | H.   _____ |              |
| I.   _____  | J.   _____     | K.   _____ | L.   _____ |              |

## Integration

Integration will begin on October 1st, 2018, and to prepare for its arrival AHCCCS will be publishing a special edition of Claims Clues and an informational series on Integration via Constant Contacts.

Both the special edition of Claims Clues and the Constant Contacts Integration Series will cover a variety of topics on Integration, including:

- Integration Basics
- Enrollment Changes for Members
- The American Indian Health Program (AIHP)
- Behavioral Health Information
- Billing Changes

- Contract Information
  - Note: Fee-For-Service providers do not need to contract with AHCCCS Tribal AIHP, ALTCS, or a TRBHA to provide services to FFS members. They simply must be an AHCCCS registered provider. CRS Corner
- Who Pays for Non-Integrated Members?
- Integration Wrap-Up

The Constant Contacts series can be signed up for [here](#) by registering for any of the email subscription lists, and the special edition of Claims Clues can be found on the Claims Clues page [here](#) in September.

## Ground Ambulance

A Fee-For-Service ground ambulance provider, who responds to an emergency call and provides medically necessary treatment at the scene, but does not transport the member, is eligible for reimbursement. This service is billed with HCPCS code A0998 (Response No Transport), and reimbursement can vary based on a provider's designation as follows:

For ground ambulance providers operating under an ADHS Certificate of Necessity (CON):

- For providers operating under a CON, ADHS does not set a rate specifically for A0998 Ambulance Response No Transport. The rate that applies for the CON provider is their ADHS-established ALS or BLS base rate.
- Where ADHS has established a base rate for the CON provider that does not include supplies, the provider may bill the supplies separately and be reimbursed separately for them; this is true for any ambulance trip by that provider whether or not a transport resulted.
- Where ADHS has established a base rate for the CON provider that includes supplies, the provider may not bill supplies separately. Reimbursement

for the supplies is included in the reimbursement for the ambulance trip; this is true whether the trip was a response with transport or A0998 Response No Transport.

- Therefore, for some CON providers, A0998 includes reimbursement for supplies and they are not permitted to bill supplies separately; for other CON providers A0998 does not include supplies and they may bill and be reimbursed separately for the supplies. This is determined by ADHS, not AHCCCS.

For non-CON ambulance providers:

- Distinct from the above, AHCCCS has established a FFS rate for A0998 for non-CON ambulance providers, and that rate is deemed to include reimbursement for any supplies used during the service. The provider may not bill supplies separately.

AHCCCS is updating the emergency ambulance rates at 10/01/2018 for IHS and Tribal 638 ambulance providers, and the update will include A0998 Response No Transport.