AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES
A Publication of the AHCCCS DFSM Claims Department

September 2021

Emergency Triage, Treat and Transport (ET3)

Emergency Triage, Treat and Transport (ET3) is a program designed to allow greater flexibility for ambulance providers registered with AHCCCS as Emergency Transportation providers (Provider Type 06) to address health care needs following a 9-1-1 call.

AHCCCS intends to implement ET3 as of October 1, 2021, pending CMS approval.

The three components of ET3 are:

1. **Transport of Member to Alternate Destination** (e.g., urgent care center, BH provider, PCP's office, FQHC/RHC, or specialist)
2. **Treatment in Place by a Qualified Health Care Practitioner *In* Person** (e.g. EMS personnel provide treatment at member's existing location, using standing orders)
3. **Treatment in Place/Triage by Qualified Health Care Practitioner** (e.g. medical triage of member via telehealth, with EMS personnel assisting as needed)

To provider and bill for ET3 services a provider must:

1. Be registered with AHCCCS as Provider Type 06; and
2. Be responding to a "call" initiated by an emergency response system ("9-1-1" call, fire, police, or other locally established system for medical emergency calls); and
3. Upon arrival at the scene, the emergency team's field evaluation determines that the member's needs are non-emergent, but medical necessary; and
4. Follow all requirements as outlined in AMPM 310-BB.

To become an AHCCCS-registered provider type 06, ambulance providers must have received a Certificate of Necessity (CON) from ADHS.

Tribal providers who choose not to receive a CON from ADHS may become an AHCCCS-registered provider type 06 by signing the AHCCCS attestation of CON equivalency.

Details regarding requirements for Transport to an Alternate Destination and Treatment in Place can be found on the DFSM Provider Training web page, on the AHCCCS ET3 Updates web page, and in Chapter 14 of the Fee-for-Service Provider Billing Manual, Transportation.

Additional information can be found at the following links:

- ET3 FAQs
- ET3 Billing Presentation

Please note that these materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, if you select Non-Person Entity (2) when submitting documentation:

- **DO NOT enter information into the Provider First Name field. If you do this as a Non-Person Entity, then your attachments will not link to the claim.**

This will cause your claim to be denied for missing documentation.

Please read the article in this edition of Claims Clues for more detailed information and images showing the issue we have been seeing.

The AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during the COVID-19 Emergency for Fee-for-Service Programs was updated on July 2nd, 2021. It can be found in the COVID FAQs on the AHCCCS website, and at the below link:

TRAINING AND CONTACTS

The DFSM Provider Training Team's Fourth Quarter Training Schedule is posted on the DFSM Provider Training web page.

For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at ProviderTrainingFFS@azahcccs.gov

- Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website.
- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5

ELECTRONIC PAYMENT SIGN UP

Electronic Payment Sign Up (Remittance Advice Sign Up/835)
ISDCustomerSupport@azahcccs.gov
OR call 602-417-4451

COVID FAQ

FAQs on the AHCCCS website.

Medical Review Documentation Requirements

Documentation Requirements for Claims Requiring Medical Review

UB-04 claims Documentation Requirements

- Emergency Department Records
- History and Physical
- Discharge Summary
- Medication Administration Record (MAR)
- Physician Orders; observation orders, if applicable
- Diagnostic Test Results
- Progress Notes
- Operative Report(s), if applicable
- Labor and Delivery Room Report, if applicable

UB-04 Outlier Documentation Requirements

In addition to the above documentation for UB-04 claims if a claim qualifies for an outlier payment the following documentation will also be needed.

- Itemized statement matching the billed charges and dates of service
- All procedure reports (bronchoscopy, laceration repair, lumbar puncture, PICC insertion, Cardiac Cath, etc.)
- Operating room and anesthesia times. (Need the operative report and anesthesia records as they contain some of the charges/supplies/implants/medications that might not be listed elsewhere)
- CT/MRI/MRA/Nuclear Medicine/Echo reports/Interventional Radiology
- Dialysis/CRRT Flowsheets
- High dollar medical supplies
- Ventilator Days
- Nitric Oxide Days
- Blood Administration (copy of blood administration tag that has the date, start/stop times, and signature of administrator)
- PACU in and out times
- Perfusion
- Cardiac Arrest Reports

Additional documentation may be requested when needed.

CMS 1500 Documentation Requirements

- Emergency Department Records
- History and Physical
- Anesthesia Records including start and stop times
- Pathology reports
- Progress notes, history and physical office records, discharge summary, and consult reports.
- Xray/Scan reports
- Procedure reports

Documentation Requirements and the Transaction Insight Portal

The Division of Fee-for-Service management 0DFSM) may require providers to submit documentation for certain services.

The Transaction Insight Portal is the preferred method for submitting medical records, the AHCCCS Daily Trip Report (for Non-Emergency Medical Transports), and any other supporting documentation required for the processing of a claim.

AHCCCS will be holding continued trainings on use of the Transaction Insight Portal throughout the 4th quarter of 2020. These trainings are also available on the DFSM Provider Training Web Page 24/7 under "Trainings by Subject" (select AHCCCS Online Provider Portal) and the "Provider Training Video Library" headings.

AHCCCS will also be offering a new training to providers on Documentation for Claims Submission and Concurrent Review requirements in the 4th quarter of 2020.

Documentation for Claims Submission and Concurrent Review

This training covers the responsibility of providers to submit required documentation with claims, and to respond to AHCCCS requests for documentation for concurrent review.

NOTE: This training does not cover 'how to use' the Transaction Insight Portal.

Trainings require advanced registration. Please visit the DFSM Provider Training Web Page and look under Training Schedules for registration links. A copy of the provider training schedule for the 4th quarter of 2020 is also contained below in this newsletter.

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Attention All Transaction Insight (TI/TIBCO) Portal / Web Upload Attachment Users

This is an **important notice** for providers who log onto the Transaction Insight Portal (also known as TIBCO or the TI Portal) to upload attachments, such as medical records and the Daily Trip Report

If you select **Non-Person Entity (2)** and then enter in information into the **Provider First Name** field, this will cause an error and your attachments will not link to the claim.

This will cause your claim to be denied for missing documentation.

AHCCCS has been seeing multiple errors amongst providers who are submitting documentation as a Non-Person Entity (2). Do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.

INCORRECT

Provider Entity Type Qualifier: Person (1) Non-Person Entity (2)

Provider Last or Organization Name: Organization Name

Provider First Name: Organization Name (If you put something here, the documentation may not attach and the claim could deny.)

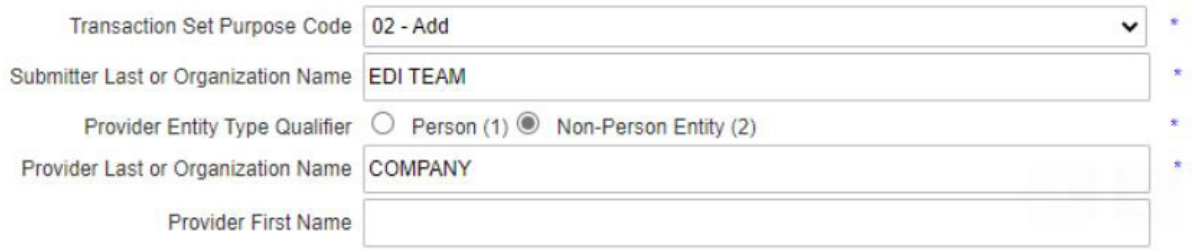
CORRECT (Provider First Name must be blank/empty)

Provider Entity Type Qualifier Person: (1) **Non-Person Entity (2)**

Provider Last or Organization Name: Organization Name

Provider First Name:

The Provider First Name field **must** be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the portal.



Please also review Page 8 (Submitter Last or Organization Name) in the guide:

Transaction Insight Web Upload Attachment Guide

If you encounter problems logging on to the TI Portal, please contact EDI Customer Support at servicedesk@azahcccs.gov
Please click on the link below to download the latest training on the new web upload attachment layout.

- New TI Portal User Guide

Any additional questions regarding training on the TI portal, please contact:

ProviderTrainingFFS@azahcccs.gov

Transaction Insight Portal - PWK 12 digit CRN matching

The AHCCCS Online Claims Submission (Attachment Tab) Control Number or Claims 837 Submission Loop 2300/PWK06 must be the same data/value entered in the Transaction Insight Payer Claim Control Number or Provider Attachment Control Number

Examples: AHCCCS Online Claims Submission Control Number = A1234567809212020

Transaction Insight Payer Claim Control Number or Provider Attachment Control Number = A1234567809212020

AHCCCS 837 Submission Loop 2300/PWK06 = A1234567809212020

Transaction Insight Payer Claim Control Number or Provider Attachment Control Number = A1234567809212020

If you received a letter that states your claim is denied due to missing documentation, then you must complete your Transaction Insight web upload using the 12 digit Claim Record Number of your claim.

Example: Transaction Insight Payer Claim Control Number or Provider Attachment Control Number = 212640001234

Example of Invalid entries: 212640001234001

Note: If you submit with the 12 digit CRN Number and the Line No, for example, 212640001234001, then your Transaction Insight web upload will not be linked to its claim and will be denied for missing documentation.

COVID-19 Information

AHCCCS is responding to an outbreak of respiratory illness, called COVID-19, caused by a novel (new) coronavirus. Health officials urge good hand washing hygiene, covering coughs, and staying home if you are sick.

To address Medicaid-related questions from providers and contractors about COVID-19, AHCCCS has developed a list of Frequently Asked Questions Regarding Coronavirus Disease 2019 (COVID-19), updated regularly as more information becomes available.

COVID-19 FAQs

Find out more at: https://azahcccs.gov/AHCCCS/AboutUs/covid19.html

Learn how to protect yourself and stop the spread of COVID-19.

Visit azdhs.gov/COVID19 and cdc.gov/COVID19.

If you are an AHCCCS member who is experiencing flu-like symptoms, please call the 24-hour Nurse Line for your health plan. Phone numbers can be found on the AHCCCS website.

AHCCCS Prior Authorization and Concurrent Review Standards during the COVID-19 Emergency for Fee-for-Service Programs

The memo on AHCCCS Prior Authorization (PA) and Concurrent Review Standards during the COVID-19 Emergency for Fee-for-Service Programs has been updated as of August 18th, 2021. Please review the PA standards.

APEP FAQs

If you're seeking quick answers to common questions regarding APEP or enrolling as an AHCCCS provider. Please visit the current list of common questions regarding the provider enrollment process. The list of FAQs can be found at: https://azahcccs.gov/PlansProviders/NewProviders/registration/APEP/faq.html

For all other enrollment questions, please contact Provider Assistance (602) 417-7670 option 5 or email APEPTrainingQuestions@azahcccs.gov

Prior Authorization Updates and Reminders

Continuation of Temporary FFS PA Lift Effective 08/01/21 to Current

In accordance with the information provided in the Fee For Service Memo dated August 20, 2021, the

effective date for the following changes is 08/01/21:

- Effective 8/1/2021 all non-emergency medical transportation (NEMT) over 100 miles will require prior authorization. All NEMT prior authorization requests must be received prior to the date of service to be considered timely.
- Temporarily waived prior authorization (PA) requirements have been continued for physical health admissions to acute hospitals, long term acute hospitals (LTACs), acute rehab facilities, Nursing Facilities (NFs/SNFs), and Assisted Living Facilities (ALFs).
- Please note that the temporary prior authorization lift does not apply to behavioral health admissions. Authorization requirements remain in place for BH admissions to acute hospitals, residential treatment facilities (RTCs), and behavioral health residential facilities (BHRFs).

Behavioral Health Hospital Admission vs Physical Health Hospital Admission for AIHP and/or TRBHA FFS Members

The primary diagnosis (behavioral health vs. physical health) will determine the process used to review inpatient hospital authorization requests for authorization and to reimburse the corresponding claims. The diagnosis type (behavioral health or physical health) on the claim must match the diagnosis type on the authorization requested by the provider for the claim to pay. Providers billing for an inpatient

behavioral health (BH) admission to a hospital must first submit a BH authorization request, which requires submission of an online authorization request to the FFS BH PA area with the applicable BH diagnosis, the required Certificate of Necessity, treatment plan, progress notes, discharge summary, and any other documentation that is requested by the BH PA team to establish medical necessity for the BH admission and continued stay. See the FFS BH PA Criteria webpage for more information on BH PA documentation requirements.

The claim billed for an inpatient BH hospital admission must have a corresponding approved BH authorization on file or it will deny. An authorization for a medical admission (requested with a medical diagnosis) will not correspond with a claim for the same admission that is billed with a BH diagnosis and will deny. An authorization for a BH admission will not correspond with a claim billed for the same admission with a medical diagnosis and will also deny. The servicing provider must determine the admission type (behavioral health or physical health) and is required to submit the request for prior authorization in accordance with the type of claim that they intend to bill. The documentation submitted by the service provider must support the authorization request and claim billed. If this does

not occur, the provider may be required to correct the authorization or claims submission for reimbursement to occur.

Providers billing for a physical health admission to an acute hospital must submit the facility face sheet, history and physical, discharge summary, and any additional documentation requested by the medical PA area to establish medical necessity for the admission. Please note the temporary PA Lift for inpatient physical health admissions. There is no PA requirement for physical health inpatient hospital

admissions during the temporary PA lift. Requests submitted for physical health inpatient hospital authorization requests submitted during the timeframe of the temporary FFS PA Lift will be revoked. Please review the FFS Memo for effective dates for the temporary FFS PA Lift.

Note: Providers entering a request for an inpatient BH hospital admission must use Event type BI.

Providers entering a request for an inpatient physical health hospital admission must use Event type IP.

For questions regarding PA please contact the PA Line at 602-417-4400 or 800-433-0425 (outside the Phoenix area).

APEP Updates – Service Addresses May Now Be Updated Directly in APEP

The APEP system now allows service addresses to be updated directly in APEP. This means uploading the list of service addresses is no longer required. The service address(es) are updated in Step 2: Locations and require a minimum of one service address to complete the step.

Providers that submitted a list of service address(es) along with the application that has not been approved, the application will be placed back into an "In Process" status to allow the user to update the service address(es) and resubmit.

Providers in an approved status requiring a service address, If the user has domain permissions to access the file, submit a modification request in APEP and add the service address(es) in Step 2: Locations.

If the user doesn't have domain permissions, email APEPTrainingQuestions@azahcccs.gov to open a service ticket, include the APEP username of the person requesting domain permissions and the provider NPI and name.

ROPA Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who refer AHCCCS members for an item or service, who order nonphysician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA".

Until these acts passed, referring, ordering, prescribing, and attending providers were required to obtain a National Provider Identifier (NPIs), but were not required to be registered as an AHCCCS provider.

As of May 27, 2021, due to the continuing public health emergency and in an effort to ensure that no members experience disruptions in care, the ROPA registration deadline has been extended to the latter of January 1, 2022 or the end of the public health emergency. The extension will help impacted providers: 1) Work through the analysis of who still needs to be registered and who does not, and 2) Ensure denials and access to care impacts are limited and/or negated.

Learn more on the website.

Tribal ALTCS Digital Tool Box

The AHCCCS DFSM Tribal ALTCS team has created a Case Management Digital Tool Box (DTB). The DTB is intended to centralize the various ALTCS case management related resources into one location so Tribal ALTCS Program Supervisors and Case Managers can find them quickly and easily. The Tribal ALTCS Digital Tool Box can be found at the following link on our website.