

July/August 2022

## Serious Mental Ill (SMI) Changes Effective 10/1/2022

American Indian Health Program (AIHP) Integration for Members with a Serious Mental Illness (SMI) Designation Effective October 1st, 2022 – Information for Providers

The Arizona Health Care Cost Containment System (AHCCCS) Division of Fee-for-Service Management (DFSM) serves as the health plan for Fee-for-Service (FFS) Medicaid members. The DFSM is responsible for the clinical, administrative and claims functions for the FFS population. Effective 10/1/22, American Indian/Alaskan Native (AI/AN) members with a Serious Mental Illness (SMI) designation will have the choice to be part of the integrated American Indian Health Program (AIHP) for coverage of both behavioral and physical health services.

Individuals with an SMI designation currently enrolled with the American Indian Health Program (AIHP) for physical health services and receiving behavioral health services from a Regional Behavioral Health Authority (RBHA) will have:

- Behavioral Health services transition to AIHP effective 10/1/2022, and
- Physical health services continue with AIHP.

Individuals with an SMI designation currently enrolled with an AHCCCS Complete Care (ACC) plan for physical health services and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA) will have:

- Physical health services transition to AIHP effective 10/1/2022, and
- Behavioral health services continue with the TRBHA.

Effective 10/1/22, RBHAs will be called ACC-RBHAs (AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements). SMI members' choice of enrollment remains intact; they may choose between integrated ACC-RBHA or integrated FFS (AIHP). They may also continue to receive services via IHS/638 tribal facilities, same as they can today.

This integration of AI/AN SMI designated members will not affect the ability of both physical and behavioral health providers to offer services to these members. AHCCCS encourages all providers to continue to care for members with an SMI designation. Providers currently serving AI/AN SMI designated members who continue to serve these members after 10/1/22 may be eligible for Differential Adjusted Payments (DAP).

The DFSM seeks to partner with facilities/providers for ongoing care management support and health plan technical assistance. All providers of behavioral and physical health services who are registered with AHCCCS can provide care and submit claims to DFSM for services provided to members enrolled with AIHP. No separate contract beyond the Provider Participation Agreement is required. See the [AHCCCS Provider Enrollment website](#) for more information.

For additional care management resources please contact [casemanagers@azahcccs.gov](mailto:casemanagers@azahcccs.gov).

For technical assistance with billing, claims and prior authorization please [visit our website](#) or email [ProviderTrainingFFS@azahcccs.gov](mailto:ProviderTrainingFFS@azahcccs.gov).

Please sign up for [DFSM's "Constant Contact" E-mail notifications](#) for providers and select the SMI Service list to receive SMI specific notifications.

### ANNOUNCEMENTS

**IMPORTANT:** For Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address of [servicedesk@azahcccs.gov](mailto:servicedesk@azahcccs.gov)

### TRAINING AND CONTACTS

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website at: [https://www.azahcccs.gov/Resources/Training/DFSM\\_Training.html](https://www.azahcccs.gov/Resources/Training/DFSM_Training.html)

The DFSM Provider Training Team's [First 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](mailto:ProviderTrainingFFS@azahcccs.gov)

- 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

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Claims Customer Service Billing Questions (602) 417-7670 - Option 4

Provider Registration Process Questions (602) 417-7670 - Option 5

Provider Registration – Fax Applications (602) 256-1474

Electronic Payment Sign Up (Remittance Advice Sign Up/835)

**ELECTRONIC PAYMENT SIGN UP** (Remittance Advice Sign Up/835) Contact: [ISDCustomerSupport@azahcccs.gov](mailto:ISDCustomerSupport@azahcccs.gov) –OR- call (602) 417-4451

**COVID FAQ**  
[FAQs COVID Fact Sheet.](#)

## Payment Error Rate Measurement (PERM) Audit

The Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) program recorded the Provider Education webinar conducted in April 2022. The recorded webinar is intended to educate the provider and supplier community about the PERM program and explain the responsibilities to those who are participating in the Medicaid program and/or Children's Health Insurance Program (CHIP). The PERM program is designed to measure and report improper payments in the Medicaid and CHIP programs. Improper payment rates are based on reviews of Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Reporting Year (RY) under review. The improper payment rate is not a "fraud rate" but a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. These improper payments may be overpayments or underpayments and do not necessarily represent expenses that should not have occurred.

The objectives of this recorded webinar is for those participating in the Medicaid and CHIP programs to better understand:

- The PERM program.
- The PERM medical review process.
- PERM medical record and documentation requests.
- Methods for record submission.
- Provider best practices.
- PERM resources for providers.

CMS uses a 17-state rotational approach to review the states' Medicaid program and CHIP so that the PERM program measures each state once every three years. Listening to this recorded webinar is an opportunity for the provider and supplier community to better understand their responsibilities during a PERM cycle. For additional information, please go to the [CMS PERM website](#).

## Participating Provider Reporting Requirements Effective 10/1/2022

Effective for dates of service on or after October 1, 2022, Participating Provider Reporting Requirements will also apply to the following provider types and claim forms. To retain information related to the actual professional practitioner that is participating in or performing services associated with the clinic visit, this information must be reported on the claim.

### Claim Form Types:

- CMS 1500 claim form, Field 19 Field Title: Additional Claim Information

- ADA claim form, Field 35 Field Title: Remarks

### Provider Types

- 05 – Clinic
- 77 - Outpatient Behavioral Health Clinic
- IC – Integrated Clinic
- Denial Edit Code H482 "NPI Missing or Invalid" will append to the claim if the participating provider information is not entered or is in the incorrect format.

## Provider Denial Resolution Guide

DFSM has created a denial resolution guide that includes the most common claim submission error codes and the steps a provider can take to help resolve the denial and/or how to avoid the same

denial on future claim submissions. The information contained in this document is to provide general guidance only.

[Provider Denial Resolution Guide](#)

## Tips: Behavioral Health Prior Authorization

Behavioral Health Inpatient Prior Authorizations: 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.

## AHCCCS Provider Enrollment Portal (APEP)

If you are new to using the AHCCCS APEP system, an APEP training plan and registration instructions is posted under APEP training. APEP training can also be conducted upon request. Please visit the

[APEP section](#) of our website

[APEP Frequently Asked Questions](#)

## Tips: BHRF Prior Authorization Reminders

Behavioral Health Residential Facility (BHRF) PT (B8)

BHRF prior authorization requests should be submitted prior to the admission of the member to the BHRF. The treatment plan should include but is not limited to “referring evaluation, all treatment including speciality services.” BHRF’s must continue to work with the TRBHAs to coordinate care and services for the members.

Medical Documentation should include but not limited to consecutive treatment notes for all treatment provided by BHRF, daily treatment

schedule and intake assessment.

If the prior authorization is missing required documentation, the denial reason code PD900 will present on the PA status screen.

The treatment plan should include that details all needed treatment in accordance with AMPM Policy 320-O BH Assessments, Services and Treatment Planning and AMPM Policy 320-V Behavioral Health Residential Facility

## DD-THP Tribal Health Program Prior Authorization Forms

The Prior Authorization (PA) unit has added prior authorization forms specifically for prior authorization requests or providers to use for members enrolled in the DD-THP Tribal Health Program.

DD-THP Tribal Health Program PA Correction Form

DD-THP Tribal Health Program Prior Authorization Medical Documentation Form

DD-THP Tribal Health Program Authorization Request Form

## Update: 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-Ser-

vice Programs has been updated as of 08/01/2022. Please review the PA standards.

## Review Of Documentation Signature Requirements

Valid signatures may be electronic or physically handwritten, however both shall have legible name of the signer printed, signer’s credentials (specific license type of professional credentials), and date of signing. The signature must be unique to that individual and linked to the medical record. Providers shall adhere to all electronic signature requirements as described in detail in AHCCCS policy AMPM 940, ARS 44-7031 and applicable CMS rules.

Not allowed: Rubber stamps, copy/paste signatures, manually typed or word-processed name or “electronic signature” or typed time-stamp if not part of certificate of secure electronic system.

Per ARS 18-106, “An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated.”

## Reminder: Non-Emergency Medical Transportation (NEMT) Policy Change for Local Community Based Support Programs

For dates of services on or after 07/01/2022, due to the changes in AMPM Policy 310-BB, AHCCCS will discontinue covering NEMT transports to the following local community-based support programs:

- Alcoholics Anonymous (AA)
- Narcotics Anonymous (NA)
- Cocaine Anonymous
- Crystal Meth Anonymous
- Dual Recovery Anonymous
- Heroin Anonymous Marijuana Anonymous
- Self-Management and Recovery Training (SMART Recovery)
- National Alliance on Mental Illness (NAMI) Programs
- Living Well with a Disability and Working Well with a Disability Program

## Reminders: Important Billing Information for Paper Claim Submissions

AHCCCS has identified an increase in multiple errors on paper claim submissions. If the paper claim submission contains incomplete, invalid information or misaligned data fields, the claim may be returned to the provider.

Paper claim submissions must be submitted on the standard Red and White CMS 1500 or UB-04 claim form. Reproductions and copies to include black and white copies of the CMS 1500 and UB-04 claim forms are not accepted. AHCCCS will accept the standard Black and White American Dental Association (ADA) claim form only.

### Offline Claims:

**Incorrect:** One of the most common errors noted on paper claim submissions is information that is misaligned with the appropriate field.

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
	From	To							
MM	DD	YY	MM	DD	YY				
1	11	22	02	11	22	02	21		99232

**Correct:** Printed information must be aligned correctly with the appropriate section/box on the form.

### Stamps on Claims:

1	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
	From	To							
MM	DD	YY	MM	DD	YY				
1	02	28	21	02	28	21	21		99291
2									

**Incorrect:** Claim forms with labels and stamps will not be accepted, as that is considered an alteration of the claim.

**Correct:** It is important to note that the **only** exception is a stamped provider signature. Stamped provider signatures will be accepted only in field 31 (CMS 1500) and field 53 (UB-04, ADA 2012).



When submitting paper claim forms to AHCCCS, the following are the general rules that apply to the CMS-1500 claim forms:

1. The preferred font for claim submission is Lucinda Console and the preferred font size is 10.
2. ICD-10 codes are required on all claim forms.
3. Any behavioral health service billed with a DSM-4 diagnosis code will be denied.
4. The following **should not** be included on the claim form:
  - White Out paper correction fluid,
  - Correction tape,
  - Labels and stamps except for stamped signatures are allowed.
5. Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system, so should not be used.
6. Handwriting is not permitted on any part of the claim form. The only exception to this is the signature field, where a written signature will be accepted

## Payment Error Rate Measurement (PERM) Audit

### What is Payment Error Rate Measurement (PERM) AUDIT

The PERM Audit is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Improvement Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 IPERIA). The improper payment rates are based on reviews of the Fee-for-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the year under review.

### Provider Billing Reminders:

It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement. For each claim submitted, you must be sure to include the correct member's name and AHCCCS ID number, date(s) of service, revenue, procedure codes, units, and charge amounts

(etc.). Claims should adhere to standard coding practices to also include modifiers if applicable. Providers should utilize the respective state and federal billing & coding resources to ensure claims meet the appropriate billing guidelines.

[https://www.azahcccs.gov/Resources/Training/DFSM\\_Training.html](https://www.azahcccs.gov/Resources/Training/DFSM_Training.html)

### Responding to PERM Documentation Requests:



Providers must submit the requested information by the due date noted on the request. Please note that it will be the responsibility of the provider identified on the claim to ensure that all supporting medical records, from the provider who rendered an AHCCCS covered service for which the claim payment under review was requested, is submitted in a timely manner.

<https://www.azahcccs.gov/PlansProviders/OtherProviderProgramsAndInitiatives/PERM.html>

## Reminder: Transaction Insight Portal-Important Information for Users Reporting the Date of Service

Here are a few tips to keep in mind to ensure the successful linking of documentation to a claim submission when entering the claim service period start and end date on the Transaction Insight Portal.

The Claim Service Period Start Date is a **required/mandatory** field, while the End Date field is not. Providers may submit documentation using only the Start Date field. Providers can enter the date manually using a **MM/DD/YYYY** format or use the Date icon and select the date from the calendar.

Claim Service Period Start Date	<input type="text" value="07/01/2022"/>		•	<b>(REQUIRED)</b>
Claim Service Period End Date	<input type="text"/>			<b>(OPTIONAL-LEAVE BLANK)</b>

The Claim Service End Date (optional): It is **recommended that Providers leave the Claim Service End Date field blank**. Providers who choose to enter a Service End Date must make sure the begin date is not later than the end date of service. **If the begin date is later than the end date, then documentation may fail to link up to the claim.**