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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

May 2024

May is Mental Health Awareness Month

May is Mental Health Awareness Month 2024. This is a time to raise awareness of the importance of emotional wellness and overall well-being, remove the stigma surrounding behavioral health issues and how mental illness and addition can affect everyone.

Extension of the Provider Moratorium to June 8, 2024.

In accordance with Section 42 CFR 455.470, I, Carmen Heredia, Cabinet Executive Officer of the Arizona Health Care Cost Containment System (AHCCCS), will implement for an additional 6 months a statewide moratorium on the enrollment of Behavioral Health Outpatient Clinic, Integrated Clinic, Non-Emergency Medical Transportation, Community Service Agencies, and Behavioral Health Residential Facility providers.

This moratorium extension will **expire on June 8, 2024**. This moratorium allows provider enrollment applications to be considered for an exemption on a case by case basis, under any of the following circumstances:

1. Medically Underserved Service Area and access to care with review and approval by State Medicaid Agency,
2. Service expansion in support of a State Medicaid Agency initiative,
3. At the request of an AHCCCS contracted managed care plan to ensure that access to care standards (i.e., time and distance) are not out of compliance, or
4. Additional exemptions as appropriate and as needs are identified.

These moratoria were approved by the Centers for Medicare and Medicaid Services (CMS) and is effective on December 8, 2023. This action is necessary to safeguard AHCCCS members, public funds, and to maintain the fiscal integrity of the AHCCCS program.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

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: servicedesk@azahcccs.gov

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

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).

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

Beginning July 1, 2024, claims submitted by fee-for-service providers that include a referring, ordering, or attending provider who is NOT registered with AHCCCS will be denied.

Fee-for-service claims that include an unregistered prescribing provider are not subject to this deadline. Referring Ordering Attending Provider Information. To begin the enrollment process, visit AHCCCS Provider Enrollment.

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 non-physician 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 and maintain a National Provider Identifier (NPI), but were not required to be registered as an AHCCCS provider, but with the implementation of ROPA requirements any registrable healthcare provider who is not already registered as an active AHCCCS provider must register or be identified as an Exception non-registerable provider*, if applicable.

To make the ROPA registration process as simple as possible, AHCCCS developed a streamlined application for ROPA providers who meet all of the following criteria:

- Have a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES),
- Already fully enrolled in Medicare or another state's Medicaid program, and
- Do not intend to bill AHCCCS for services.

Steps To Comply with ROPA

If you are a provider who refers, orders, or acts as an attending provider for AHCCCS members, and you are not represented on either of the above lists, you must begin the registration or exception provider designation process.

If you are a provider who receives a referral or order from a provider who is not on either of these lists (as appropriate), your fee-for-service claim will not be paid as of July 1, 2024.

ROPA enrollment can be initiated using the AHCCCS Provider Enrollment Portal (APEP)

Reminders: Behavioral Health Residential Facility Providers

BHRF's must submit the prior authorization request prior to the member being admitted to the facility. PAs must be completed in full to include the Activity information, date span and required units.

To ensure timely review of the BHRF PA request, ensure the documentation has the appropriate signatures, date stamp and supports the services and duration requested.

All BHRFs shall coordinate care with the outpatient treatment team throughout the admission, assessment, treatment, and discharge process,

Assessment: Except as provided in subsection A.A.C. R9-10-707(A)(9), a behavioral health assessment for a member shall be completed before treatment is initiated and within 48 hours of admission.

Treatment Plan: A treatment plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours. The applicable outpatient treatment team shall be included in the treatment plan development within 48 hours of admission.

AHCCCS Daily Trip Report Reminders for Non-Emergency Medical Transportation Providers PT28

As a reminder the AHCCCS daily trip report must be completed correctly and submitted with each NEMT claim.

Common errors include but are not limited to the following:

- Missing member and driver signatures
- Driver full name not entered,
- Driver information not provided to the program,
- Missing / invalid vehicle type,
- Under reporting of actual trip miles,
- Incorrect reporting of trip miles per member,
- Alterations to the AHCCCS Daily Trip Report,
- NEMT transports are to a service that is NOT covered under the program.

Instructions How to Complete the AHCCCS Daily Trip Report

How to Correct the Duplicate Prior Authorization Case Creation Error

The “duplicate case error” message will present when the system identifies an existing prior authorization case number is on file for the member and the same provider NPI or AHCCCS 6-digit ID number that is used for for atypical provider types only.

The PA portal is reading the **effective dates span** field on the existing authorization case number and comparing the effective date span of the exisiting PA with the dates the provider is attempting to enter for the ***New*** *PA* request.

If the date of service is within the effective date span of the first case a new Event should be created under the same PA case number.

Existing Case Example: 001234567

Note: this case is created under the same provider NPI/ID number.

Effective Date span field for this case spans **01/01/2023 - 12/31/2023.**

Next Step: Adding a New Event Under The Existing Case Number.

- Click on the PA Submission tab and search for the appropriate case number,i.e. 001234567.
- Click on the case number, this will take you to the Event List page.
- Click on the tab “Create a New Event” and enter the service begin and end date and other details for the new PA request.
- Complete the Activity Tab and click submit to finalize the new PA request.

Hysterectomy Consent and Acknowledgement Form

AHCCCS requires the hysterectomy consent form to be submitted with the claim. This form may be found in the AMPM Chapter 800 Exhibit 820-A Hysterectomy Consent Form. If this form is not available the hospital consent form that contains the same information as the Exhibit. 820-A can be submitted for consideration. The consent form must state that the patient will be permanently incapable of having children.

Reminders: Behavioral Health Residential Facility Billing Update:

Behavioral Health Residential Facilities (B8). Any claim received on or after March 1, 2024, the Arizona Health Care Cost Containment System (AHCCCS) will require BHRF providers to bill the HCPCS code H0018 on a single line item per date of service.

Claim submissions that include a date span will not be accepted and will result in a denial of the claim. This billing change will also apply to replacement, or corrections claims for dates of services prior to March 1, 2024.

Elective Sterilization Consent Form Requirement

AHCCCS requires a completed AMPM Exhibit 420A Federal Sterilization Consent Form to be submitted with all claims for voluntary sterilization procedures. For additional information related to this sterilization service providers can review

For additional information related to these services and guidelines, providers can review FFS Provider Billing Manual Chapter 10 Individual Practitioner Services

Reminder: New Dental Claim Form 2024

A new version of the 2024 American Dental Association claim form and its updated completion instructions will be effective January 1, 2024. Starting January 1, 2024, AHCCCS will only accept dental services claims submitted on the new ADA 2024 Dental Claim Form to include replacement claims submitted on and after January 1, 2024.

Tribal Self-Insurance and Required Documentation

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted, per A.R.S. §36-2946.

Per R9-22-1002, AHCCCS is not the payer of last resort (AHCCCS will be the primary payer) when the following entities are the third-party:

- The payer is Indian Health Services contract health (IHS/638 Tribal Plan); or
- Title IV-E; or
- Arizona Early Intervention Program (AZEIP); or
- Medical services provided through schools under the federal Individuals with Disabilities Education Act under 34 CFR Part 300; or
- Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. Seq.

Once the provider has identified the member's plan is a tribal self-insurance plan, the provider must submit a letter/document from the TPL plan. The letter/document must confirm the plan is a tribal self-insurance and must identify the member by name and identification number.

A new claim is not required for processing, the provider can attach a copy of the documentation to the existing claim using the Transaction Insight Portal.

Important Note: A copy of the tribal insurance confirmation letter must be submitted with each claim submission.

Reminder: Federal Emergency Services Inpatient Hospitals Services Prior Authorization Not Required for FES Members:

In accordance with R9-22-217 (D) A provider (hospital) is not required to obtain prior authorization for emergency services for Federal Emergency Services (FES) members, except outpatient dialysis services. Based on this guidance, providers should not submit to AHCCCS FFS a prior authorization request for a FES enrolled member.

Per R9-22-217 All services must meet the federal definition of emergency services to be considered for reimbursement. Based upon these criteria, all claims are subject to retrospective review.

What Not to Do:

Filing an appeal should never be done when the prior authorization and the claim details do not match.

What to do:

- The provider must review the claim details and prior authorization details to determine what information is inconsistent and may require correction.
- For those cases in which the prior authorization does not match the services provided, this information should be communicated to your staff to initiate the appropriate changes to the prior authorization (if applicable)
- The Prior Authorization Correction Form is used to identify what services were actually provided and the documented reasons for the change i.e. changes to the dates of service, HCPCS/CPT, the number of units.
- The PA Correction Form must be uploaded via the PA Submission tab, faxed copies are not accepted.
- For those cases in which the PA details are correct, but the claim details are incorrect this information should be communicated to your billing staff to submit a correction claim (if applicable).
- If a correction claim is required, the correction claim should not be billed until the PA is corrected (if applicable) and the updated changes are reflected on the AHCCCS Online Provider portal.
- Timely file timeframes will still apply to the initial claim and for replacement/correction claims. Submitting a correction to a prior authorization does not extend the clean claim timely filing period.