

Revisions: 10/1/2018; 4/26/2018; 3/9/2018

## USE OF THIS MANUAL

The AHCCCS *IHS/Tribal Provider Billing Manual* is for IHS and Tribally owned and/or operated 638 facilities and providers. It is a publication of the Arizona Health Care Cost Containment System's (AHCCCS) Claims Department of the Division of Fee-For-Service Management (DFSM). The Claims Department also publishes *Claims Clues* as a supplement to this manual.

Questions or comments related to this manual should be directed to:

The AHCCCS Claims Policy Unit  
701 E. Jefferson Mail Drop 8000  
Phoenix, AZ 85034

This manual also is available online at:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHSTribalBillingManual.html>

Any updates to the manual will be posted on the AHCCCS website and available to providers for viewing. Any updates will *also* be listed at the bottom of each, individual chapter, under the Revision History section, so that providers may see, at a glance, the most recent updates to each chapter.

This manual contains basic information concerning AHCCCS, Arizona's Medicaid program (Title XIX), KidsCare and Arizona's SCHIP Program (Title XXI). The intent of this manual is to furnish Indian Health Service (IHS) and tribal providers' billing staffs and contracted billers with information about AHCCCS, coverage of specific services, and requirements for the completion and submission of Fee-For-Service claims that are submitted to DFSM. Additional requirements are found in AHCCCS regulations, the Provider Agreement, and the Claims Clues publications.

Physicians, hospital administrators, and other medical professionals may only be interested in reviewing chapters pertaining directly to their specialty, in addition to chapter 1 of this manual. However, the office staff and billers of IHS and tribal providers should also become familiar with the requirements for member eligibility and enrollment, prior authorization requirements, claims submissions, billing policies and procedures, and the use of modifiers. Use of the manual will help reduce questions and expedite the claims process by ensuring that claims are submitted correctly the first time.

This manual provides 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.

Note: The covered services, limitations, and exclusions described in this manual are global in nature and are included to offer general guidance to providers. The *AHCCCS Medical Policy Manual (AMPM)* contains more specific information about covered services, limitations and exclusions, and is available on the AHCCCS website at:

<https://www.azahcccs.gov/shared/MedicalPolicyManual/>.

## AHCCCS OVERVIEW

The Arizona Health Care Cost Containment System (AHCCCS) was implemented on October 1, 1982, as the nation's first statewide indigent health care program designed to provide services to eligible persons primarily through a prepaid capitated managed care system. Operating as a demonstration project under the federal Medicaid program, AHCCCS receives federal, state and county funds to operate, plus some monies from Arizona's tobacco tax.

The Arizona Long Term Care System (ALTCS) was implemented December 19, 1988, for the developmentally disabled and on January 1, 1989, for the elderly and physically disabled. ALTCS provides institutional care and home and community based services to individuals who meet financial eligibility requirements and are at risk of institutionalization.

On October 1, 2018 AHCCCS integrated physical and behavioral health care for most members. This is referred to as AHCCCS Complete Care (ACC). For additional information on integration please visit the AHCCCS website.

**NOTE:** In this manual, the term "member" is used to describe an AHCCCS or ALTCS eligible individual who may be either Fee-For-Service (such as an AIHP member) or enrolled with a health plan or program contractor. The term "contractor" refers to both health plans and program contractors.

AHCCCS reimburses IHS and Tribally owned and/or operated 638 providers/facilities on a Fee-For-Service basis for services provided to American Indian members, who are eligible for AHCCCS or ALTCS, when the following criteria are met:

- The member must be Title XIX (Medicaid) eligible; and

- The member must be enrolled with the American Indian Health Program (AIHP) or one of the AHCCCS Complete Care (ACC) health plans or program contractors; and
- The services must be provided directly by the IHS or 638 tribally owned and/or operated provider/facility.

Note: If the member is a KidsCare (Title XXI) member, the claim must be sent to the member's enrolled health plan and not to the AHCCCS' Division of Fee-For-Service Management's (DFSM) Prior Authorization Department. This department will be referred to as DFSM throughout the remainder of the billing manual.

Note: If the member is enrolled with a health plan or program contractor (such as an ACC plan), then any services provided off-reservation must be billed to the member's health plan or program contractor and not to AHCCCS.

For information on whether or not a service qualifies for reimbursement at the All-Inclusive Rate (AIR) please refer to the individual chapter within this manual pertaining to the service in question.

## AHCCCS FEE-FOR-SERVICE PROGRAMS AND POPULATIONS

The Fee-For-Service populations include members that are enrolled in the following programs:

- The American Indian Health Program (AIHP),
- Tribal Regional Behavioral Health Authority (TRBHA),
- Tribal ALTCS,
- Federal Emergency Services Program (FESP),
- FFS Regular,
- FFS Temporary,
- FFS Prior Quarter,
- Hospital Presumptive Eligibility (HPE), and
- Third Party Accounts.

## AHCCCS FEE-FOR-SERVICE PROVIDERS

The provider's primary role is to render medically necessary services to AHCCCS members. Prior to billing for services, the provider must be an active registered provider with AHCCCS. Providers may elect to only provide services to AHCCCS Fee-For-Service members or may subcontract with one or more contractors to provide services to enrolled members.

**NOTE:** The provider **must** be registered with AHCCCS in order to receive payment for any services provided from **either** AHCCCS or any contractor.

## AHCCCS-COVERED SERVICES

### Emergency Services

Per A.A.C. R9-22-210, AHCCCS provides coverage for emergency medical and behavioral health services for members who are not in the Federal Emergency Services Program (FESP), for the treatment of an emergency condition.

An emergency condition is a medical or behavioral health condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health, including mental health, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Serious physical harm to self or another person.

Emergency medical services are covered for members when there is a demonstrated need and/or after triage/emergency medical assessment services indicate an emergency condition. A provider is not required to obtain prior authorization for emergency services..

For additional information on emergency services for members, who are not in FESP, please refer to AMPM 310-F, Emergency Services.

For information on FESP coverage please refer to AMPM Chapter 1100, Federal Emergency Services (FES) Program or to Chapter 18, Federal Emergency Services Program of the Fee-For-Service Provider Billing Manual.

## ACUTE AND LONG TERM CARE SERVICES

AHCCCS provides coverage for medically necessary services furnished to American Indian members by registered AHCCCS providers.

Coverage of services falls into two broad categories: AHCCCS Acute Care and the Arizona Long Term Care System (ALTCS).

### AHCCCS Acute Care

The AHCCCS acute care program offers preventive, acute, and behavioral health care services (except for members determined to be SMI, or Seriously Mentally Ill), and it also covers General Mental Health and Substance Use Disorders (GMH/SA). There is limited

coverage of rehabilitative services, home health care and long term care, as specified in A.A.C. Title 9, Chapter 22, Articles 2 and 12.

- For an overview of AHCCCS covered services for Acute Care refer to:
  - AMPM Exhibit 300-1, AHCCCS Covered Services Acute Care; and
  - The AHCCCS Medical Policy Manual (AMPM), which has policies that detail additional covered and uncovered services
- For an overview of AHCCCS covered services for Behavioral Health refer to AMPM Exhibit 300-2A, AHCCCS Covered Services Behavioral Health.

Acute care services covered under Title XXI, the State Children’s Health Insurance Program (also known as KidsCare), are specified in A.A.C. Title 9, Chapter 31, Articles 2, 12, and 16.

- For an overview of AHCCCS covered services for Title XXI (KidsCare) members refer to:
  - AMPM Exhibit 300-1, AHCCCS Covered Services Acute Care; and
  - The AHCCCS Medical Policy Manual (AMPM), which has policies that detail additional covered and uncovered services
- For an overview of AHCCCS Behavioral Health services for Title XXI (KidsCare) members refer to AMPM Exhibit 300-2A, AHCCCS Covered Services Behavioral Health.

### **AHCCCS Long Term Care System (ALTCS)**

The Arizona Long Term Care System covers, but is not limited to, the below list of services.

- Preventive and acute medical care services such as:
  - Doctor visits,
  - Hospitalizations,
  - Prescriptions (prescription coverage is limited for people who have Medicare),
  - Labs,
  - X-rays, and/or
  - Tests and other specialist treatments.
- Home and Community Based Services (HCBS) such as:
  - Home Health Nursing;
  - Personal Care;
  - Homemaker;
  - Home Health Aide;
  - Habilitation;
  - Medical Transportation;
  - Attendant Care;
  - Home Delivered Meals;

- Adult Day Care;
- Behavioral Health;
- Respite Care;
- Hospice;
- Nursing services for ventilator dependent individuals residing at home;
- Services may also be provided in a supervised alternative setting, such as an Adult Foster Care Home, Assisted Living Home, Group Home, or a Level I, II, or III Behavioral Health Center.
- Long term care institutional services such as:
  - Alternative residential living services,
  - Nursing Home Care, or
  - Intermediate Care Facility.
- Residential treatment facility for persons under 21 years of age;
- Psychiatric hospital for persons age 65 or older;
- Speech, physical, respiratory, and occupational therapies; and/or
- Dental, including:
  - Medically necessary dental services up to \$1,000.00 per benefit year for:
    - Diagnostic,
    - Therapeutic,
    - Preventative care; and/or
    - Dentures.
  - Emergency dental services up to \$1,000 per benefit year.

Arizona Long Term Care services are covered more extensively in the ALTCS regulations, as specified in A.A.C. Title 9, Chapter 28, Articles 2 and 11.

**Note:** Out-of-state services are covered when the conditions outlined in 42 CFR, Part 431, Subpart B are met.

- Services are needed because of a medical emergency;
- Services are needed and the member's health would be endangered if he were required to travel to his/her State of residence;
- The State determines, on the basis of medical advice, that the needed services, or necessary supplemental resources, are more readily available in the other State; or
- It is the general practice for the members in a particular locality to use medical resources in another State.

**Note:** Services furnished to AHCCCS members outside the United States are not covered.

**Note:** Out-of-state services are covered when the conditions outlined in 42 CFR, Part 431, Subpart B are met.

## MEDICAL NECESSITY

Medical necessity may be determined through a professional review for appropriateness of services related to severity of illness and intensity of services. Documentation submitted by providers is key to the determination of medical necessity. Failure to submit documentation that substantiates medical necessity may result in denial of reimbursement.

## UTILIZATION MANAGEMENT

Payment for services is subject to AHCCCS rules, the Provider Agreement, policies and requirements, including, but not limited to the following Utilization Management functions:

- Prior Authorization
- Concurrent Review
- Medical Claims Review
- Post-Payment Review
- Special Consent Requirements

## Prior Authorization

Prior Authorization (PA) is a process by which the AHCCCS Division of Fee-For-Service (FFS) Management (DFSM) determines in advance whether a service that requires prior approval will be covered, based on the initial information received.

No Prior Authorization is required for Title XIX members receiving services at an IHS or 638 facility. Title XXI (KidsCare) and Tribal ALTCS members may require PA for certain services.

For information on Prior Authorization please refer to Chapter 6, Prior Authorization, of the IHS/Tribal Provider Billing Manual and to AMPM 820, Prior Authorizations. Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process and services requiring PA, which can be found at:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html>

## Contact Telephone Numbers

Please see Exhibit 1-4 in the Fee-For-Service Provider Billing Manual for a quick reference to important telephone numbers.



## Revision History

Date	Description of changes	Page(s)
10/1/2018	Information on Integration/AHCCCS Complete Care (ACC), when it begins, and which populations are excluded added.	2-3
	Clarification added to the AHCCCS Acute Care section.	5
	“AHCCCS contracted health plans” changed to “AHCCCS Complete Care (ACC) health plans” “MCOs” removed throughout.	All
4/26/18	Prior Authorization section added, including a link to the PA webpage.	7
3/9/18	AHCCCS Fee-For-Service Populations section updated	3
	Emergency Services section added	3-4
	AHCCCS Covered Services section updated for Emergency Services, Acute Care Services, and ALTCS Services	4-5
	Contact Telephone Numbers section added	7
	Formatting	All