REVISION DATES: 7/8/24; 3/11/24; 8/29/24; 10/1/2021; 9/12/2019; 10/1/2018; 4/13/2018; 3/15/2018; 2/9/2018; 1/24/2018;12/29/2017; 11/1/2017

GENERAL INFORMATION

A person or company may participate as an AHCCCS provider if the person or company is qualified to render a covered service and comply with AHCCCS policies and procedures for provider participation.

To become an AHCCCS provider, a provider must sign the Provider Participation Agreement (PPA). Per the PPA providers must follow all AHCCCS guidelines, policies and manuals, including but not limited to the following: the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Fee-For-Service Provider Billing Manual, AHCCCS Claims Clues, and Reporting Guides. These guidelines, policies and manuals are available on the AHCCCS website.

Providers are encouraged to subscribe to receive notifications about upcoming trainings, forums, and important business updates via AHCCCS' email notification system.
The email notifications, sent straight to a FFS provider's email inbox, are sent out regarding changes to the program, claims and billing updates and requirements, and system changes.

In accordance with the Affordable Care Act, Section 6401 and 42 CFR Subpart E, institutional and other designated providers are required to submit an enrollment fee.

For purposes of the enrollment fee, institutional and other designated providers includes, but it is not limited to:

- The range of ambulance service suppliers;
- Ambulatory Surgical Centers (ASCs);
- Community Mental Health Centers (CMHCs),
- Comprehensive Outpatient Rehabilitation Facilities (CORFs);
- Durable Medical Equipment Prosthetics/Orthotics Suppliers (DMEPOS);
- End State Renal Disease (ESRD) facilities;
- Federally Qualified Health Centers (FQHCs);
- Histocompatibility Laboratories;
- Home Health Agencies (HHAs);
- Hospices;
- Hospitals, including but not limited to acute inpatient facilities; Inpatient Psychiatric Facilities (IPFs), Inpatient Rehabilitation Facilities (IRFs), and physician-owned specialty hospitals;
- Critical Access Hospitals (CAHs);
- Independent Clinical Laboratories;

- Independent Diagnostic Testing Facilities (IDTFs);
- Mammography Centers;
- Mass Immunizers (Roster Fillers);
- Non=Emergency Transportation Providers;
- Organ Procurement Organization (OPOs);
- Outpatient Physical Therapy, Occupational Therapy, and Sspeech Pathology Groups;
- Personal Care Agencies;
- Portable X-Ray Suppliers;
- Skilled Nursing Facilities (SNFs);
- Radiation Therapy Centers;
- Religious Non-Medical Health Care Institutes (RNHCIs);
- Residential Treatment Centers; and
- Rural Health Clinics (RHCs).

In addition to the providers and suppliers listed previously, other agencies may be included.
The enrollment fee **does not** apply to physicians or non-physicians practitioners.

Provider types requiring an enrollment fee can be found on the AHCCCS website at www.azahcccs.gov. Providers will be instructed during the registration process regarding payment submission requirements.

Note: If a provider appropriately validates that the fee has previously been paid to Medicare or another Medicaid State Agency, the fee for Arizona may be waived. The enrollment fee is effective as of January 1, 2012.

Fee-For-Service providers do *not* need to contract with AHCCCS AIHP, Tribal ALTCS or a TRBHA to continue providing Medicaid Title XIX and XXI services to FFS members. A provider simply must be an AHCCCS registered provider.

Definitions:

Servicing/Rendering Provider:

A servicing (rendering) provider is the provider who actually performed the services for/to an AHCCCS eligible member.

- For purposes of AHCCCS claim submissions, the servicing (rendering) provider cannot be an AHCCCS registered provider type “01,” a Group Billing Entity. Health care service providers were associated with the group and one check was produced and paid to the Group Billing Entity.

The Billing Provider:

The billing provider is the "Pay-To" provider associated in the AHCCCS system (PMMIS) with the rendering provider. This is the entity/person who will receive the check/wire/remit.

A Billing Entity:

AHCCCCS identifies a billing entity as the "member of the payment." This provider can be a servicing (rendering) provider, a group billing entity/group biller (provider type 01), or a billing entity.

Group Billing Entity:

The group billing entity is the "member of the payment." This provider can be a servicing (rendering) provider, a group billing entity/group biller (provider type 01), or a billing entity.

AHCCCS Provider Registration Materials

Providers are required to:

- Complete an application;
- Sign a provider agreement;
- Complete and sign all applicable forms (i.e., criminal offense forms, attestations, etc.);
- Submit documentation of their applicable licenses, certificates, and/or CMS certification;
- Submit documentation of their National Provider Identification (NPI) Number (if applicable); and
- Submit a Disclosure of Ownership if registering as a company or facility.

Information and registration materials may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area:(602) 417-7670 (Option 5)

In-state: 1-800-794-6862 (Option 5)

Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials are also available on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/NewProviders/packet.html.

This can also be reached by going to the AHCCCS website at www.azahcccs.gov. Once there click on the "Plans/Providers" tab and choose the "Provider Registration" option. Once on the "AHCCCS Provider Registration" page, in the left hand column under "New Providers" click on "Provider Registration Packets." The forms can be filled out on the AHCCCS website, but must be submitted by fax or mail to the Provider Registration Unit.

AHCCCS Provider Registration Unit
Mail Drop 8100
P.O. Box 25520
Phoenix, AZ 85002

Documentation Requirements for Electing 638 FQHC Status

Any Tribal 638 Clinic electing to become a Tribal 638 FQHC must submit written notification to the AHCCCS Administration's Provider Registration Section. The written notification must include:

- The name of the Tribal 638 Clinic electing to change its designation,
- The full address of the Tribal 638 Clinic,
- The date that the Tribal 638 Clinic is requesting the designation change to go into effect, and
- A signature from one of the authorized signers on record for the provider, within the provider's current provider profile.

Notification of election to become a 638 FQHC may be mailed or faxed. If mailing, mail to:

AHCCCS Provider Registration
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

If faxing, fax to:

Attention: AHCCCS Provider Registration
602-256-1474

There is no cost to the provider to elect to change from a Tribal 638 Clinic to a Tribal 638 FQHC.

If a provider has not been previously registered with AHCCCS, the provider will need to follow all existing new provider registration steps

Documentation Requirements for American Indian Medical Homes (AIMH)

Any IHS or Tribal 638 facility wishing to do so may elect to become an American Indian Medical Home (AIMH). For providers electing this option, the provider must:

- Complete the AIMH Registration Form;
- Have a Primary Care Case Management (PCCM) accreditation from the National Committee for Quality Assurance (NCQA) or another appropriate accreditation body;
- Sign a National IHS Improving Patient Care (IPC) program annual attestation;
- Be willing to enter into an AIMH Intergovernmental Agreement (IGA); and
- Be able to provide members with 24 hour access to a care team.

Eligible IHS/638 Provider Types:

- 02 – Hospital
- 05 – Clinic (excluding dental providers)
- IC – Integrated Clinic
- C2 – Federally Qualified Health Center (FQHC)
- 29 – Community/Rural Health Center (RHC)

Required documentation that must be submitted to AHCCCS includes:

- The AIMH Registration Form;
- The AIMH Application Request Form (if faxing it is the fax cover sheet);
- The AIMH Intergovernmental Agreement (IGA);
- Supporting documents for service level and accreditation;
- The Electronic Data Interchange (EDI) checklist; and
- W9 Form.

The required documentation to elect to become an AIMH may be faxed, emailed, mailed or hand delivered to AHCCCS. The AIMH Registration Form can be found at:
https://www.azahcccs.gov/AmericanIndians/Downloads/AIMHProviderPacketSubmissionDocuments/AIMHProviderRegistrationForm.pdf

If faxing, the AIMH Application Request Form must be included as the packet's cover sheet and can be found at:
https://www.azahcccs.gov/AmericanIndians/Downloads/AIMHProviderPacketSubmissionDocuments/AIMHApplicationFaxRequestForm.pdf

Additional information about the AIMH may be found on the AHCCCS website at:
https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/

The AIMH will be required to submit a renewal application and an AIMH IGA renewal amendment annually. In addition to the renewal application, if there is a change in tier level the AIMH shall submit the appropriate documentation and any additional supporting documents as requested by AHCCCS.

AHCCCS Provider Registration Application Approval

When a provider's application is approved, an AHCCCS provider ID number is assigned, and the provider is notified by letter.

Out-Of-State Waiver (One Time Only):

Out-of-state providers, under limited circumstances, may qualify for a one-time waiver of full registration requirements. A provider who qualifies for this waiver must complete the following:

- Provider Agreement
- Form W-9: Request for Taxpayer Identification Number and Certification
- Copies of license and/or certifications
- Copy of the provider's claim

Medicare-certified facilities are registered as active providers for the dates of service.

Other providers who qualify for this waiver are registered for 30 days. The provider must complete the full registration process, except in extenuating circumstances when approved by the AHCCCS Office of the Inspector General.

For additional information about registering as an out-of-state provider please contact the AHCCCS Provider Registration Unit at:

Phoenix area:	(602) 417-7670 (Option 5)
In-state:	1-800-794-6862 (Option 5)
Out of state:	1-800-523-0231, Ext. 77670

AHCCCS Provider Types

All AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. Provider types indicate what type of providers can bill for certain services. The AHCCCS Provider Registration Unit will help providers identify

the most appropriate provider type, based on the provider's license/certification and other documentation.

A listing of provider types can also be found in AMPM 610, Attachment A – AHCCCS Provider Types.

AHCCCS Provider Categories of Service (COS)

Within each provider type, mandatory and optional categories of service (COS) are identified.

Mandatory COS are defined by mandatory license or certification requirements. The provider must submit documentation of licensure and/or certification for each mandatory COS.

Optional COS are those that the provider may be qualified to provide and chooses to provide.

- Optional COS, which do not require additional licensure and/or certification, are automatically posted to the provider's file.
- Optional COS, which do require additional licensure and/or certification, are posted once proof of current, valid licensure and/or certification is received.

Mandatory and optional COS, licensure/certification requirements, and the applicable procedure codes for each provider type are listed in the Provider Profile. Providers may be limited to certain procedures within a COS. If limitations are applicable, the allowable procedures are identified in the Provider Profile.

DOCUMENTS REQUIRED FOR PROVIDER REGISTRATION (EXCEPT FOR ONE TIME WAIVER)

The following documents must be completed, signed by the appropriate parties, and on file with the Provider Registration Unit before an AHCCCS Provider Registration number will be issued and the provider registration records activated:

- Provider Registration Application Form

  This form must be completed in its entirety and must be signed by the provider, administrator, CEO, or owner.

- Provider Agreement

The Provider Agreement is a contractual arrangement between the AHCCCS Administration and the provider.
The agreement's form and content are consistent with Medicaid regulations, and no changes may be made to the language of the agreement.

By signing the agreement, the provider indicates the following:

- The provider has read the document in its entirety,
- The provider understands all the terms of the agreement, and
- The provider agrees to all of the stipulations in the agreement.

Any provider who violates the terms of the agreement is subject to penalties and sanctions, including termination of the Provider Agreement.

The Provider Agreement remains in effect until terminated by either the AHCCCS Administration or the provider.

The agreement for long term care facilities must be renewed annually, concurrent with the expiration date (survey date) for Medicare/Medicaid recertification.

This agreement is required of all providers, including one-time-only providers.

- Proof of Licensure and Certification

  Each provider must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

  Documentation of all licenses and certifications must be provided.

  IHS providers do not require an Arizona license, as long as the provider has a valid license in another state.

- Form W-9: Request for Taxpayer Identification Number and Certification
- CMS Certification for Tribal Providers
- Disclosure of Ownership and Criminal Offenses Statements (when applicable)
- All providers are required to revalidate their enrollment with AHCCCS every five years beginning January 1, 2012. Providers will be contacted when their renewal is due.

  Providers registered prior to January 1st, 2012 will be required to re-enroll and then revalidate every five years thereafter. Providers will be contacted regarding their reenrollment date.

REGISTRATION OF IHS PROVIDERS

An IHS facility must be a federally qualified and certified in order to be registered as an AHCCCS provider. Services provided by the facility must be in accordance with the inter-governmental agreements that are in place between IHS, AHCCCS and/or CMS.

Individual IHS providers are registered under one of 14 provider types:

- MD - Physician
- DO - Physician Osteopath
- Podiatrist
- Dentist
- Psychologist
- Optometrist
- Physician Assistant
- Nurse Practitioner
- Certified Nurse-Midwife
- Speech Therapist
- Occupational Therapist
- Physical Therapist
- Certified Registered Nurse Anesthetist
- Respiratory therapist

Each IHS Area Office or IHS facility must maintain a roster of its AHCCCS-registered individual providers. As staff changes occur, including both staff additions and deletions, each IHS Area Office or IHS facility must notify AHCCCS of those changes. Each IHS Area Office or IHS facility is responsible for informing AHCCCS when one of its AHCCCS-registered providers terminates IHS employment.

Each physician and mid-level practitioner must complete a Provider Application packet and AHCCCS Provider Agreement. The “Pay To” address on the Provider Application must list the IHS facility with which the provider is employed, the facility address, and facility tax identification number.

A copy of the provider's current license must be attached with the application. An Arizona license is not required if the provider has a current, valid license from another state.

REGISTRATION OF TRIBAL PROVIDERS

Because tribal providers are located on Indian reservations where the Arizona Department of Health Services (ADHS) does not have jurisdiction, these providers do not have ADHS facility licenses. In place of the ADHS facility licensure, CMS certification is required.

The tribal provider must complete the CMS certification form (available from Provider Registration) and submit the form to AHCCCS with the application. The authorized representative for the tribe must sign the certification and recertification forms indicating that the tribe certifies that the provider meets the same standards as all other AHCCCS providers and that the tribe assumes full liability for the certified provider. If someone other than the tribal chairman signs the form, CMS will need documentation to show that the person signing the form has the authority to sign for the tribe.

The Provider Registration staff will review the provider application and CMS certification submittal and forward it to CMS for its approval. CMS will notify Provider Registration that the tribe is certified to provide services. Provider Registration then will notify the tribe of CMS' certification or recertification.

On the initial certification, Provider Registration will notify the tribal provider of the AHCCCS provider ID number once the registration process is complete.

Tribal providers seeking recertification should request the forms from Provider Registration at least 90 days before the current certification expires.

BILLING PROVIDERS AND GROUP BILLING PROVIDERS

An AHCCCS-registered IHS facility or a tribal facility or organization wishing to act as the financial representative for a provider or group of providers, who have authorized this arrangement, may register as a Group Biller with AHCCCS. Group billers may not provide services or bill as the service provider. They will receive a separate AHCCCS Registration Number.

The service provider must sign a Group Billing Authorization Form. The form allows the group biller to submit the provider's claims and to receive the provider's AHCCCS payments. The Authorization Form may be obtained from the AHCCCS Provider Registration Unit or online at

https://www.azahcccs.gov/PlansProviders/Downloads/ProviderRegistration/GroupBillingAuthorization.pdf.

The tribal administrator or the IHS facility administrator must sign the group biller application form.

The service (rendering) provider's AHCCCS provider ID number must appear on each claim, even though a group billing number may be used for payment.

The servicing (rendering) provider will remain affiliated with the authorized group billing provider until the provider furnishes written notification, signed by the authorized signer or the provider, to the Provider Registration Unit indicating a termination from the group billing arrangement.

All payments for the service provider will be sent to the pay-to address of the group billing provider, with whom the service provider is affiliated, if the group billing provider ID number is entered on the claim.

IHS group billers must use the facility's "pay-to" address and tax ID number.

If a provider has multiple locations, the provider may have multiple billing provider affiliations.

REGISTERING FOR THE PROVIDER PORTAL (AHCCCS ONLINE)

Providers may register for the provider portal (AHCCCS Online) and typically register after they have received approval as an AHCCCS registered provider. The provider portal allows providers to check for member eligibility, to submit and track the status of prior authorization requests, and to submit and track the status of claims.

To create an account and begin using AHCCCS Online providers must go to the following web address and follow the instructions provided on the website:

https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

There is no charge for creating an account and there is no transaction charge.

When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the **master account holder**.

- Note: The master account holder is typically the first employee or agent to register an account from that provider. However, another user can be designated as the master account holder at the provider's request.

Upon registering the master account holder's *account*, AHCCCS will send the master account holder a temporary password. The master account holder will then log into AHCCCS Online with the temporary password and shall change it to a new password.

After the master account holder is set up, other employees and agents of the newly registered provider (such as a biller) may then register for an account on AHCCCS Online.

- At that point, **it will be the master account holder's responsibility** to change that user's account settings to ensure they have been granted the appropriate access to the subsystems that are directly related to that user's specific employment related duties.

The master account holder is responsible for informing itself and its employees and agents of the requirements of all applicable privacy laws.

In the event that a master account holder leaves employment with the provider, the facility must call AHCCCS to request that another user's account be changed to the master account holder designation.

CORRESPONDENCE, PAY-TO, AND SERVICE ADDRESSES

AHCCCS maintains a correspondence address, a pay-to address or addresses, and a service address or addresses for each provider except group billers. For group billers, AHCCCS maintains a correspondence address and a pay-to address only.

- The *correspondence address* is the address where billing instructions, letters, and all other correspondence, except checks, are mailed.

  Each provider has only one correspondence address, even if a provider has multiple service addresses.

  - Even if a provider has multiple service addresses, the provider has only one correspondence address.
  - A provider must indicate the address where the provider wishes correspondence to be sent regardless of the service address(es).

  If the provider changes practices, partnerships, or place of practice, the provider must timely update the correspondence address; otherwise new

correspondence will not be directed to the correct address. The provider may update this by using the AHCCCS Online provider portal at: https://azweb.statemedicaid.us

- The *pay-to address* is the address on the reimbursement check from AHCCCS.

  The Remittance Advice, along with the reimbursement check, are mailed to the provider's pay-to address as determined by the provider's tax identification number (see next section).

  NOTE: ACH payments (electronic reimbursement) are sent directly to your bank. Paper copies of the Remittance Advice are mailed to your pay-to address. If your pay-to address is a lockbox at the bank, you should contact the Provider Registration Unit to change the pay-to address to the location where your payment posting occurs. This will prevent delays in receiving the remits from the lockbox. Should duplicate remits be required, the AHCCCS Finance Unit charges $2.00 per page to reproduce.

- The *service address* is the business location where the provider sees patients or otherwise provides services.

  A locator code (01, 02, 03, etc.) is assigned to each service address.

  As new service addresses are reported to AHCCCS, additional locator codes are assigned.

  When a service address is no longer valid, then the provider must notify AHCCCS of the new service address to ensure the new service address locator codes are updated. A provider must report in APEP a change in servicing address at least 30 days prior to the effective date of the change.

TAX IDENTIFICATION NUMBER

A provider's tax identification number (TIN) determines the address to which payment is sent.

AHCCCS requires providers to enter their TIN on all Fee-For-Service claims submitted to the AHCCCS Administration. If no TIN is on file, the AHCCCS system will deny the claim because it will be unable to direct payment to a specific address.

If a provider's record shows more than one address linked to a TIN, the system will direct payment and the Remittance Advice to the first address with that TIN. Providers who want reimbursement checks directed to more than one address must establish a separate TIN for each pay-to address.

Note: Previously, a provider's two-digit service address locator code (01, 02, 03, etc.) was linked to one or more pay-to addresses. The locator code determined the address to which payment was sent.

Providers should continue to append the service address locator code to their AHCCCS provider ID number to indicate the location where a service was performed. However, using the locator code will no longer direct payment to a specific address.

Providers must enter the appropriate TIN on the claim form to direct payment to the correct address.

Providers who have questions about TIN information on file with AHCCCS should contact the AHCCCS Provider Registration Unit.

Changes to Information on File

It is the provider's responsibility to notify the Provider Registration Unit in writing of any changes to the information on file at AHCCCS. Failure to report changes may result in misdirected payments and correspondence and could result in the termination of the provider's active status or recoupment of payment.

All changes to information on file must be signed by the provider or the provider's authorized agent. The authorized agent must be authorized by the provider and on file with the Provider Registration Unit.

Changes that must be reported include, but are not limited to, changes affecting:

- Licensure/Certification

  A copy of the licensure or certification document should accompany notification.

- Addresses (correspondence, pay-to, and/or service)

  Change of address forms are available from the Provider Registration Unit.

  When a provider changes an address, a letter is sent to the provider for verification.

  If the information on the verification letter is incorrect, the provider must indicate the necessary changes, sign the letter, and return it to the Provider Registration Unit.

  If the address information on the verification letter is correct, no further action by the provider is required.

  A provider must report in APEP a change in servicing address at least 30 days prior to the effective date of the change.

- Name

  A letter advising AHCCCS of the name change and supporting documentation (marriage license, divorce decree, or a copy of the provider's current license) is required.

- Group Billing Arrangements
- Ownership

  The Provider Registration Unit will mail the provider a new registration packet.

  The provider must complete a new Provider Registration Packet.

  When all information is received from the appropriate agencies, the Provider Registration Department will assign a new AHCCCS Registration number.

- Hours of Operation

  A provider must report in APEP a change in hours of operation at least 5 days prior to the effective date of the change.

  In case of an emergency that results in a facility closure, a provider must provide AHCCCS written notice within 24 hours of the emergency. The closure and the reason for closure must be posted at the entrance of the facility.

Licensure/Certification Updates

Each provider must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

AHCCCS systematically sends a letter requesting a renewed license/certificate to a provider's license/certification board or agency (except the Arizona Medical Board), prior to expiration of the provider's license.

If a response is not received from the board or agency within 45 calendar days, a request for a copy of a renewed license/certificate is sent directly to the provider. If the provider does not provide a copy of current license/certification within 21 calendar days of the notification, the provider's active status will be terminated.

All providers are required to revalidate their enrollment with AHCCCS every five years beginning January 1, 2012. Providers will be contacted when their renewal is due.

Providers registered prior to January 1st, 2012 will be required to re-enroll and then revalidate every five years thereafter. Providers will be contacted regarding their reenrollment date.

MEDICAL RECORDS

As a condition of participation, a provider must maintain and make available all records and information including, but not limited to, medical and financial records, relating to the AHCCCS program. Such records shall be provided at no cost to the AHCCCS Administration or its Contractors.

The member's medical records must be maintained in a current, detailed, organized, and comprehensive manner that permits effective review. Records must be legible and reflect all aspects of care, including ancillary services.

Electronic Health Records

Providers must ensure that its Electronic Health Records (EHR) System accurately records, maintains, and reflects all original entries including, but not limited to, original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). Providers shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.

Signature Requirements

Medical records documented on hard copy shall be written legibly in blue or black ink, signed, and dated by the rendering provider for each entry. Electronic format medical records shall also include the provider's name who made the entry and the date for each entry. Providers in multi-provider offices shall have the treating provider sign his or her treatment notes after each appointment and/or procedure. Provider signature shall occur as close to the actual entry of treatment notes as possible and based on either professional standards of care and/or requirements specified within A.A.C. Title 9, Chapter 10.

Acceptable Signatures:

Valid signatures may be electronic or physically handwritten; however, both shall have the legible name of the signer printed, signer's credentials (specific license type of professional credentials), and the 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 timestamp if not part of the 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."

On-Sight Audit

For providers serving AHCCCS members AHCCCS reserves the right to conduct on-sight audits for quality-of-care purposes, either directly or via a Managed Care Organization. On-sight audits will be conducted on any related documentation for these members.

1. AHCCCS and/or MCO audit teams will internally identify documentation to be audited, and a list of specified items will be given to the provider at the commencement of the on-site visit.

2. Audits will occur on site and will be based on members utilization of services.

3. Providers shall supply the complete documentation as requested by the AHCCCS and/or MCO Audit Team within two hours of the request. Documentation shall be delivered as a paper copy of the documents.

Substance Use Disorder Part 2 Rule

The federal confidentiality law and regulations protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized disclosure of patient records except in limited circumstances. If a provider treats or diagnosis a patient for treatment of SUD and is subject to the Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) as a Part 2 Program, that provider must comply with these terms with respect to any claim or other information they submit to AHCCCS that contains patient identifying information.

Agencies/Companies

Agencies and companies without licensing requirements must provide **documentation** of all employees (i.e. attendant care companies, non emergency transportation providers etc.) and their required licenses or certification upon request.

Agencies and companies are responsible for verification of their employees' qualifications to participate in the Medicaid program. Failure to do so will result in termination of participation in the Medicaid program.

Incentives

Contractors may not offer members incentive items (e.g. gift cards, discounts for merchandise or services, manufacturer or store coupons for savings on products) to influence their enrollment or continued enrollment with a particular Contractor, as specified in A.A.C R9-22-504.

Among other activities not permitted, 42 USC 1320a-7b (b)(2) prohibits individuals from (knowingly and willfully) offering or paying any remuneration, whether it is cash or in kind, to anyone for the purpose of inducing that individual to order or arrange for any service or item for which payment may be made by a federal health care program, including Medicaid. The offer or payment may be direct or indirect. Such conduct is considered a felony with the possibility of imprisonment up to 5 years as well as a fine not to exceed $25,000.

Contractors *may* offer incentive items to members to participate in health-related promotions, but the total value of the items at each event or program may not exceed $50.00 per member annually.

Physician/Mid-Level Practitioner Registration

Hospitals and clinics may not bill the AHCCCS Administration or its Contractors for physician and mid-level practitioner services using the hospital or clinic NPI number.

Physicians and mid-level practitioners must register with AHCCCS and bill for services under their individual NPI numbers.

Mid-level practitioners include:

- Physician Assistants
- Registered Nurse Practitioners
- Clinical Nurse Specialist
- Certified Nurse-Midwives
- Certified Registered Nurse Anesthetists (CRNAs)
- Surgical First Assistants
- Affiliated Practice Dental Hygienist

Note**:** Physician Assistants, Certified Nurse-Midwives, Clinical Nurse Specialist and Nurse Practitioners are reimbursed at 90 per cent of the AHCCCS capped fee or billed charges, whichever is less. Surgical First Assistants are reimbursed at 70 per cent of the AHCCCS capped fee or billed charges, whichever is less. CRNAs are reimbursed at 100 per cent of the AHCCCS capped fee or billed charges, whichever is less. Affiliated Practice Dental Hygienists are reimbursed at 80 per cent of the AHCCCS capped fee or billed

charges, whichever is less.

Hospitals and clinics may register as group billers and bill as an agent for physicians and mid-level practitioners. In these cases, the claims submitted to AHCCCS must include *both* the physician's/mid-level practitioner's NPI as the rendering/service provider and the hospital's/clinic's or group biller NPI number.

AHCCCS Registration in Accordance with 42 CFR 455.410

Per 42 CFR 455.410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) must require all ordering or referring physicians, or other professionals providing services under the State plan or under a waiver of the plan, to be enrolled as participating providers. All providers, including but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

After January 1st, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny.

A provider who chooses to order, refer, or prescribe items and/or services for AHCCCS members, but who chooses not to submit claims to AHCCCS directly, must still be registered with AHCCCS to ensure payment of those items and/or services. If a rendering provider submits a claim to AHCCCS based on the order, referral, or prescription of a provider *not* registered with AHCCCS then that claim will be denied. To ensure payment of claims when submitting for items and/or services ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is both registered with AHCCCS and that their NPI number is on the submitted claim.

Locum Tenens

BILLING UNDER LOCUM TENENS ARRANGEMENTS

It is the policy of the AHCCCS Administration to recognize locum tenens arrangements but to restrict them to the length of the locum tenens registration with the Arizona Medical Board. The Arizona Medical Board issues locum tenens registration for a period of 180 consecutive days once every three years to allow a physician, who does not hold an Arizona license, to substitute for or assist a physician who holds an active Arizona license. Locum tenens registration with the Arizona Medical Board is required before AHCCCS recognizes a locum tenens arrangement.

The locum tenens provider must submit claims using the AHCCCS provider ID number of the physician, for whom the locum tenens provider is substituting for or temporarily assisting.

All services provided by the locum tenens provider must be billed with the "Q6" modifier.

providers are substituting for or assisting which AHCCCS-registered providers.

Provider Types 40 (Attendant Care)

Effective 6/1/2015 a provider registering as a Provider Type 40 will be required to be an AHCCCS registered provider for a period of twelve (12) months prior to being able to bill for non-emergency medical transportation (NEMT) services. Upon completion of the 12 month period these provider types will be able to bill NEMT services. However, the NEMT services should not exceed 30% of the overall services billed.

TERMINATIONS

There are several reasons a provider's participation in the AHCCCS program may be terminated.

- Voluntary Termination

  Upon thirty (30) days written notice, either party may voluntarily terminate this Agreement. Providers may voluntarily terminate participation in the program by providing 30 days written notice to:

  AHCCCS Provider Registration Unit MD 8100
  P.O. Box 25520
  Phoenix, AZ 85002

- Loss of Contact

  AHCCCS may terminate a provider's participation due to loss of contact with the provider.

  Contact is considered to be lost if mail is returned as undeliverable by the Postal Service.

  Providers must inform the Provider Registration Unit of any address changes to avoid misdirected or lost mail and possible termination of provider status.

- Termination for Cause

  The AHCCCS Administration has the right to terminate participation in the program by providing 24 hours written notice when:
  - It is determined that the health or welfare of a member is endangered,
  - That the provider fails to comply with federal and state laws and regulations, or
  - There is a cancellation, termination, or material modification in the provider's qualifications to provide services.

  Any provider determined to have committed fraud or abuse related to AHCCCS or

ALTCS or the Medicaid program in other states may be terminated or denied participation. This provision is also extended to providers terminated from Medicare participation.

Providers who AHCCCS determines to be rendering substandard care to AHCCCS or ALTCS members may be terminated, suspended, or placed on restrictions or review. Restrictions may be placed on the scope of services, service areas, health plan participation, or other limitations imposed related to quality of care.

If the provider's mandatory license or certification is revoked, is suspended, or lapses, the provider's participation may be terminated or suspended.

Providers may be suspended or terminated when arrested by law enforcement.

Providers whose scope of service has been restricted by the licensing board may be terminated from the AHCCCS program.

SANCTIONS

Providers may be sanctioned by AHCCCS for violations of the terms of the Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the provider. The decision to sanction will be based on the seriousness of the offense, extent of the violation, and prior violation history.

AHCCCS may impose any one or any combination of the following sanctions against a provider who has been determined to have abused the AHCCCS or ALTCS programs:

- Recoupment of overpayment
- Review of claims (prepayment or postpayment)
- Filing a complaint with licensing/certifying boards or agencies or with local, state or federal agencies, and/or reporting to National Data Banks.
- Peer review
- Restrictions (e.g., restricted to certain procedure codes)
- Suspension or termination of provider participation

AHCCCS may impose any one or a combination of the following sanctions against a registered provider, who AHCCCS has determined to be guilty of fraud or convicted of a crime related to the provider's participation in Medicare, Medicaid, AHCCCS, or ALTCS programs:

- Recoupment of overpayment
- Suspension of provider participation
- Termination of provider participation

- Civil monetary penalty
- Criminal prosecution

NOTICE OF ADVERSE ACTION

The Provider Registration Unit will provide written notice of termination or suspension to providers, which will include the effective date, the reason, and the provider's grievance rights.

- Actions based on fraud or abuse convictions are effective on the date of the conviction.
- Actions due to revocation, suspension, or lapse of licensure or certification are effective the date that the license or certification becomes invalid.
- Actions due to the quality or appropriateness of care provided are effective on the date specified by the AHCCCS Office of Special Programs.
- All other adverse actions are effective 15 calendar days from the date of notification.

For adverse actions requiring 15 calendar days notice, the provider may submit evidence to Provider Registration disputing the action within 15 calendar days of the date of the notice. Provider Registration will review all documentation received by the first workday following the expiration of the 15-day notice period.

If Provider Registration confirms that the provider is eligible to participate, a notice will be sent to the provider verifying that no action will be taken to terminate participation.

Providers may grieve any adverse action including termination, suspension, and restriction.

Claim Types

Claims submitted for reimbursement at the All Inclusive Rate must be submitted on the UB-04 Claim Form. Claims submitted for professional services, not to be reimbursed at the AIR, must be submitted on the CMS-1500 Claim Form. Dental claims, not to be reimbursed at the AIR, must be submitted on the ADA Dental Claim Form.

UB-04, FL01
The name and service location of the provider submitting the bill.

CMS-1500 (08/05), Item Number 24J, if not the same as 33
The Rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care.

ADA Dental Claim Form, Data Element 53

The treating, or rendering, dentist's signature and date the claim form was signed.

(The ADA Dental Claim form does not contain a place for the treating dentist name, separate from the signature line.)

Revision/Update History

Date	Description of changes	Page(s)
7/8/24	Added Substance Use Disorder Part 2 Rule	17
3/11/24	Medical Records section updated with new subsection for Electronic Health Records, Signature Requirements, and Acceptable signatures.	12
8/29/23	Additional details added to the Servicing Address requirements. New language added for Hours of Operation change requirements. New section added for On-site Audit process	9 & 11 11 12
10/1/2021	Added Clinical Nurse Specialist to the list of Mid-level practitioners	17
9/12/2019	The Provider Inactivity section was removed as this is not standard practice.	19

10/1/2018	The following clarification was added: "To become an AHCCCS provider, a provider must sign the Provider Participation Agreement (PPA). Per the PPA providers must follow all AHCCCS guidelines, policies and manuals, including but not limited to the following: the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Fee-For-Service Provider Billing Manual, AHCCCS Claims Clues, and Reporting Guides. These guidelines, policies and manuals are available on the AHCCCS website. Providers are encouraged to subscribe to receive notifications about upcoming trainings, forums, and important business updates via AHCCCS' email notification system. The email notifications, sent straight to a FFS provider's email inbox, are sent out regarding changes to the program, claims and billing updates and requirements, and system changes." The following was added regarding integration questions: "Fee-For-Service providers do *not* need to contract with AHCCCS AIHP, Tribal ALTCS or a TRBHA to continue providing Medicaid Title XIX and XXI services to FFS members. A provider simply must be an AHCCCS registered provider."	1 2
4/13/2018	A new section called "AHCCCS Registration in Accordance with 42 CFR 455.410" was added, detailing the Affordable Care Act's requirement for all providers to be registered with AHCCCS in order to be reimbursed.	17
3/15/2018	Registration requirements to become a 638 FQHC	3-4
2/9/2018	Registration requirements to become an AIMH	4-5
1/26/2018	Registering for the Provider Portal (AHCCCS Online) section added, detailing information about the Master Account Holders account.	8-9

12/29/2017	Acronym clarifications were added. Definitions section was added. The Provider Registration Materials section was updated. The revalidation of enrollment information was updated. The Billing Providers & Group Billing Providers section was updated Correspondence, Pay-To, and Service Addresses section updated	1 2 3 3 9 10
	The Tax Identification Number section was updated. Changes to Information on File section as updated. Licensure/Certifications section as added Agencies/Companies section was added. An Incentives section was added. Physician/Mid-Level Practitioner Registration section was added. Locum Tenens section was added. Attendant Care section was added. The Terminations section was updated. Claim Types section was added. General Formatting & Updates	11 11-12 12 13 13 13-14 14 15 15 17 All
01/01/2015	New document format; content, definitions updated by Provider Registration	All