ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

AHCCCS MEDICAL CODING RESOURCE GUIDE

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GENERAL INFORMATION

The AHCCCS Medical Coding Resource Guide is provided as a resource for general information regarding medical coding. This Guide does not supersede any information contained in the AHCCCS Medical Policy Manual (AMPM), AHCCCS Contractors Operations Manual (ACOM), the Fee-for-Service (FFS) Provider Billing Manual, or the AHCCCS IHS/Tribal Provider Billing Manual. AHCCCS-contracted Managed Care Organizations (MCOs) and providers shall conform all coding and billing practices to comply with all federal, state and local laws, rules, regulations, standards, executive orders, AHCCCS and/or MCO provider manuals, policy requirements, and standards (including reference tables), ICD10, CPT, HCPCS, CDT, and Health Insurance Portability and Accountability Act Transactions and Code Sets (HIPAA TCS) compliance standards, notwithstanding anything contained in this document, whether expressed or implied.

The Medical Coding Resources guide does not contain an exhaustive list of all available or open codes. Providers compliance with all coding and billing practices shall comply with all federal, state, and local laws, rules, regulations, standards, executive orders, AHCCCS and/or MCO provider manuals, policy, and the AHCCCS Provider Participation Agreement (PPA).

Coding and Billing practices and compliance with all applicable standards are subject to verification during standard monitoring and auditing activities conducted by AHCCCS, TRBHAs, and MCOs. Exceptions to limitations on service frequency or duration may be approved based on medical necessity. Providers shall submit requests for exceptions to the applicable MCO, TRBHA, or AHCCCS and follow the applicable process for submitting documentation to support a request to exceed a limitation.

The medical coding unit does not teach you how to code, nor do we advise you how to code your claims. This is a guide, and you must follow the policies and national coding and billing requirements. This is informational only and not a policy! It is meant to assist you with the coding requirements only.

All CPT, HCPCS, ICD-10 CM and ICD-10 PCS codes submitted must be documented in the medical record and signed by the provider who performed the service. The items listed in this document are for reference, and it is up to the provider/entity to make sure they meet all the requirements for all codes, modifiers, place of service, provider scope of practice.

All CPT®HCPCS® and ICD-10 CM® and ICD-10 PCS® codes are found in the current year books which can be purchased for your business. AHCCCS does not publish all the CPT/HCPCS codes on the AHCCCS website. It is up to the provider or entity to have their own coding and billing personnel as well as all resources needed to assist with your daily business needs. It is always up to the provider/entity to make sure that all documentation, scope of practice, National Correct Coding, and medical requirements are met.

Coding guidelines related to CPT are published yearly in the CPT Professional or Hospital coding book of your choice. These guidelines are updated yearly and quarterly. The AMA website will publish an erratum with coding changes or notices. There are also coding specific rules listed in the CPT book regarding midlevel providers and correct coding guidelines related to this specific topic.

AHCCCS follows Medicaid's Correct Coding Initiative (CCI) policy and performs CCI edits. Correct coding means billing procedures with the appropriate comprehensive code. These can be found on the Medicaid NCCI Website or on the direct link found on the Medical Coding Resources page.

AMA guidance in the instructions for the use of the CPT codebook: When advanced practice nurses and physician assistants are working with physicians, *they are considered working in the exact same specialty and subspecialty as the physician*. A "physician or other qualified health care professional" is an individual

who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. Their professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility professional service. Other policies may also affect who may report specific services.

AHCCCS LINKS

Policies, Guides, Billing Manual Links most requested from the coding unit:

- All AHCCCS AMPM (AHCCCS Medicaid Policy Manual) Policies are located here: AMPM Policies
- Fee For Service Billing Manual is located here: FFS Billing Manual
- Rate specific information is located here: Rates
- Daily limits related to our system can be found here: HCPCS-CPT Procedure Daily Limits or OPFS Related Extracts these are updated on the website quarterly. These lists only contain codes that are covered, so it will not list all the CPT or HCPCS codes.
- AHCCCS Policy Dictionary defines terms in our policy is located here: AHCCCS Contract and Policy Dictionary
- Medical record criteria AMPM 940
- AHCCCS Pharmacy approved drug list.

MEDICAL CODING RESOURCES

The following information can be found on the Medical Coding Resources page.

• Crisis, COE, COT, MABG, SABG Billing Indicators/Modifiers • Telehealth Code Set • Pay and Chase EPSDT Diagnoses Extract • Multiple Surgery Indicator Codes Extract • FFS Authorization Guidelines • Dental Coding specific • COVID Coding and Billing Requirements • News and Updates • Behavioral Health Services Matrix, Guide and Same Day Disallow Table • RTRU form to update the system related to Coding. • AMPM 430 EPSDT Service Code Requirements • SED / SMI code lists	• School CTDS Information • ICD-10 Trauma Code Set • Agency with Choice service Codes & Units • Self-Directed Attendant Care Codes and Units • ALTCS (Arizona Long Term Care System) Service Codes and Units • COE, COT FAQ • Group Therapy Codes • AHCCCS Behavioral Health Diagnosis List • HCPCS CPT Procedure Daily Limits • Medicaid NCCI Files Link • AHCCCS Modifiers List • Place of Service list

Social Determinants of Health should be reported if documented in the medical record as appropriate within their scope of practice. Providers should routinely screen for and document the presence of social

determinants. Information about the social determinants should be included in the members' chart if discussed at that visit.

- These SDOH codes are never a primary diagnosis.
- The SDOH code range is from Z55-Z65 only per ICD-10 CM
- See ICD-10 CM Chapter 21 for complete guidelines on how to use this code set.

ICD-10 CM and ICD-10 PCS codes are updated every October and April.

- These codes are effective from 10-01-20xx to 09-31-20xx and update in April.
- DSM-V codes should never be submitted on claims. All codes must use ICD-10 CM specifically for billing.
- These codes sets and an online code book can be found on the CMS.gov website for you to download.
- You need to read the ICD-10 Guidelines available online if you do not have a book.

CPT and HCPCS are updated yearly and quarterly.

- January 1st is the largest new code set , and AHCCCS updates the coding tables in PMMIS around December 15th of the prior year.
- Every April, July, and October there are quarterly updates. These are found on the CMS.gov website under HCPCS if you do not have a book or if you want the complete download.
- All specific coding rules for the CPT codes are in the CPT book. Timed code (15 minutes, hourly, monthly, per diem) must be followed, and documentation must be supported as listed by National Coding Guidelines. The AMA CPT Professional book has posted the timed rules and requirements. This book is updated yearly! All codes submitted must be reported to the highest specificity and supported by medical documentation. Codes must always meet the scope of practice and medical necessity.

AHCCCS SPECIFIC MODIFIERS

*The following is not a complete list of modifiers, and all appropriate modifiers must be submitted based on medical documentation. Refer to your CPT and HCPCS coding books for the complete list of all modifiers.

AHCCCS requires certain modifiers on specific codes as related to a policy. These modifiers must be utilized to meet policy requirements.

- CG - Policy Criteria Applied
  - S5110
  - ET3 Services
- ET - Emergency services
    - Crisis Services
- EP - Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program.
- FQ - The service is furnished using audio-only communication technology.
- GT - Via interactive audio and video telecommunication systems
- GQ - Via asynchronous telecommunications system
- H9 - Court-ordered COE and COT
- HA - Child/Adolescent program.

- HB – Adult program, non-geriatric.
- HC - Adult program, geriatric
- HF - Substance abuse program
    - S5150
- HG - Opioid addiction treatment program
- HK - Specialized mental health programs for high-risk populations
    - HK modifier must indicate the specific usage of the SOAR approach and cannot be used with any other service.
- HM - Less than bachelor's degree level
- HN - bachelor's degree level
- HO - master's degree level.
- HQ - Group setting
    - Applicable to H codes that do not designate group in description, when performed to a group of individuals.
    - 2 or more define a group (See policies for our group allowances)
- HR - Family/couple with client present
- HS - Family/couple without client present
- HT - Multidisciplinary team
    - H2011
- HW - Funded by state mental health agency.
- SE - State and/or federally funded programs/services
- TD - RN
- TE - LP/LVN
- TF - Intermediate level of care
- TJ - Program group, child, and/or adolescent
    - 97154 + TJ is not to be reported for 1 tech working with multiple patients but multiple techs working with multiple patients in group ABA settings. All services must be clearly documented to support this code to modifier combination. This is related to the ABA providers utilizing the community school model.
    - TJ to 99201-99205, 99211-99215, 99381099385 and 99391-99395.
        - TJ modifier is used for tracking these EPSDT services for our CHP members only.
- TM - Individualized Education Program
    - AHCCCS requires the TM modifier (Individualized Education Program (IEP) to track any expenditure related to additional medical support services offered to members remotely vs. in a school setting. Use TM to indicate services that are provided during "school hours."
    - The following codes can be submitted using the TM modifier.
    - S9123 Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)
    - S9124 Nursing care, in the home; by licensed practical nurse, per hour.
    - G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, every 15 minutes.

  - G0300 Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, every 15 minutes.
  - T1002 RN services, up to 15 minutes
- TN - Rural/outside providers' customary service area (Transportation modifier)
  - AHCCCS has established separate urban and rural rates and procedure codes for certain non-ambulance transportation services. Urban transport originates within the Phoenix and Tucson metropolitan areas.
  - All other forms of transport, outside of the Phoenix and Tucson metropolitan areas, are defined as rural and must be billed with the "TN" modifier.
  - A rural designation is meant to accommodate atypical conditions, such as the use of unmaintained and/or dirt roads, long distances required to reach the member, and a lack of providers in the area.
- U1 - Dual Use modifier
  - U1 required for Child and Family Team (CFT) Child (ACT) Adult
  - Medicaid Level of care Level 2
- U2 - Dual Use Modifier.
  - Self-Directed Care
  - Unskilled
- U3 - Spouse Limit to 160 units per week
- U4 - Family member non-spouse, not residing at home.
- U5 - Family member, non-spouse, residing in a member's home.
- U6 - Dual use modifier.
  - Self-Directed Care
  - Skilled
- U7 - Dual use modifier.
  - Agency with Choice
  - BH SABG Funded
- U8 - Dual modifier.
  - Medicaid Level of Care 8
  - Governor's Office Substance Use Disorder Fund
- U9 - Dual modifier.
  - ASAM CONTINUUM
  - Medicaid Level of Care 9
- UB - Dual use modifier.
  - Monthly services per member
  - BH – MHBG Funded
- UF - Dual use modifier.
  - Co-occurring BH-PH condition
  - Services performed in the morning.
- UG - Dual modifier.
  - Co-occurring BH cognitive

    - Services performed in the afternoon.
- UH - Dual use modifier.
    - Primary psychotic condition
    - Services performed in the evening.

CODING POLICY SPECIFIC CRITERIA

The information in this section is added to help you do your research before reaching out to the coding unit for updates. This section is meant to help identify what resources you should be verifying for correct coding as it relates to AHCCCS. Utilizing these resources will help avoid denials and help avoid multiple RTRU table updates.

THERAPEUTIC FOSTER CARE (CHILDREN)

Policy 320-W Therapeutic foster care services place children with foster families that have received special training in caring for children with specific medical or behavioral needs. Foster parents in these homes require greater training to provide more support for their children. These codes report child therapeutic foster care on a monthly or per diem basis.

- S5145 (Open effective 4/1/2021) - Foster care, therapeutic, child; per diem
- A5 - Behavioral Health Therapeutic Home
- Regarding this policy the following modifiers for this specific code will identify:
- UF - Co-occurring Behavioral-physical health conditions.
- UG - Co-occurring Behavioral health and cognitive conditions.
- Primary psychotic conditions

HOME HEALTH AIDE OR CERTIFIED NURSE ASSISTANT

- T1021 Home health aide or certified nurse assistant, per visit
- Policy Dictionary: Visit defined as: All services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g., a surgery in an Ambulatory Surgical Center (ASC) where both the ASC and the surgeon provide the same service.
- U4 Family members, non-spouses not residing in the member's home.
- U5 Family member, non-spouse residing in the member's home.

TREAT AND REFER

A0998 (Ambulance response and treatment, no transport) with the appropriate modifier as listed below:

- UA -- Treat at home, refer to PCP/Specialist
- UB – Treat at home, refer to Crisis Response
- UC – Treat at home, refer to Behavioral Health Provider
- UD – Treat at home, refer to Urgent Care

TELEHEALTH

AHCCCS publishes a complete list of approved telehealth codes on the Medical Coding Resources page. AHCCCS uses the members' place of service when provided. The code must be on the approved list, and supporting modifiers are identified by code. AMPM Policy 320-I AHCCCCS Telehealth Approved Code Set

- AHCCCS requires the place of service of the member as per policy.
- AHCCCS does not utilize POS 02 and POS 10 if the member has AHCCCS only.
- POS 02 and 10 are only allowed if the member has primary insurance, other than AHCCCS, and the primary insurance requires these specific places of service.
- AHCCCS does not utilize modifier 93 nor modifier 95.
- Review AHCCCS telehealth code set for the appropriate modifiers for AHCCCS claims.
- If AHCCCS is not the primary payor, you will follow the primary payor guidelines.

DIABETES SELF MANAGEMENT

Diabetes Self-Management will now be allowed **10 hours annually** and not per code. The limits are set to be 10 hours per year, but if the member has an individual or group session, the total is only 10 hours. Total units are based on the combination of G0108 and G0109, not per code.

Members must be initially diagnosed with diabetes. Members must have been diagnosed and changed circumstances or not meeting outcomes to qualify. Service must be prescribed by their PCP.

- G0108 Diabetes outpatient self-management training services, individual, 30 minutes.
- G0109 Diabetes outpatient self-management training services, group session (two or more), per 30 minutes

DRUG TESTS

AHCCCS has placed limits on the Urine Drug Screen code set.

- Effective 10/01/2024 the KX modifier must be used for claims that exceed the maximum threshold, and the provider has documented the medical necessity of the service(s) in the member's medical record.
- 80305 -80307 Drug test(s), presumptive, any number of drug classes, any number of devices or procedures
    - Maximum of 3 in 7 days and maximum of 12 in 1 month.
- G0480 Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers)
    - Maximum 1 in 7 days; maximum 4 in 1 month
- G0481 Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers),
    - Maximum of 1 in 7 days; maximum of 2 in 1 month
- G0482 & G0483 Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers.
    - Maximum of 1 in 30 days and maximum of 6 in 12 months.

POLICY RELATED CODING RESOURCES AND LINKS

AHCCCS medical coding receives requests which often require the coding unit to include the policy for the requestor to review. In this section, you will find the most common policies and links to the specific policy for you to review. The AHCCCS website is searchable for the user to find topics and answers to questions. Please visit the policy main page for all policies, guides, and manuals that AHCCCS has published.

AHCCCS COVERED MEDICAL SERVICES

- www.azahcccs.gov/Members/AlreadyCovered/coveredservices.html

AHCCCS GUIDES, MANUALS FOR HEALTH PLANS AND PROVIDERS

- Main Page
- AMPM
- ACOM
- FFS Billing Manual
- Rates Expand page and on the left-hand menu you will find the specific rate categories.
- Pharmacy Main Page
- AHCCCS Approved Drug List
- AHCCCS Provider Enrollment Policy Manual (PEPM)

BIOMARKER POLICY

- AMPM 310KK

DENTAL SERVICES

- AMPM 310 D1
- AMPM 310 D2 Arizona Long Term Care Adult Dental Services

EPSDT POLICY AND CODING

- Please refer to the current policy and Service Guide for this specific topic.
  - AMPM 430 EPSDT
  - EPSDT Service Code
- EP Service provided as part of Medicaid early periodic screening diagnosis and treatment (EPSDT) program.
  - EP Modifier must be listed to designate all services related to the EPSDT child check-up, including routine vision and hearing screenings.
  - SL State supplied vaccine.

HOSPICE SERVICES

- Hospice Services are covered as defined in our policy AMPM 310-J
- AMPM 310-J

CODING SPECIFIC CRITERIA AND GUIDELINES

AMBULATORY SURGICAL CENTER

- An Ambulatory Surgical Center (ASC) is a certified, free-standing facility that operates exclusively for the purpose of furnishing outpatient surgical services. AHCCCS will follow the Facility Outpatient Fee Schedule (OPFS) Correct Coding Initiatives (CCI). AHCCCS follow the CMS codes that are allowed in an ASC, you can find that list on the CMS.gov website. AHCCCS medical coding will only add the approved codes to the ASC provider table. If a surgical procedure code is excluded, it will not be added to the ASC provider table.
- AHCCCS follows the CMS code list for ASC approved services. ASC Addendum AA-EE will identify the codes allowed, included, or excluded from an ASC facility.
- Addendum AA -- ASC Covered Surgical Procedures for CY 20xx Including Surgical Procedures for Which Payment is Packaged)
- Addendum BB -- ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 20xx (Including Ancillary Services for Which Payment is Packaged)
- Addendum EE -- Surgical Procedures to be Excluded from Payment in ASCs for CY 20xx
- Addendum FF -- ASC Device Offset Percentages for CY 20xx (For Covered Surgical Procedures and Surgical Procedures for Which Payment is Packaged)
- SG Modifier Ambulatory surgical center (ASC) facility service
- POS 24 Ambulatory Surgery Center (ASC)
- Revenue Code 0490 Ambulatory Surgical Care
- AHCCCS follows the CMS PPRRVU to identify which services are allowed on the assistant provider and modifier tables; this includes the modifiers AS, 80, 81, and 82.
- The PPRRVU must have an indicator of 2 to be approved for assistant surgeon.
- Indicator 2=Payment restriction for assistants at surgery does not apply to this procedure. An assistant at surgery may be paid.
- If the code in question has an indicator of 0, the provider must submit supporting documentation to the specific health plan and will then review medical necessity.
- These codes will not be added to the provider's tables, and the health plan will pay or deny appropriate without the presence of the code on any provider tables.

ANESTHESIA

- There are anesthesia specific modifiers you should report based on documentation and these could include:
  - QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.
  - QX - CRNA service: with medical direction by a physician
  - QY - Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
  - AD - Medical supervision by a physician: more than four concurrent anesthesia procedures
  - AA - Anesthesia services performed personally by an anesthesiologist.
  - P1 A normal healthy patient

- P2 A patient with mild systemic disease
- P3 A patient with severe systemic disease
- P4 A patient with severe systemic disease that is a constant threat to life.
- P5 A moribund patient who is not expected to survive without the operation.
- P6 A declared brain-dead patient whose organs are being removed for donor purposes.
- ASC unlisted code 41899 is for a surgeon to bill when no other surgical code matches and is used for our dental members. This is NOT a dental service code, and this is not normally approved as an ASC approved code.

PPRRVU MODIFIERS AND INDICATORS

AHCCCS utilizes the PPRRVU for the following modifiers and their indicators to update and support these modifiers and any indicator on the PPRRVU for the following modifiers that need medical review will not be added to the system. The health plan will review and pay or deny based on medical necessity.

- 26 Professional Component
- 50 Bilateral Surgery
- 51 Multiple Procedure
- 53 Discontinued Procedure
- 62 Co Surgeons
- 66 Team Surgery
- 80 Assistant Surgeon
- 81 Minimum Assistant Surgeon
- 82 Assistant Surgeon (when qualified resident surgeon not available)
- AS Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
- TC Technical component; Under certain circumstances, a charge may be made for the technical component alone; under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable x-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles

NCCI CODING CHAPTERS

The National Correct Coding Initiative (NCCI) is a program developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and prevent improper payments. It uses a system of edits, particularly Procedure to Procedure (PTP) edits, to identify and prevent incorrect bundling of services.

- There are chapter specific guidelines you must review to make sure you are coding and billing correctly.
- Procedure-to-Procedure (PTP) edits define pairs of Healthcare Common Coding System (HCPCS) /Current Procedural Terminology (CPT) codes that should not be reported together for a variety of

reasons. PTP edits prevent improper payments when incorrect code combinations are reported.

- Medically Unlikely Edits (MUEs) define the maximum Units of Service (UOS) reported for a HCPCS/CPT code on most appropriately reported claims by the same provider/supplier for the same beneficiary on the same date of service.
- These edits are updated quarterly and available online.
- How to Use the NCCI tools can be found: www.cms.gov/files/document/mln9018659-how-use-medicaid-national-correct-coding-initiative-ncci-tools.pdf
- NCCI Chapter Specific guidelines are published and updated yearly. You can find those guidelines on the following web page. https://www.cms.gov/medicare/coding-billing/ncci-medicaid/medicaid-ncci-policy-manual

OTHER RESOURCES

DURABLE MEDICAL EQUIPMENT

- AMPM 310-P is our AHCCCS policy for DME.
- CMS publishes the DME list and identifies which codes/categories as well as modifiers that are allowed or required.
- Appropriate DME modifiers include the following, but are not a complete list:
  - JB Administered subcutaneously.
  - JW Drug amount discarded/not administered to any patient.
  - JZ Zero drug amount discarded/not administered to any patient (must be in Status K or G to be added to RF121 facility tables).
  - KX Requirements specified in the medical policy have been met.
  - NU New equipment
  - RA Replacement of a DME, orthotic or prosthetic item
  - RB Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair.
  - RR Rental (use the RR modifier when DME is to be rented)
  - UE Used durable medical equipment.
  - Extremity Function Levels K0-K4
  - Oxygen Modifiers – N1-N3, QA-QR
  - Digit Modifiers – FA-F9, TA-T9
  - Dressing Modifiers – A1-A9

PHARMACY

- AHCCCS Approved Drug List

- Updated quarterly.
- Found here: https://www.azahcccs.gov/PlansProviders/Pharmacy/
- AMPM 310-V Prescription Medications/Pharmacy Services
- Includes 340B criteria.

GENETIC TESTING

- AMPM 310 II

BIOMARKERS

- AMPM 310KK
- AMPM 310KK Attachment A Prior Authorization Request for Biomarker Testing

FEE-FOR-SERVICE BILLING LINKS

- Fee-For-Service Provider Manual
- Fee-For-Service Claims

PROVIDER CLAIM DISPUTES

- Provider Dispute FFS and MCO

HEALTH PLAN COMPLIANCE CONCERNS

The AHCCCS Operations Compliance team assists with providers and the Managed Care Organizations to resolve compliance concerns, including assistance with resolving claims issues. The provider and the health plan should work to resolve all issues prior to completing this form. If you are unable to resolve and have exhausted all appropriate avenues, you can then use the form below.

- Compliance form for MCO