BHRF – Prior Authorization and Claim Submission

Fall 2020
These materials are designed for the AHCCCS Fee-For-Service programs, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).
Preferred Method of Prior Authorization Submission
BHRF Prior Authorization Requirements

Updated Prior Authorization and Policy Information regarding Behavioral Health Residential Facilities (BHRF) can be found on the DFSM Prior Authorization Requirements Web Page at:

- https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

Under the “Services that require Prior Authorization section, there are two documents that are periodically updated, with the most up-to-date PA guidance.

**Services that require Prior Authorization:**

- Behavioral Health Residential Facility Documentation Requirements [BHRF in Word Version]
- Behavioral Health Residential Facility AMPM 320-V Guidance
- Non Emergency Acute Inpatient Admissions
BHRF Prior Authorization Requirements

It is the provider’s responsibility to familiarize themselves with the following:

• BHRF Prior Authorization Requirements;
• Information contained within AMPM Policy 320-V, Behavioral Health Residential Facility; and
• The AHCCCS Online Provider Portal
Preferred Method of Submission

When submitting a Prior Authorization request, use of the AHCCCS Online Provider Web Portal is the preferred method.

- Online submission allows PA staff to process prior authorization requests more efficiently.

There are two ways to access the AHCCCS Online Provider Portal:

1. Main AHCCCS website www.azahcccs.gov

2. Via the direct web address at: https://azweb.statemedicaid.us
Preferred Method of Submission

Providers shall take the following steps:

1. New Users: If a provider does not have an online account, they can register by going to https://azweb.statemedicaid.us. Under the heading “New Account” click on Register for an AHCCCS Online Account and follow the instructions to submit a request.

2. Once an AHCCCS online account has been set up, the provider can proceed.

3. Enter the authorization request via the PA submission link in the AHCCCS online web portal.

4. Attach required clinical documentation via the online attachment feature.

5. An authorization number is generated automatically, which will remain in a pending status until an authorization decision is made. A PA confirmation letter is then mailed to the provider indicating the pending authorization status, and

6. After documentation submitted by the provider has been reviewed and an authorization decision is made, a PA confirmation letter is mailed to the provider indicating the updated authorization status.

7. Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.
Preferred Method of Submission

Providers are encouraged to use the web portal to enter authorization requests for immediate access to a provisional authorization number that can be used to track authorization status.

The ability to view authorization status online is delayed pending authorization entry for Faxed authorization requests.

- **Important Note:** If the online submission of a Prior Authorization request or documentation is not possible due to internet outage or other unforeseen events, then it can be done via fax.
- If the documents are faxed, the Prior Authorization Request Form must continue to be utilized.

[https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/forms.html](https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/forms.html)
How to Submit a BHRF Prior Authorization Request Using the AHCCCS Online Provider Portal
**Step 1:** Sign In. The user **must** have a valid Username and Password.
Step 2: On the Main Page, select **Prior Authorization Submission**

**AIMH SERVICES PROGRAM**
Pending SPA approval by CMS, AHCCCS proposes to offer services that support an American Indian Medical Home Program, including Primary Care Case Management (PCCM), diabetes education, care coordination, and promoting participation in the state Health Information Exchange, to AHCCCS AI/AN members who are enrolled in AIHP. AIMH PCCMs will be charged with addressing health disparities between American Indians and other populations in Arizona, specifically by enhancing case management and care coordination. AHCCCS registered IHS/638 facilities who meet AIMH registration criteria will be eligible for prospective per member per month payments based on the services and activities they are providing to empaneled members. For further details on the program, please click on AIMH Home.

**CLAIM STATUS**
Claim Status allows providers to check the status of Fee-For-Service claims submitted to AHCCCS. If a recipient is enrolled in a capitated Health Plan, the Health Plan must be contacted for claim inquiries. For a listing of the Health Plan contact information, please click on Health Plan Listing.

**CLAIM SUBMISSION**
Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM each business day are processed that night. Claims submitted after 4:00 PM Friday will be processed the following Monday. The status of the claims can be viewed online by searching for the claim by submission date. Average processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.
There are three Steps to Create a Prior Authorization Case Type.

1. PA CASE CREATION
2. EVENT TYPE
3. ACTIVITY TYPE
AHCCCS Online is an AHCCCS website designed for registered providers. It offers the convenience and efficiency of several online services.

CLAIM SUBMISSION
Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM each business day are processed that night. Claims submitted after 4:00 PM Friday will be processed the following Monday. The status of the claims can be viewed online by searching for the claim by submission date. Average processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.

MEMBER VERIFICATION
Eligibility and Enrollment Status allows providers to verify an AHCCCS recipient’s eligibility and their enrollment in a Health Plan. Providers can also obtain Medicare, Share Of Cost and other third party coverage information for a recipient.

NEWBORN NOTIFICATION
Newborn Notification allows providers to submit newborn information to AHCCCS during the hours when the COM Center is not available. Status of these submissions can also be viewed from the web site within 48 business hours.

PROVIDER VERIFICATION
Provider Information allows providers to update their correspondence addresses. Providers may also view (but not update) their Service and Pay-To Addresses, Group Affiliations and Authorized Signatures. For further information, please click on AHCCCS Provider Registration.

PROVIDER RE-ENROLLMENT/REVALIDATION
Provider Re-Enrollment/Revalidation allows providers to submit their re-enrollment information electronically. Providers who were registered with AHCCCS prior to 01/01/2012 will be notified by mail or e-mail when it is time to re-enroll. All data must be submitted by the indicated timeframe on the letter or the AHCCCS Identification number will be terminated for failure to re-enroll. Providers must wait to receive a re-enrollment notice, if documents are received prior to the re-enrollment notice being mailed out, the documents will be processed as regular updates due to system requirements. Data may be submitted by authorized signers on file with AHCCCS. For further information, please click on AHCCCS Provider Re-Enrollment Frequently Asked Questions.

Prior Authorization Inquiry
Prior Authorization Inquiry will allow providers to verify the status of previously submitted prior authorization requests. Inquiries can be performed by Case Number, AHCCCS ID or Provider ID. The related case, event and activity data related to the prior authorization will be displayed.

For security purposes, your session will be logged out after 15 minutes of inactivity.
Welcome to the FEE-FOR-SERVICE Prior Authorization Web Portal

To facilitate Prior Authorization requests, guidelines are provided to assist you in determining whether Prior Authorization is required. This is not an exhaustive list. For more detail, see Chapters 200, 400, 800, and 1100 in the AHCCCS MEDICAL POLICY MANUAL (AM/PM)

Services that require Prior Authorization:
- Tribal ALTCSS Acute Inpatient Behavioral Health
- Durable Medical Equipment (DME) consumable >$100.00 and durable > $500.00 and all rentals.
- Elective (scheduled) Hospitalizations
- Home Health
- Hospice
- Skilled Nursing Facility
- Non – Emergency Outpatient Procedures
- Non – Emergency Surgery
- Pediatric
- Acute Inpatient Rehabilitation
- Outpatient Physical Therapy for Members > 21 years old.
- Non – Emergency Transportation > 100 miles

Services that do not require Prior Authorization:
- Services performed during a Retroactive Eligibility Period.
- When another coverage is primary, e.g.: Medicare or Commercial Insurance.
- Emergency Hospitalization < 24 hours; ICU and Non – ICU < 72 hours.
- Diagnostic procedures, e.g.: EKG, MRI, CT Scans, X-rays, Labs, colonoscopy, EGD, Sleep Studies.
- Non – Surgical Procedures, e.g.: PICC Line removal or placement, Central Line removal or placement, PEG removal, Blood Transfusions.
- Outpatient Chemotherapy and Radiation.
- Emergency Dental and Dental Services for Members < 21 years old (see AM/PM chapter 400).
- Eye Glasses for members < 21 years old.
- Family Planning Services
- Physician Consultations and Office Visits
- Respite Care
- Emergency Transportation

Services that are not managed by AHCCCS FFS Prior Authorization Units: You must contact the appropriate entity for authorization.
- Non-Acute Services for Tribal ALTCSS members (contact Case Manager)
- Transplant Services (contact Transplant Coordinator in the Division of Health Care Management at AHCCCS).
- Prescription Medication (contact the contracted PBM).
- Behavioral Health Services for Acute Care Members (contact Regional Behavioral Health Authority or Tribal Regional Behavioral Health Authority).

Next - Click on the tab "Prior Authorization Submission" located at the bottom of the page.
Prior Authorization Search

**PA Recipient/Case Search**

* Indicates a required field.

- **Search System:** ACUTE
- **Search By:** AHCCCS ID
- **AHCCCS ID:**
- **Service Provider ID:** -SELECT -
- **Begin Date Of Service:**
- **End Date Of Service:**

(Format: MM/DD/YYYY)

Select the down arrow key next to each heading to select your preference for the Case Search.

**HINT:** To obtain the maximum number of search results, provide data only for required fields.
Prior Authorization Search

PA Recipient/Case Search

Search System: ACUTE

Search By: AHCCCS ID

AHCCCS ID: A12345678

Service Provider ID: --- SELECT ---

Begin Date Of Service: MM/DD/YYYY

End Date Of Service: MM/DD/YYYY

The AHCCCS member ID is the recommended Search By option.

(Ex. A12345678)

Click the down arrow to select the provider NPI or 6 digit provider ID number.

(Format: MM/DD/YYYY)

Select the SEARCH button after completing the required fields.

* Indicates a required field.

HINT: To obtain the maximum number of search results, provide data only for required fields.
If this is the First Case created for the client, the “Service Dates” and “Case List” fields will be blank. The message “No Records Found” will be present.

Click "Add New Case" button to add new case. Click Case number to view all events in the case. Click Update link to update the case. NOTE: Approved PA cases cannot be updated online.
Enter CASE Information - The **Effective Begin Date** field should be entered with the first date of service for the prior authorization request. The **Effective End Date** field must be entered as the end date of the current year (i.e. 12/31/2019). (the system will default and enter the end date).

(The actual Effective End date for the PA request will be entered on the next PA screen).

Click the Next button to view the Case details.
Verify the Case Information

### Service Provider

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Provider Name</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>111111</td>
<td>BHRF</td>
<td></td>
</tr>
</tbody>
</table>

### Verify Case Information

- **AHCCCS ID:** A12345678
- **Provider ID:** 111111
- **Service Provider NPI:** XXXXXXXX
- **Provider Contact Name:** BHRF
- **Contact Phone Number:** 602-417-4000
- **Effective Begin Date:** 04/01/2019
- **Effective End Date:** 12/31/2019
- **Description:** BHRF

If the information entered is correct press the Submit button. If you need to make a correction, press the Edit button, make the correction than select the Submit button to accept the changes.
* A list of existing Case Numbers will appear.
To make your selection, Click on the appropriate Case No.
Select the **Case number** by clicking on the Case number as shown below. This will take you to step #2 - “Add New Event”
Event List

Click "Add New Case" button to add new case. Click Case Number to view all events in the case. Click Update link to update the case. NOTE: Approved PA cases CANNOT be updated online.

Service Provider

Provider ID: 111111

Provider Name: BHRF

NPI: 1234567890

Search Dates

Begin Date: 

End Date: 

EVENT LIST

No Records Found

ADD NEW EVENT

Select the ADD NEW EVENT tab. This will take you to the page to Enter Event Information.
The Event Begin date is the **Admission Date**. A valid ICD-10 Mental, Behavioral, or neurodevelopment Disorder Diagnosis is required for the PA. The BH Diagnosis codes range is (F01 thru F99).
Verify Event Information –

If the event information is correct, Click the Submit button to proceed.

If the information is correct, Click the SUBMIT button. If you need to make a correction, press the EDIT button, make the correction, then Click SUBMIT to accept the correction.
You will see a list of Events. If there are multiple Events under the PA case number, select the correct Sequence number. This example shows only one Event.

The option to add an Attachment is located on the Event List tab only.
From the Event List page, Click “Attachments” to upload documentation.
The PA Attachment screen will appear

AHCCCS will accept up to 99 files per Event. After files have been uploaded, click the "Submit" button to send the files to AHCCCS for processing. NOTE: Once the files are submitted to AHCCCS they can no longer be deleted from the system. Please contact the PA Group for further assistance.

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Case No:</th>
<th>Event Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS, BUDDY</td>
<td>Begin Date: 04/01/2019</td>
<td>Service Begin Date: 04/01/2019</td>
</tr>
<tr>
<td>DOB: MM/DD/YYYY</td>
<td>End Date: 12/31/2019</td>
<td>Service End Date: 06/30/2019</td>
</tr>
<tr>
<td>Gender:</td>
<td>Status: Pended</td>
<td>Status: Pended</td>
</tr>
</tbody>
</table>

**Pending Attachments**

***NO PENDING ATTACHMENT(S) FOUND***

**Submitted Attachments**

***NO SUBMITTED ATTACHMENT(S) FOUND***
1. In the Request Type field click the down arrow and select the request type “BH AIHP”.

2. Next click the **Browse** button and select **Choose File** to search your computer for the file to attach to the Prior Authorization request.

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AHCCCS will accept up to 99 files per Event. After files have been uploaded, click the "Submit" button to send the files to AHCCCS for processing. NOTE: Once the files are submitted to AHCCCS they can no longer be deleted from the system. Please contact the PA Group for further assistance.

<table>
<thead>
<tr>
<th>AHCCCS ID</th>
<th>Name</th>
<th>DOB</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>A##############</td>
<td>AHCCCS, BUDDY</td>
<td>MM/DD/YYYY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Case No:</th>
<th>Begin Date: 04/01/2019</th>
<th>End Date: 12/31/2019</th>
<th>Status: Pended</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Event Detail</th>
<th>Begin Date: 04/01/2019</th>
<th>End Date: 06/30/2019</th>
<th>Status: Pended</th>
</tr>
</thead>
</table>

**Request Types**: BH AIHP

**Select file to upload**: K:\BHRF OML NE SUBMISSION.pbx

**Pending Attachments**: ***NO PENDING ATTACHMENT(S) FOUND***

**Submitted Attachments**: ***NO SUBMITTED ATTACHMENT(S) FOUND***
You will see a message confirming “File Successfully Uploaded”.

Next CLICK the Submit Button.
After confirming the attachment was successful, go back to the top right side of the page and select the tab **Event List**, this will take you back to the Event List page to continue with entering the PA information.
To add the Activity Codes (CPT/HCPCS), Click the **Sequence number** next to the date span that you want to add.

```
<table>
<thead>
<tr>
<th>Sequence</th>
<th>Event Type</th>
<th>Begin Date</th>
<th>End Date</th>
<th>Admit Date</th>
<th>Status</th>
<th>Reason</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>BP</td>
<td>04/01/2019</td>
<td>06/30/2019</td>
<td>PENDED</td>
<td>PH009</td>
<td>F99</td>
<td></td>
</tr>
</tbody>
</table>
```

Sequence Number
Next select the "Add New Activity" tab to enter the Activity Codes (CPT/HCPCS) for billing.

<table>
<thead>
<tr>
<th>Provider ID: 111111</th>
<th>Provider Name: BHRF</th>
<th>Service provider</th>
<th>NPI: 1234567890</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHCCCS ID: A12345678</td>
<td>Name: AHCCCS</td>
<td>Recipient</td>
<td>Gender: F</td>
</tr>
<tr>
<td>Case No: 000000012</td>
<td>Begin Date: 04/01/2019</td>
<td>Case Detail</td>
<td>End Date: 12/31/2019</td>
</tr>
<tr>
<td>Event No: 01</td>
<td>Serv Begin Date: 04/01/2019</td>
<td>Event Detail</td>
<td>Serv End Date: 06/30/2019</td>
</tr>
</tbody>
</table>

No Records Found.

ADD NEW ACTIVITY
Activity Type * Select type “HCPCS”.

Activity Codes * Enter the HCPCS code H0018.

Allowed Units * Enter the number of units (units=days) based on the dates of service requested for the prior authorization.

Click "Add New Activity" button to create new activity. Click "Update" link to update the activity. NOTE: Approved activities
Reminder: Fields with a RED ASTERISK* must be completed.

If the information entered is correct, click the “Next” button.
On the “Verify Activity Information” page, if the information is correct, Select the “Submit” button to finalize your PA request.

If a correction is required, select the EDIT button, make the correction then select the Submit button to finalize your Prior Authorization request.
Successful Submission of the PA.
Claim Submission Using the AHCCCS Online Provider Portal
Claim Submission - Sign In Page

**Step 1:** Sign In. The user **must** have a valid Username and Password.

Enter Username and Password and click “Sign In”
Step 2: On the Main Page, select **Claim Submission**

AIMH SERVICES PROGRAM
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CLAIM STATUS
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CLAIM SUBMISSION
Claim Submission allows providers to submit Professional, Dental and Institutional claims to AHCCCS for nightly processing. Claims submitted prior to 4:00 PM each business day are processed that night. Claims submitted after 4:00 PM Friday will be processed the following Monday. The status of the claims can be viewed online by searching for the claim by submission date. Average processing time may take 24-72 hours, depending on the number of claims processed and the time of the submission.
Claim Submission Page

Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a Replacement or Void. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

Payer/Receiver Electronic Transmitter Identification Number: 8XXXXXXXX

NOTE: You cannot view the processing status of claims submitted by other users.

Enter New Claim

Type of Claim: Professional

BHRF services are submitted using the Professional Claim form type. Select "professional" from the drop down box and then press 'Go'.

View Claim Processing Status

Submission Date(s):

Go...
Professional Claim Submission Page
Professional Claim Submission

Billing Provider

- Tax ID: 8XXXXXXXXX  SSN  X EIN
  - Enter the Tax Id number and check the EIN bullet.

- CMMS National Provider ID (NPI): X0XXXXXXXXX
  - Enter the BHRF NPI number and select the FIND button.

- Entity Type: ☐ Person  ☒ Non-Person Entity

- Select Non-Person Entity

- When you have completed these fields, go back to the top of the tool bar and select the tab "Rendering Provider".

- DO NOT SELECT THE SAVE OR SUBMIT BUTTON!!.
DO NOT SELECT THE SAVE OR SUBMIT BUTTON. !!!
Enter the BHRF NPI number and select Non-person Entity and click the Find button.

DO NOT SELECT THE SAVE OR SUBMIT BUTTON.
Payer Responsibility field - If the member does not have any other insurance that may cover the service, from the drop down box select P-Primary.

Enter the recipient ID number and the date of birth, next click the Find button to verify the member's information is a match.

DO NOT SELECT THE SAVE OR SUBMIT BUTTON.
Informational Only - If you are submitting a correction to a previous claim on file, in the "Original Reference Number" field you will enter the 12 digit ICN or CRN number of the claim that you want to correct. Next select the Replacement button and continue with entering the claim information.

Do not select the Save or Submit button.
Complete all fields with a Red Asterick and then Click the Add button.

Verify the dates, total charges and units billed are correct.
This page will display the claim information for your final review. Next to each line line is a image of a pencil and this is the "Edit" tool. If you need to make a change click on the "pencil" and make the correction. If the claim meets your approval, Click the Submit button to transmit your claim.
DFSM Provider Education and Training Unit
DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

• How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).

• Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.
The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

• Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov

• Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
  o NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider’s professional coder/biller.

• ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov
Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- **Phone**: (602) 417-7670 – Select Option 4
- **From**: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

**NOTE**: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.
Prior Authorization Questions?

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- **AHCCCS Online Provider Portal:**

- **DFSM Prior Authorization Web Page:**
  - [https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html](https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html)

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.
Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548

**NOTE:** Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.
Questions?
Thank You.