

**201 - MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND  
MEDICAID**

EFFECTIVE DATE: 10/01/97, 02/01/13, 07/01/13, 12/01/14

REVISION DATE: 06/01/01, 03/11/10, 01/03/13, 06/06/13, 07/18/13, 11/20/14

STAFF RESPONSIBLE FOR POLICY: DHCM ADMINISTRATION

**I. PURPOSE**

This Policy applies to Acute, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. The purpose of this Policy is to define Contractor cost sharing responsibilities for members that are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan. The purpose of this Policy is also to maximize cost avoidance efforts by Managed Care Contractors and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

**II. DEFINITIONS**

<b>COST SHARING</b>	The Contractors' obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.
<b>DUAL ELIGIBLE MEDICARE BENEFICIARIES (DUALS)</b>	An AHCCCS member who is eligible for both Medicaid and Medicare services. There are two types of Dual Eligible members: QMB Duals and Non-QMB Duals (FBDE, SLMB+, QMB+)
<b>FULL BENEFIT DUAL ELIGIBLE (FBDE)</b>	An AHCCCS Member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.
<b>IN-NETWORK PROVIDER</b>	A provider that is contracted with the Contractor to provide services.

**MEDICARE ADVANTAGE PLAN**

A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include Local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and Local and Regional Preferred Provider Organizations (RPPOs).

**MEDICARE PART A**

Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.

**MEDICARE PART B**

Coverage for medically-necessary services like doctors' services, outpatient care, home health services, and other medical services

**MEDICARE PART D**

Medicare prescription drug coverage.

**NON-QUALIFIED MEDICARE BENEFICIARY (NON-QMB) DUAL**

A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program (R9-29-101).

**OUT OF NETWORK PROVIDER**

A provider that is neither contracted with nor authorized by the Contractor to provide services to its members.

**QUALIFIED MEDICARE BENEFICIARY DUAL (QMB DUAL)**

QMB Duals include QMB Plus and QMB Only individuals. QMB Plus Duals are entitled to all QMB benefits (Medicaid payment of Medicare Part A and B premiums, plus cost sharing) as well as all Medicaid benefits consistent with the Medicaid State Plan. (As outlined by the AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing, under authority of the Social Security Act, Sec. 1902.) A QMB Only is an individual who is entitled to Medicare benefits (Part A and B) as well as Medicaid payment of Medicare Part B premiums and cost sharing (except for Part D) and who is not enrolled in a Medicaid health plan.

**SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB)**

Persons entitled to Medicare Part A whose incomes are between 100-120 per cent of the National Poverty Level. Medicaid also covers the beneficiary's Part B premium costs.

**SUPPLEMENTAL  
BENEFITS**

Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and preventative vision benefits.

**III. POLICY**

For QMB and Non-QMB Duals, the Contractor shall have no cost sharing obligation for services covered by both Medicare and Medicaid if the Medicare payment exceeds the Contractor's contracted rate for the services with a contracted provider or the AHCCCS Capped FFS Schedule if the provider is not contracted.

For a contracted provider, the Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the Contractor's contracted rate for the service.

In the absence of a contract, the Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed the AHCCCS Capped FFS Schedule.

There is no cost sharing obligation if the Contractor has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing.

The exception to these limits on payments as noted above is that the Contractor shall pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Contractor has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For Contractor responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to ACOM Policy 434.

**A. QMB DUALS****CONTRACTOR PAYMENT RESPONSIBILITIES**

1. QMB Duals are entitled to **all** Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their AHCCCS Medicare record and typically by a two in the third digit of the rate code.
2. A QMB Dual eligible member who receives services under 9 A.A.C. 22, Article 2 or 9 A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copayment, coinsurance or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

3. The Contractor is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS; subject to the limits outlined in this Policy. See also AHCCCS Medical Policy Manual (AMPM) Chapter 300. These services include:
  - Chiropractic services for adults,
  - Outpatient occupational and speech therapy coverage for adults,
  - Orthotic devices for adults,
  - Cochlear implants for adults,
  - Services by a podiatrist,
  - Any services covered by or added to the Medicare program not covered by Medicaid.
4. The Contractor only has responsibility to make payments to AHCCCS registered providers.
5. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the Contractor's network or prior authorization has been obtained.
6. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS registered provider in or out of network the following applies (Table 1 and Figure 1):

**TABLE 1: QMB DUALS**

<b>QMB DUALS</b>	
<b>WHEN THE SERVICE IS COVERED BY:</b>	<b>THE CONTRACTOR SHALL PAY</b> <i>(Subject to the limits outlined in this Policy)</i>
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: <ol style="list-style-type: none"> <li>a. The Medicare copay, coinsurance or deductible, <b>or</b></li> <li>b. The difference between the Contractor's contracted rate and the Medicare paid amount.</li> </ol>

**FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES**

<b>SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID</b> <i>Subject to the limits outlined in this Policy</i>			
	<b>EXAMPLE 1</b> (b. In Table 1 above)	<b>EXAMPLE 2</b> (b. In Table 1 above)	<b>EXAMPLE 3</b> (b. In Table 1 above)
Provider charges	\$125	\$125	\$125
Medicare rate for service	\$100	\$100	\$100
Medicaid rate for Medicare service (Contractor's contracted rate)	\$100	\$90	\$90
Medicare deductible	\$0	\$0	\$40
Medicare pays 80% of Medicare rate less deductible	\$80	\$80	\$48
Medicare coinsurance (remaining 20%)	\$20	\$20	\$12
<b>CONTRACTOR PAYS</b>	<b>\$20</b>	<b>\$10</b>	<b>\$42</b>

**B. NON-QMB DUALS**

The Contractor only has responsibility to make payments to AHCCCS registered providers.

**CONTRACTOR PAYMENT RESPONSIBILITIES (IN NETWORK)**

1. In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within 9 A.A.C. 22, Article 2, the member is not liable for any balance of billed charges and the following applies (Table 2):

**TABLE 2: NON-QMB DUALS (IN NETWORK)**

<b>NON-QMB DUALS (IN NETWORK)</b>	
<b>WHEN THE SERVICE IS COVERED BY:</b>	<b>THE CONTRACTOR SHALL <u>NOT</u> PAY:</b>
Medicare Only	Medicare copay, coinsurance or deductible
<b>WHEN THE SERVICE IS COVERED BY:</b>	<b>THE CONTRACTOR SHALL PAY: (SUBJECT TO THE LIMITS OUTLINED IN THIS POLICY)</b>
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): a. The Medicare copay, coinsurance or deductible,  <b><u>or</u></b>  b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (Contractor's contracted rate).

**CONTRACTOR PAYMENT RESPONSIBILITIES (OUT OF NETWORK)**

2. In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracting provider the following applies (Table 3):

**TABLE 3: NON-QMB DUALS (OUT OF NETWORK)**

<b>NON-QMB DUALS (OUT OF NETWORK)</b>	
<b>WHEN THE SERVICE IS COVERED BY:</b>	<b>THE CONTRACTOR</b> <i>Subject to the limits outlined in this Policy</i>
Medicare Only	Has no responsibility for payment.
Medicaid only and the Contractor <b>has not</b> referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the Contractor <b>has</b> referred the member to the provider or has authorized the provider to render services or the services are emergent	Shall pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the Contractor <b>has not</b> referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the Contractor <b>has</b> referred the member to the provider or has authorized the provider to render services or the services are emergent	Shall pay the lesser of: a. The Medicare copay, coinsurance or deductible, <b>or</b> b. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

**C. PRIOR AUTHORIZATION**

The Contractor can require prior authorization. If the Medicare provider determines that a service is medically necessary, the Contractor is responsible for Medicare cost sharing if the member is a QMB dual, even if the Contractor determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the Contractor must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Contractor shall cover the cost of the service for QMB Duals.

**D. PART D COVERED DRUGS**

For QMB and Non-QMB Duals, Federal and State laws prohibit the use of AHCCCS monies to pay for cost sharing of Medicare Part D medications.

**E. INSTITUTIONAL STATUS REPORTING – PART D CO-PAYS**

1. **Acute, ADHS/DBHS, CMDP and CRS** When a dual eligible member is inpatient in a medical institution or nursing facility and that stay is funded by Medicaid for a full calendar month, the dual eligible person is not required to pay copayments for their Medicare covered prescription medications for the remainder of the calendar year. (See Chapter 16b, Section 80.4.3 of the Medicare Managed Care Manual and Medicare Prescription Drug Benefit Manual, Chapter 13, Section 60). To ensure appropriate information is communicated for these members to CMS, the Contractor must notify the AHCCCS, Member Database Management Administration (MDMA), using the form provided in Attachment A of this Policy, as soon as it determines that a dual eligible person is expected to be in a medical institution that is funded by Medicaid for a full calendar month, regardless of the status of the dual eligible person's Medicare lifetime or annual benefits. This includes:
  - a. Members who have Medicare Part "D" only;
  - b. Members who have Medicare Part "B" only;
  - c. Members who have used their Medicare Part "A" life time inpatient benefit; and
  - d. Members who are in a continuous placement in a single medical institution or any combination of continuous placements in a medical institution.
  
2. **Types of Medical Institutions** For purposes of the medical institution notification, medical institutions are defined as:
  - a. Acute hospitals,
  - b. Psychiatric hospital – Non IMD,
  - c. Psychiatric hospital – IMD,
  - d. Residential treatment center – Non IMD,
  - e. Residential treatment center – IMD,
  - f. Skilled nursing facilities, and
  - g. Intermediate Care Facilities for the Intellectually Disabled.

ALTCS/EPD and DDD are not required to provide this information as the State is already aware of the institutional status of these members and provides this information to CMS.

#### **IV. REFERENCES**

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- DCS/CMDP Contract, Section D
- CRS Contract, Section D
- DES/DDD Contract, Section D
- AHCCCS State Plan Amendment 96-13 - Medicare Cost Sharing
- Arizona Administrative Code R9-29 Article 3
- Title 42: Public Health, Code of Federal Regulations
- Social Security Act, Sec. 1905(p)(3)
- Social Security Act, Sec. 1902
- Medicare Prescription Drug Benefit Manual, Chapter 13, Section 60.2
- Medicare Managed Care Manual Chapter 16b, Section 80.4.3
- 9 A.A.C. 22, Article 2
- ACOM Policy 434
- Attachment A, AHCCCS Notification to Waive Medicare Part D Co-Payments



**ATTACHMENT A, AHCCCS NOTIFICATION TO WAIVE MEDICARE PART D CO-PAYMENTS**

**SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY**



**ACOM POLICY 201, ATTACHMENT A,  
AHCCCS NOTIFICATION TO WAIVE MEDICARE PART D CO-PAYMENT**

*FAX TO AHCCCS MEMBER DATABASE MANAGEMENT ADMINISTRATION (MDMA): (602) 253-4807*

**MEMBER NAME:** \_\_\_\_\_ **AHCCCS ID NUMBER:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

TYPE OF MEDICAL INSTITUTION	DATE OF ADMISSION	AHCCCS PROVIDER ID NUMBER	NAME OF MEDICAL INSTITUTION

**COMMENTS:** \_\_\_\_\_

**CONTRACTOR NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SUBMITTED BY:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

**202 – RESERVED**

## **203 – CLAIMS PROCESSING**

EFFECTIVE DATE: 02/01/97, 04/13/12, 10/01/13, 12/01/14, 06/01/15

REVISION DATE: 11/01/02, 06/15/05, 04/13/12, 09/19/13, 11/20/14, 12/29/14, 05/12/15

STAFF RESPONSIBLE FOR POLICY: DHCM OPERATIONS

### **I. PURPOSE**

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. This Policy stipulates requirements for the adjudication and payment of claims.

### **II. DEFINITIONS**

#### **ADMINISTRATIVE SERVICES SUBCONTRACTS**

An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:

- a. Claims processing, including pharmacy claims,
- b. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization).
- c. Management Service Agreements;
- d. Service Level Agreements with any Division or Subsidiary of a corporate parent owner;
- e. DDD acute care and behavioral health subcontractors;
- f. ADHS/DBHS subcontracted Tribal/Regional Behavioral Health Authorities and the Integrated Regional Behavioral Health Authority.

Providers are not Administrative Services Subcontractors.

#### **CLEAN CLAIM**

A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.

**SUBCONTRACTOR**

1. A provider of health care who agrees to furnish covered services to members.
2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.
3. A person, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.

**III. POLICY**

The Contractor shall develop and maintain claims processes and systems that ensure the correct collection and processing of claims, analysis, integration, and reporting of data. These processes and systems shall result in information on areas including, but not limited to, service utilization, claim disputes and appeals [42 CFR 438.242(a)].

The Contractor shall ensure they have a mechanism in place to inform providers of the appropriate place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

**A. DATE OF RECEIPT**

The receipt date of the claim is the date stamp on the claim or the date electronically received. The receipt date is the day the claim is received at the Contractor's specified claim mailing address, received through direct electronic submission to the Contractor, or received by the Contractor's designated Clearinghouse.

**B. TIMELINESS OF CLAIM SUBMISSION**

Unless a subcontract specifies otherwise, Contractors shall ensure that for each form type (Dental/Professional/Institutional) 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

1. The Contractor shall not pay:
  - a. Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
  - b. Claims that are submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later (A.R.S.§36-2904.G).

Regardless of any subcontract with an AHCCCS Contractor, when one AHCCCS Contractor recoups a claim because the claim is the payment responsibility of another AHCCCS Contractor (responsible Contractor), the provider may file a claim for payment with the responsible Contractor. The provider must submit a clean claim to the responsible Contractor no later than:

1. 60 days from the date of the recoupment,
2. 12 months from the date of service, or
3. 12 months from date that eligibility is posted, whichever date is later.

The responsible Contractor shall not deny a claim on the basis of lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

#### **C. DISCOUNTS**

In the absence of a subcontract specifying otherwise, the Contractor shall apply a quick pay discount of 1% on hospital claims paid within 30 days of the date the clean claim was received (A.R.S. §36-2903.01.G).

#### **D. INTEREST PAYMENTS**

In the absence of a subcontract specifying other late payment terms, a Contractor is required to pay interest on late payments as specified below.

1. For hospital clean claims, the Contractor is required to pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the 61<sup>st</sup> day until the date of payment (A.R.S. §36-2903.01).
2. For authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS provider, or a home and community based ALTCS provider, the Contractor is required to pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment (A.R.S. §36-2943.D).
3. For non-hospital clean claims the Contractor is required to pay interest on payments made after 45 days of receipt of the clean claim. Interest shall be paid at the rate of 10% per annum (prorated daily) from the 46<sup>th</sup> day until the date of payment.

The Contractor shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

When interest is paid, the Contractor must report the interest as directed in the AHCCCS Encounter Manual and the AHCCCS Claims Dashboard Reporting Guide.

#### **E. ELECTRONIC PROCESSING REQUIREMENTS**

The Contractor is required to accept and generate required HIPAA compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission. Electronic submissions to be accepted include eligibility verifications, claims, claims status verifications and prior authorization requests, along with generating an electronic remittance. The Contractor must also be able to make claim payments via electronic funds transfer and have the capability to accept electronic claim attachments.

#### **F. REMITTANCE ADVICES**

The Contractor must produce a remittance advice related to the Contractor's payments and/or denials to providers and each must include at a minimum:

1. The reason(s) for denials and adjustments,
2. A detailed explanation/description of all denials and adjustments,
3. The amount billed,
4. The amount paid,
5. Application of Coordination of Benefits (COB) and copays,
6. Providers rights for claim disputes, and

Additionally, the Contractor must include information in its remittance advice which informs providers of instructions and timeframes for the submission of claim disputes and corrected claims. All paper remittance advices must describe this information in detail. Electronic remittance advices must either direct providers to the link where this information is explained or include a supplemental file where this information is explained.

The related remittance advice must be sent with the payment, unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT must be sent to the provider, no later than the date of the EFT.

**G. GENERAL CLAIMS PROCESSING REQUIREMENTS**

1. The Contractor must include nationally recognized methodologies to correctly pay claims including but not limited to:
  - a. Medicaid Correct Coding Initiative (MCCI) for Professional, Ambulatory Surgery Centers (ASC) and Outpatient services,
  - b. Multiple Procedure/Surgical Reductions,
  - c. Global Day E & M Bundling standards.
  
2. The Contractor's claims payment system must be able to assess and/or apply data related edits including but not limited to:
  - a. Benefit Package Variations,
  - b. Timeliness Standards,
  - c. Data Accuracy,
  - d. Adherence to AHCCCS Policy,
  - e. Provider Qualifications,
  - f. Member Eligibility and Enrollment,
  - g. Over-Utilization Standards.

If a claim dispute is overturned, in full or in part, the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of decision.

The Contractor's claims payment system must not require a recoupment of a previously paid amount when the provider's claim is adjusted for data correction (excluding payment to a wrong provider) or an additional payment is made. The Contractor shall ensure encounters are submitted in accordance with AHCCCS' standards and thresholds. The Contractor shall adhere to the Coordination of Benefits/Third Party Liability requirements per the AHCCCS Contract, ACOM Policy 201 and 434, Claims Reprocessing requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS Claims Dashboard Reporting Guide.

The Contractor shall adhere to all Health Insurance, Portability and Accountability Act (HIPAA) requirements according to 45 CFR Parts 160, 162, and 164.

**H. CLAIMS PROCESSING BY SUBCONTRACTORS**

The Contractor shall obtain prior approval from AHCCCS of all Administrative Services Subcontracts including those that call for claims processing to be performed by or under the direction of a subcontractor. The subcontract shall be submitted to the designated Operations and Compliance Officer for prior approval and shall adhere to all requirements as specified in ACOM Policy 438.

Per the AHCCCS contract Section D, Subcontracts, *"No subcontract shall operate to terminate the legal responsibility of the Contractor to assure that all activities carried out by the subcontractor conform to the provisions of this contract."* Accordingly,

AHCCCS holds its Contractors responsible for the complete, accurate, and timely payment of all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of subcontract arrangements.

The Contractor shall forward all claims received to the subcontractor responsible for claims adjudication. The Contractor shall require the subcontractor to submit a monthly claims aging summary to the Contractor to ensure compliance with claims payment timeliness standards. The Contractor may consider requiring such reports to be consistent in format with the AHCCCS required reports. The Contractor shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan. The results of the performance review and the correction plan shall be communicated to AHCCCS upon completion.

The Contractor shall monitor the volume of encounters received from the subcontractor so that encounters are submitted in accordance with AHCCCS' standards and thresholds.

#### **IV. REFERENCES**

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- A.R.S. §36-2904
- A.R.S. §36-2903.01
- A.R.S. §36-2943.D
- 45 CFR Parts 160, 162, and 164
- 42 CFR 438.242
- AHCCCS Encounter Manual
- AHCCCS Claims Dashboard Reporting Guide
- ACOM Policy 201
- ACOM Policy 412
- ACOM Policy 434
- ACOM Policy 438
- Health Insurance Portability and Accountability Act
- Medicaid Correct Coding Initiative (MCCI) for Professional, Ambulatory Surgery Centers (ASC), Outpatient services
- Global Day E & M Bundling standards.

**204 – RESERVED**

## **205 – GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT GUIDELINES FOR NON-CONTRACTED PROVIDERS**

EFFECTIVE DATE: 05/01/2006, 04/01/2013

REVISION DATE: 04/04/2013

STAFF RESPONSIBLE FOR POLICY: DHCM ADMINISTRATION

### **I. PURPOSE**

This policy applies to Acute Care, Behavioral Health Services (BHS), Arizona Long Term Care System Elderly and Physically Disabled (ALTCS/EPD), Children’s Rehabilitation Services (CRS), Comprehensive Medical and Dental Program (CMDP) and ALTCS Division of Developmental Disabilities (DDD) Contractors. The purpose of this policy is to provide ground ambulance transportation reimbursement guidelines. It is limited to AHCCCS Contractors and ambulance or emergent care transportation providers when a contract does **not** exist between these entities.

**NOTE:** A contract agreement between parties would **not** be subject to this policy.

Refer to the AHCCCS Medical Policy Manual Chapter 300, Policy 310-BB, Transportation for a general description of the transportation policy.

### **II. DEFINITIONS**

For purposes of this policy the following definitions apply:

**ADVANCED LIFE SUPPORT (ALS)** 42 CFR 414.605, describes ALS as **either** transportation by ground ambulance vehicle, that has medically necessary supplies and services, and that the treatment includes administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer’s Lactate); **or** transportation, medically necessary supplies and services, and the provision of at least one ALS procedure.

**AMBULANCE**

Under AR.S. §36-2201, ambulance means “Any publicly or privately owned surface (ground), water or air vehicle that contains a stretcher and necessary medical equipment and supplies pursuant to section §36-2202 and that is especially designed and constructed or modified and equipped to be used, maintained or operated primarily for the transportation of individuals who are sick, injured or wounded or who require medical monitoring or aid. “Ambulance” does not include a surface vehicle that is owned and operated by a sole proprietor, partnership, private corporation or municipal corporation for the emergency transportation and in–transit care of its employees or a vehicle to accommodate an incapacitated or disabled person who does not require medical monitoring, care or treatment during transport and that is not advertised as having medical equipment and supplies or qualified ambulance attendants as defined in A.R.S. §36-2201.”

**BASIC LIFE SUPPORT (BLS)**

Under 42 CFR 414.605, BLS is transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT–Basic).

**EMERGENCY AMBULANCE SERVICES**

Emergency ambulance services are as described in 9 A.A.C. 22, Article 2, 9 A.A.C. 25, and in 42 CFR 410.40 and 414.605.

**EMERGENCY AMBULANCE TRANSPORTATION**

Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility.

**EMERGENCY MEDICAL CONDITION**

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

1. Placing the member’s health in serious jeopardy
2. Serious impairment to bodily functions or
3. Serious dysfunction of any bodily organ or part.

**EMERGENCY MEDICAL SERVICES**

Emergency medical services means services provided for the treatment of an emergency medical condition.

**EMT-BASIC (EMT-B)**

The EMT-B provides basic life support without providing invasive procedures or cardiac monitoring or ALS procedures.

Under A.R.S. §36-2201 and 9 A.A.C. 25 and as administered by the Arizona Department of Health Services (ADHS), bureau of emergency medical services, the EMT-basic is certified to perform or provide all of the medical treatments, procedures, medication and techniques included in the U.S. Department of Transportation, National Highway Safety Administration EMT-B curriculum. In addition to the examples of BLS services/procedures in Section III(A)(2)(a), the following are examples of member conditions requiring the basic skill level of the EMT-B:

1. Labor and delivery in route to medical care (no history of complications)
2. ETOH (intoxication) and passed out due to intoxication.

**EMT-PARAMEDIC (EMT-P)**

The EMT-P is educated and capable to perform invasive procedures, heart monitoring and administer a wide variety of drugs and other ALS procedures.

Under A.R.S. §36-2201 and 9 A.A.C. 25 and as administered by the Arizona Department of Health Services (ADHS), Bureau of Emergency Medical Services, the EMT-P is certified to perform or provide all of the medical treatments, procedures, medication and techniques included in the U.S. Department of Transportation, National Highway Safety Administration EMT-P curriculum. In addition to the examples of ALS services/procedures noted in Section III(A)(1)(a)(4)(a) of this policy, the following are examples of member conditions requiring the advanced skill level of the paramedic:

1. Gun shot/stab wounds/major trauma
2. Impending birth/complications of pregnancy
3. Chest pain /heart attack
4. Hemorrhage/shock/profuse bleeding
5. Unconscious/coma/uncontrolled seizures/severe head injury
6. Unresponsive/"found down"
7. Diabetic coma
8. Stroke
9. Respiratory distress (respiratory arrest/asthma).

**III. POLICY****A. GROUND EMERGENCY AMBULANCE TRANSPORTATION**

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by AHCCCS Contractors a percentage proscribed by law of the ambulance provider's ADHS-approved fees for covered services. For ambulance providers whose fees are not established by ADHS, the AHCCCS Capped Fee for Service (FFS) Schedule will be used.

Criteria and reimbursement processes for Advanced Life Support (ALS) and Basic Life Support (BLS) are as follows.

**1. Advanced Life Support (ALS) level**

- a. In order for ambulance services to be reimbursable at the ALS level, all of the following criteria must be satisfied:
  - i. The ambulance must be ALS licensed and certified in accordance with A.R.S. §36-2212 and 9 A.A.C.13, Articles 10 and 11
  - ii. ALS certified personnel such as the EMT-P described in Section II are present ALS services/procedures are medically necessary, based upon the member's symptoms and medical condition (refer to examples in Section II under EMT-P) at the time of the transport and
  - iii. ALS services/procedures and authorized treatment activities were provided.
    - a) ALS services/procedures performed by an EMT-P include but are not limited to:
      - i) Manual defibrillation/cardioversion
      - ii) Endotracheal intubation
      - iii) Esophageal obdurate airway
      - iv) Monitor central venous line
      - v) Cardiac pacing
      - vi) Chest decompression
      - vii) Surgical airway
      - viii) Intraosseous line
      - ix) Gastric suction

- x) parenteral fluid, as a directed medical therapy and not for the purpose of maintaining an intravenous line
- xi) Medication administration excluding oxygen
- xii) Required, medically necessary pre-hospital phlebotomy
- xiii) Placement/establishment of a peripheral venous catheter
- xiv) Basic cardiac monitoring
- b) Services/procedures that do not qualify as ALS include, but are not limited to:
  - i) Parenteral fluid, for the purpose of maintaining an open line or other non-therapeutic rate of fluid administration
  - ii) Oxygen delivery (by any means)
  - iii) Pulse oximetry
  - iv) Blood glucose testing
  - v) Assisting a member in the administration of their own home medications
- b. Emergency ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:
  - 1) Medical condition, signs and symptoms, procedures, treatment
  - 2) Transportation origin, destination, and mileage (statute miles)
  - 3) Supplies and
  - 4) Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

Contractors must process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

## 2. Basic Life Support (BLS) level

- a. In order for ambulance services to be reimbursable at the BLS level, all of the following criteria must be satisfied:
  - 1) The ambulance must be BLS licensed and certified in accordance, A.R.S. §36-2212 and 9 A.A.C.13, Articles 10 and 11
  - 2) BLS certified personnel, for example, the EMT-B described in Section II are present
  - 3) BLS services/procedures, are medically necessary, based upon the member's symptoms and medical condition at the time of the transport and

- 4) BLS services/procedures and authorized treatment activities were provided. BLS services/procedures performed by an EMT-B include but are not limited to:
  - a) Monitoring intravenous lines during interfacility transfers
  - b) Blood glucose monitoring
  - c) Utilizing the automatic external defibrillator (AED)
  - d) Assisting a patient to take the following prescribed medications (must be the patient's prescription)
    - i. Nitroglycerin
    - ii. Auto injectable epinephrine
    - iii. Bronchodilating inhalers
- b. Emergency ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:
  - 1) Medical condition, signs and symptoms, procedures, treatment
  - 2) Transportation origin, destination, and mileage
  - 3) Supplies and
  - 4) Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

Contractors must process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

#### **B. NONEMERGENT GROUND AMBULANCE TRANSPORTATION-PAYMENT GUIDELINES**

1. All Hospital-to-Hospital transfers for the Contractor will be paid, minimally, at the BLS rate, unless the transfer requires ALS level of service. This includes transportation between general and specialty hospitals.
2. At the Contractor's discretion, nonemergent ambulance transportation, other than the scenario described in #1 above, may not require prior authorization or notification, but is subject to review for medical necessity by the Contractor. Medical necessity criteria is based upon the medical condition of the member and includes ground ambulance services provided because the member's medical condition was contradictory to any other means of transportation. This may include after hour calls. An example would be as follows: an ambulance company receives a call from the emergency room to transport a nursing facility member back to the facility and the Contractor can not be reached.
3. Transportation reimbursement will be reduced to the level of the appropriate alternative transportation when services provided do not qualify as ALS or BLS (Refer to Section II, Definitions), or the ALS/BLS services rendered at the time of transport are deemed not medically necessary. If the transportation vendor does not have established non-ALS or non-BLS levels, claims will be paid at the AHCCCS established capped-fee-for-

service amount for the appropriate alternative transportation service for example: taxi or van (ambulatory, wheelchair or stretcher).

4. Nonemergent transportation by ambulance is appropriate if:
  - a. Documentation that other methods of transportation are contraindicated and
  - b. The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.
5. Nonemergent transportation ordered by the Contractor cannot be denied upon receipt. This claim is not subject to further medical review.

#### **IV. REFERENCES**

- Title 42 of the Code of Federal Regulations (42 CFR) 410.40 (Coverage of Ambulance Services)
- 42 CFR 414.605 (Definitions)
- A.R.S. §36 Chapter 21.1 Articles 1, 2 (Emergency Medical Services)
- 9 A.A.C. 13, Article 10 (Ambulance Service Licensure)
- 9 A.A.C. 13, Article 11 (Ambulance Registration Certificate)
- 9 A.A.C. 22, Article 2 (Transportation Services)
- 9 A.A.C. 25 ((Department of Health Services Emergency Medical Services)
- AMPM, Chapter 300, Policy 310-BB, Transportation

**206 – RESERVED**

## **207 - PRIMARY CARE ENHANCED PAYMENTS**

EFFECTIVE DATE: 01/01/13

REVISION DATE: 01/15/15

STAFF RESPONSIBLE FOR POLICY: DHCM FINANCE AND DATA ANALYSIS AND RESEARCH

### **I. PURPOSE**

This Policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DCS/CMDP (CMDP), and DES/DDD (DDD) Contractors. Section 1202 of the Affordable Care Act requires minimum levels of Medicaid payment for certain primary care services, provided by certain physicians. These reimbursement requirements for the enhanced payments apply to payments made for dates of service January 1, 2013 through December 31, 2014. This Policy establishes the Contractor requirements for Primary Care Provider (PCP) enhanced payments and the cost settlement of those payments.

### **II. DEFINITIONS**

<b>AFFORDABLE CARE ACT (ACA)</b>	Federal statute signed into law in March, 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (PPACA).
<b>CLAIM DISPUTE</b>	A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.
<b>ENCOUNTER</b>	A record of a health care-related service rendered by a provider registered with AHCCCS to a member who is enrolled with a Contractor on the date of service and has been adjudicated by the Contractor.
<b>PREMIUM TAX</b>	The premium tax is equal to the tax imposed pursuant to A.R.S §36-2905 for payments made to the Contractors for the contract year.
<b>PRIMARY CARE SERVICES</b>	For the purposes of this Policy, primary care services are described in Section 1902(a)(13)(C) of the Social Security Act, as amended by the Affordable Care Act and 42 CFR 447.400(c).

### III. POLICY

#### A. QUALIFYING SERVICES

Federal regulations require state Medicaid programs to pay qualified PCPs at fees that are no less than the Medicare fee schedule in effect for Calendar Years (CY) 2013 and 2014, or the fee schedule rate that would result from applying the 2009 Medicare Conversion Factor, whichever is greater, for certain services designated by specific Current Procedural Terminology (CPT) codes.

The increased payment requirements apply to primary care and vaccine administration services described by the following codes:

1. Current Procedural Terminology (CPT) Evaluation and Management (E&M) Codes 99201 through 99499; and
2. Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, 90474 or their successor codes.

In addition, vaccines administered to children under the Vaccines for Children (VFC) program, indicated by appending modifier 'SL' to the appropriate CPT code, must be reimbursed at the lesser of the billed charge or the enhanced regional maximum VFC fee.

#### B. QUALIFYING PROVIDERS

**In order to qualify for the Enhanced Payments, the physician must:**

1. **Self-attest** as practicing in family medicine, general internal medicine or pediatric medicine or a subspecialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties.

**AND**

2. **The physician must also self-attest to being either:**
  - a. Board certified with a specialty designation of family medicine, general internal medicine, or pediatric medicine, or a subspecialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Physician Specialties

**OR**

- b. A primary care physician or subspecialist who works in one or more of the above specialty designations **but who does not** have a certification specified in number

2a above **but** has billed at least 60% of Medicaid (AHCCCS) services using the E&M and vaccine administration codes listed in Section III (A). For physicians registered as AHCCCS providers in Calendar Year (CY) 2012, the 60% billing requirement applies to Medicaid (AHCCCS) claims billed during the 2012 calendar year. For physicians who registered as AHCCCS providers in CY 2013 or 2014, the 60% billing requirement applies to Medicaid (AHCCCS) claims billed for the month prior to the attestation.

Increased payment rates may apply to Nurse Practitioners (NP) and Physician Assistants (PA) *when they practice under the supervision of a qualified physician*. These physician extenders are not permitted to attest on their own; supervising physicians must include the names of subordinate physician extenders on their attestations.

AHCCCS has elected to extend the enhanced payments to these same qualifying providers when they provide services to KidsCare members.

Physicians who have successfully attested on or before April 30, 2013 will be paid the enhanced fee retroactively for dates of service from January 1, 2013 or the begin date of their qualification whichever is later, through the attested end date or December, 31, 2014 whichever is earlier for all qualified primary care services. Physicians successfully filing the required Attestation on or after May 1, 2013 will be paid the enhanced fee from the time the Attestation is received, through the attested end date or December, 31, 2014 whichever is earlier.

### **C. PCP ENHANCED RATES**

Eligible primary care physicians must receive the full benefit of the enhanced payment at the rate mandated for eligible services rendered. The enhanced payments apply for the services described by the CPT codes listed above provided during CY 2013 and 2014. The primary care enhanced rates can be referenced in fee schedule screen RF144 in the AHCCCS payment system.

The Contractor is required to reimburse at the lesser of billed charges or the enhanced rate. The Contractor may pay above the enhanced rate, depending on specific contractual arrangements with a provider, but may not apply any quick payment or other contractual discounts to the enhanced rates. Provider type percentage pay discounts mandated by AHCCCS Policy are allowable. If a Contractor has sub-capitation arrangements that are less than the enhanced rate, the Contractor is obligated to provide additional payments to providers to ensure that every unit of primary care services provided is reimbursed at the enhanced rate required under Section 1202.

### **D. ENCOUNTER SUBMISSIONS**

The Contractor is required to report PCP enhanced payments on all impacted encounters. AHCCCS has developed system updates for submitted encounters in order to determine if

the PCP enhanced payment criteria is met. The Contractor must include indication of payment of the enhanced rates versus the non-enhanced rates within submitted encounters. PCP enhanced payments will not be included in reconciliations or capitation rate setting.

PCP enhanced rate encounter flow, criteria, and example scenarios can be referenced in Attachment A.

#### **E. COST-SETTLEMENT PAYMENTS**

Enhanced payments for qualifying claims by qualifying providers with dates of service on or after January 1, 2013 will not begin until after August 1, 2013, but will be made retroactively to January 1, 2013 or the individual provider attestation date whichever is later.

AHCCCS will reimburse the Contractor for PCP enhanced payments made to providers via a quarterly cost settlement process. Cost settlement payments to the Contractor are based on the Contractor's actual adjudicated encounters and will be paid outside of capitation rates. AHCCCS will consider all adjudicated/approved encounter data flagged by AHCCCS as eligible for PCP enhanced payment.

On a quarterly basis the Contractor will be sent a report by the AHCCCS DHCM Finance Unit with all Encounter Claim Reference Numbers (CRNs) (and other key identifying data) that have been reported and validated as correctly paid by the Contractor using the enhanced rates since the last quarter (based upon the encounter adjudication status date).

The Contractor will be given a two-week period to review and reconcile claims payments to the cost settlement report. Once the Contractor agrees on the reported CRNs and amounts, the cost settlement payment including the premium tax component will be made based upon the finalized list of CRNs. This will happen up until the Federal two year claiming timeframe expires. PCP enhanced payments are eligible for quarterly premium tax reporting, see ACOM Policy 304.

In the event that a provider's eligibility for enhanced payments is subsequently revoked due to audit or any other reason, the Contractor shall recoup enhanced payments made after the effective date of the revocation. In the event that the supervising physician's qualification is revoked, then the supervised Nurse Practitioner and Physician Assistant will not qualify for enhanced payments. The Contractor will be required to submit all reprocessed claims in their reported encounters. These encounters will be included in the quarterly cost settlement process as payments due to AHCCCS.

In the event that a provider is retroactively flagged as Board Certified or Attested (60% or new provider) or loses this designation as noted above, the Contractor is expected to identify and automatically reprocess any impacted claims for enhanced payments or the It

is expected that this reprocessing will be conducted by the Contractor without requirement of further action by the provider.

## **F. AHCCCS AUDITS**

In accordance with federal regulations, for 2013 and 2014 AHCCCS must conduct annual random sample audits of physicians submitting attestations regarding both the Board Certification and the 60% billing requirements [42 CFR 447.400(b)]. If a physician is determined to not meet the requirements, the physician will receive notice from AHCCCS Office of the Inspector General (AHCCCS-OIG), informing the provider that the requirements for receiving enhanced payments have not been satisfied and that the AHCCCS Administration and AHCCCS Contractors will recoup any enhanced payments made in error. In the event that the supervising physician has not met the qualifications, then the supervised NP and PA will also not qualify for enhanced payments and enhanced payments will also be recouped.

Prior to recouping the enhanced payments from the provider, the AHCCCS Administration and its Contractors will send written notification to the provider informing the provider of the upcoming recoupments and will provide information about the dispute resolution process.

### **1. Disputes Pertaining to Recoupment of Enhanced Payments**

The physician may contest the recoupment of the enhanced payments by filing a claim dispute with the Contractor for managed care claims and with the AHCCCS Administration for Fee-For-Service (FFS) claims. Prior to any recoupment action, the Contractor and the AHCCCS Administration, whichever is applicable, will notify the provider of the recoupment and will provide information about the dispute resolution process.

The dispute resolution process will be in accordance with the:

- Contractor Provider Claim Dispute Process for managed care claims
- A.A.C. R9-34-401 et. seq.
- A.R.S. §41-1061 et. seq
- Managed Care Contracts, Section F, Attachment F2, Provider Claim Dispute Standards

### **2. Disputes Pertaining to Enhanced Payment Amounts**

The Contractor is responsible for ensuring that its payment system accurately reflects the information that was received from AHCCCS and that the enhanced payment to the provider is consistent with this information. If the Contractor does not make the proper payment to the physician or supervised Nurse Practitioner or Physician's

Assistant based on the information provided from AHCCCS, the provider may file a claim dispute with the Contractor challenging the payment amount.

For FFS payments, the AHCCCS Administration is responsible to ensure that the physician receives the applicable enhanced payment. If the AHCCCS Administration does not make the proper payment to the FFS provider, the provider may file a claim dispute with the AHCCCS Administration challenging the payment amount.

#### **IV. REFERENCES**

- Acute Care Contract, Section D
- ADHS/DBHS Contract, Section D
- ALTCS/EPD Contract, Section D
- CRS Contract, Section D
- DCS/CMDP Contract, Section D
- DES/DDD Contract, Section D
- 42 CFR 447
- Section 1202 of the Affordable Care Act
- Sections 1902(a)(13), 1902(jj), 1932(f) and 1905(dd) of the Social Security Act
- A.A.C. R9-34-401 et. seq
- A.R.S. §41-1061 et. seq
- ACOM Policy 304
- Attachment A, AHCCCS Encounter Flow

**ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

**SEE THE ACOM WEBPAGE FOR ATTACHMENT A OF THIS POLICY**

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

**Professional/1500 Encounter Received – Determine if consideration for PCP enhanced rate criteria is met:**

1. Begin date of service must be > or = to 1/1/2013 and End date of service must be < or = to 12/31/2014;
2. Service/Rendering Provider Type must be = 08, 18, 19 or 31;
3. Provider “PCP” Specialty Code must appear on PR030 and the PCP Indicator must = B – attested Board Certified, 6 – attested 60 %; or 7 – new provider attested 60%. *If the indicator is “blank” or N – provider is not eligible enhanced rates.* The C – verified board certified indicator may also appear but will be associated with the specific specialty code for which the provider is Board certified and is for informational purposes only;
4. Dates of service on the encounter must fall within the Begin and End dates for Provider “PCP” Specialty Code; *(Included in weekly Provider Extracts to Contractors.*
5. The Provider Tax Id submitted on the Encounter must not be defined as belonging or related to an FQHC or FQHC look alike; and/or Place of Service must not be = 50 FQHC or 72 RHC. *(List will be provided to Contractors)*
6. CN1 Code is not equal to 09 and recipient does not have a 25 exception code for the date of service.

*Yes, above criteria is met.*

*No, above criteria is not met.*

*If all criteria are met, go to New Rate Schedule RF144 and check for applicable rate for the procedure on the encounter for the reported dates of service. Only those procedures eligible for enhanced rates will be on this table. Modifier related amounts/%;'s with exception of the SL Modifier are not impacted by this initiative. If a SL modifier is reported, go to New Modifier table RF147 to obtain the applicable rate for the modifier*

**Rate Not Found on RF144**

*If all criteria not met, or rate or procedure not found on RF144, continue to use current Fee Schedule (RF142/RF112 as applicable).*

**Rate Found on RF144/RF147**

Use Rate from RF144 for the encounter date of service to calculate the AHCCCS Allowed for the encounter. If applicable to the provider type 18 and 19 (per RF618) apply Provider Type %'s reduction to the calculated AHCCCS Allowed Amount. Apply applicable Medicare calculations, Other Insurance Payments, etc.); Set Pay1 code to PCP, and update subcap code on the encounter to the appropriate value as outlined on page 8 of this document, UNLESS\_CN1 code on the Encounter is 05, and Plan Allowed is greater than > or equal to = Plan Paid; or the Plan Paid is greater than the calculated AHCCCS Allowed plus interest or minus Other Insurance Paid.

**New Editing** – (applying all criteria – 1500 Form type, dates of service, provider type etc... as noted in box 1)  
 Edit A650 – AHCCCS valuation logic indicates that PCP enhanced rates should apply to the encounter, but based upon Plan Paid Amount was not applied. (AHCCCS Pay1 code = PCP; check plan paid if not equal to or greater than AHCCCS Allowed (plus interest if applicable, minus Other Insurance Paid if applicable or minus AHCCCS copay if applicable) or the Billed Charge whichever is less).  
 Edit A655 – AHCCCS valuation logic indicates that PCP enhanced rates should not apply to the encounter, but based upon Plan Paid Amount was applied. (AHCCCS Pay 1 code not equal to PCP; check plan paid if not equal AHCCCS allowed (plus interest if applicable) but equal rate applicable from RF144).

**Other Edit Considerations** – Existing editing must accommodate Plan Allowed Amounts which are less than Plan Paid Amounts.

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

**Reporting of Encounters:**

Contractors must include indication of payment of enhanced rates versus non-enhanced rates within submitted encounters for trending, analysis, and reimbursement for Contractors is as outlined by each of the following scenarios. Contractors must continue to build appropriate CAS segments for all scenarios. (Examples assume scenarios meet all basic criteria for consideration - 1500 Form type, dates of service, provider type etc... as outlined in the flowchart). Formula – (Enhanced minus COB) minus (Allowed minus COB).

1. No Subcap arrangement with provider: “Pay Parity Rate” –  
*Health Plan Allowed* = Non-enhanced payment rate  
*Health Plan Paid* = Enhanced payment rate (or Billed Charge if less)

a. **Example:**

Billed Charge = \$175.00  
Non-enhanced payment rate = \$100.00 (= Health Plan Allowed)  
Enhanced payment rate = \$113.00 (= Health Plan Paid)  
*Payment to MCO will be \$13.00*

2. No Subcap arrangement with Provider/Other Insurance Payment on claim; Other Insurance Allowed less than Health Plan Allowed: “Pay Parity Rate less Other Insurance Payment” -  
*Health Plan Allowed* = Non-enhanced payment rate  
*Health Plan Paid* = Enhanced payment rate (or Billed Charge if less) minus Other Insurance Payment

a. **Example:**

Billed Charge = \$175.00  
Other Insurance allowed = \$90.00  
Other Insurance payment = \$40.00  
Non-enhanced payment rate = \$100.00 (Health Plan Allowed)  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$63.00)  
*Payment to MCO will be \$13.00- AHCCCS will consider Other Insurance payment in calculation using the lessor or Other Insurance Allowed or Health Plan Allowed.*

Other Insurance Allowed greater than Health Plan Allowed: “Pay Parity Rate less Other Insurance Payment” -

b. **Example:**

Billed Charge = \$175.00  
Other Insurance allowed = \$120.00  
Other Insurance payment = \$40.00  
Non-enhanced payment rate = \$100.00 (Health Plan Allowed)  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$73.00)  
*Payment to MCO will be \$13.00- AHCCCS will consider Other Insurance payment in calculation*

1. Subcap arrangement with provider is < Parity Rate: “Pay Parity Rate” -  
*Health Plan Allowed* = Non-enhanced subcap payment rate would have paid  
*Health Plan Paid* = Difference between subcap payment rate would have paid and the Enhanced payment rate (or Billed Charge if less) plus Interest paid (if applicable)

a. **Example:**

Billed Charge = \$175.00  
Non-enhanced subcap arrangement = \$90.00 (= Health Plan Allowed)  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$23.00)  
*Payment to MCO will be \$23.00*

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

b. **Example with Interest:**

Billed Charge = \$175.00  
 Interest Amount = \$10.00  
 Non-enhanced subcap arrangement = \$90.00 (= Health Plan Allowed)  
 Enhanced payment rate = \$113.00 (Health Plan Paid = \$33.00)  
*Payment to MCO will be \$23.00-AHCCCS will deduct Interest Paid*

2. Subcap arrangement with provider is < Parity Rate/Other Insurance Payment on claim:

“Pay Parity Rate less Other Insurance Payment” - (Health Plan Allowed <= Other Insurance Allowed)

*Health Plan Allowed* = Non-enhanced subcap payment rate would have paid

*Health Plan Paid* = Difference between subcap payment rate would have paid and the Enhanced payment rate (or Billed Charge if less) minus Other Insurance Payment

a. **Example:**

Billed Charge = \$175.00  
 Other Insurance allowed = 100.00  
 Other Insurance payment = \$40.00  
 Non-enhanced subcap arrangement = \$90.00 (Health Plan Allowed)  
 Enhanced payment rate = \$113.00 (\$73.00 = *enhanced payment - OTI*) (Health Plan Pd = \$23.00)  
*Payment to MCO will be \$23.00- AHCCCS will consider Other Insurance payment in calculation*

3. Subcap arrangement with provider is > or = Parity Rate:

“Pay Subcap Rate” – no additional reimbursement to the Contractor.

*Health Plan Allowed* = No change to current process

*Health Plan Paid* = No change to current process

a. **Example:**

Billed Charge = \$175.00  
 Non-enhanced payment rate = \$115.00 (= Health Plan Allowed)  
 Enhanced payment rate = \$113.00 (Health Plan Paid = \$0.00)  
*No additional payment to MCO*

b. **Example:** ADD – Plan Paid > Parity Rate

4. Medicare Primary No Subcap arrangement with provider: “Pay Lessor of Patient Responsibility, or Parity Rate minus Medicare Paid”-

*Health Plan Allowed* = Lessor of Patient Responsibility, or Non-enhanced payment rate minus Medicare Paid

*Health Plan Paid* = Lessor of Patient Responsibility, or Enhanced payment rate minus Medicare Paid (or Billed Charge if less)

a. **Example:**

Billed Charge = \$175.00  
 Medicare Allowed/Approved = \$140.00  
 Medicare Paid = \$80.00  
 Patient Responsibility = \$60.00  
 Non-enhanced payment rate = \$100.00 (Health Plan Allowed = \$100.00)  
 Calculated Lessor of Amount = \$20.00  
 Enhanced payment rate = \$113.00 (Health Plan Paid = \$33.00)  
*Payment to MCO will be \$13.00*

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

b. **Example:**

Billed Charge = \$175.00  
Medicare Allowed/Approved = \$140.00  
Medicare Paid = \$80.00  
Patient Responsibility = \$15.00  
Non-enhanced payment rate = \$100.00 (Health Plan Allowed = \$100.00)  
Calculated Lessor of Amount = \$15.00  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$15.00)  
*No additional payment to MCO*

5. Medicare Primary Subcap arrangement with provider < Rate Parity: “Pay Lessor of Patient Responsibility or Parity Rate minus Medicare Paid”-

*Health Plan Allowed* = Lessor of Patient Responsibility, or Non-enhanced payment rate minus Medicare Paid  
*Health Plan Paid* = Lessor of Patient Responsibility, or Enhanced payment rate minus Medicare Paid (or Billed Charge if less)

a. **Example:**

Billed Charge = \$175.00  
Medicare Allowed/Approved = \$140.00  
Medicare Paid = \$80.00  
Patient Responsibility = \$60.00  
Non-enhanced subcap arrangement = \$90.00 (Health Plan Allowed = \$90.00)  
Calculated Lessor of Amount = \$10.00  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$33.00)  
*Payment to MCO will be \$23.00*

b. **Example:**

Billed Charge = \$175.00  
Medicare Allowed/Approved = \$140.00  
Medicare Paid = \$80.00  
Patient Responsibility = \$15.00  
Non-enhanced payment rate = \$100.00 (Health Plan Allowed = \$100.00)  
Calculated Lessor of Amount = \$15.00  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$15.00)  
*No additional payment to MCO*

6. Billed Charge < Rate Parity: “Pay Billed Charges” –

*Health Plan Allowed* = No change to current process  
*Health Plan Paid* = No change to current process

a. **Example:**

Billed Charge = \$105.00  
Non-enhanced payment rate = \$115.00 (= Health Plan Allowed)  
Enhanced payment rate = \$113.00 (Health Plan Paid = \$105.00)  
*No additional payment to MCO*

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

**MCO COST SETTLEMENT PAYMENTS:**

Payments to Contractors will be based upon adjudicated /approved encounter data, flagged by an AHCCCS subcap code 10 or 11 as eligible for PCP Enhanced Payment.

On a quarterly basis Contractors will be sent a report with all Encounter CRNs (and other key identifying data) that have been reported, and validated as correctly paid, by Contractors using enhanced rates since the last quarter (based upon the Encounter adjudication status date). Layout of this Reporting is included below.

Contractors will be given a two-week review period to review and tie their payments to the report. Contractor will agree or comment on the reported CRNs and amounts, and cost settlement payment will be made based upon the finalized list of CRNs.

Contractors will be required to include all reprocessed claims in their reported encounters and refund payments to AHCCCS for any reduced claim payments in the event that a provider is subsequently “decertified” for enhanced payments due to audit.

AHCCCS will provide a reasonable timeline or window of opportunity for Contractors to comply with this requirement, and will work with the Contractor to help identify impacted Encounter CRNs for the Contractor.

**RETROACTIVE REPROCESSING OF IMPACTED CLAIMS:**

In the event that a provider is retroactively flagged as Board Certified or Attested (60%, New Provider or Board certified) or loses this designation as noted above, Contractors will be afforded a maximum of 4 months during which it is expected that impacted claims will be identified and automatically reprocessed for enhanced payment or the recoupment of enhanced payments. It is expected that this reprocessing will be conducted by the Contractor without requirement of further action by the provider.

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

**CN1 CODE TO SUBCAP CODE CROSSWALK:**

CN1 CODE	CN1 DESC	TRANSPLANT RCP (MEMBER EXCEPTION CODE '25' TRANSPLANT)	ELIGIBLE FOR PCP RATE	SUBCAP CODE	ELIGIBLE FOR PCP ENHANCED RATE	
01	Diagnosis Related Group (DRG)	N	N	00 (FFS)	Y	10 (FFS) (PCP Rate Parity)
02	Per Diem	N	N	00 (FFS)	Y	10 (FFS) (PCP Rate Parity)
03	Variable Per Diem	N	N	00 (FFS)	Y	10 (FFS) (PCP Rate Parity)
04	Flat	N	N	00 (FFS)	Y	10 (FFS) (PCP Rate Parity)
05	Capitated	N	N	01 (SUBCAPITATED)	Y	12 (SUBCAPITATED) (PCP Rate Parity)
06	Percent	N	N	00 (FFS)	Y	10 (FFS) (PCP Rate Parity)
09	Other	N	N	08 (Negotiated Settlement)	Y	13 (Negotiated Settlement) (PCP Rate Parity)
01	Diagnosis Related Group (DRG)	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	Y	11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)
02	Per Diem	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	Y	11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)
03	Variable Per Diem	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	Y	11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)
04	Flat	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	Y	11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)
05	Capitated	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	Y	11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)
06	Percent	Y	N	05 (Non-Transplant Svc for Transplant Rcp)	Y	11 Non-Transplant Svc for Transplant Rcp) (PCP Rate Parity)
09	Other	Y	N	04 (Transplant Svc for Transplant Rcp)	Y	14 (Transplant Svc for Transplant Rcp) (PCP Rate Parity)
			NA	06 (Denied, per File type .deny)	NA	

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

<u>FIELD DEFINITION</u>	<u>FIELD NAME</u>	<u>TYPE</u>	<u>LENGTH</u>	<u>COMMENTS</u>	
Submitting Health Plan ID	CLM-HP-ID	X	6		1-6
Submitting Health Plan County	CLM-HP-LOC-CD	X	2		7-8
Submitting Health Plan TSN	TP-SUPL-ID	X	2		9-10
Adjudication Status	ADJU-STA-O	X	2	<i>31 – Approved, 32 – Voided Original, 33 – Replaced Original</i>	11-12
Adjudication Date	STA-EFF-DAT	X	8		13-20
HCPCS/CPT Code	HCPCS-PROC-CD	X	5		21-25
Service Begin Date	SRV-BEG-DAT-O	X	8		26-33
Service End Date	SRV-END-DAT-O	X	8		34-41
Service Provider NPI	SER-PR-NPI	X	10		42-51
Service AHCCCS Provider ID	SER-PR-ID	X	6		52-57
Service Provider Type	SER-PR-TYP	X	2		58-59
Tax ID Number	BIL-PR-TAX-ID	X	9	As reported on the Encounter	60-68
Claim/Encounter Reference Number	CRN	X	14		69-82
Prior CRN	PRR-CRN	X	14	<i>If Applicable</i>	83-96
Health Plan CRN	HP-CLM-NO	X	30		97-126
Recipient AHCCCS ID	PRI-AHCCCS-ID	X	9		127-135
Sub-capitated Code	SUBCAPITATED-CD	X	2		136-137
CN1 Code	CN1-CODE	X	2		138-139
Billed Charge		D	9		140-148
Health Plan Allowed Amount	HP-ALLOW-AMT	D	9		149-157
Health Plan Paid Amount	HP-PAID-AMT	D	9		158-166
Other Insurance Allowed		D	9		167-175
Other Insurance Paid		D	9		176-184
Medicare Approved		D	9		185-193
Medicare Paid		D	9		194-202
Interest Paid		D	9		203-211
Co-Pay Amount	From Co-Pay Table	D	9		212-220

**ACOM POLICY 207, ATTACHMENT A, AHCCCS ENCOUNTER FLOW**

<u>FIELD DEFINITION</u>	<u>FIELD NAME</u>	<u>TYPE</u>	<u>LENGTH</u>	<u>COMMENTS</u>	
PCP Parity Payment Rate		D	9	<i>From Fee Schedule (RF144) – minus Provider Type Discount (Equal AHCCCS Allowed Amount)</i>	221-229
Calculated PCP Rate Parity Amount		D	9	<i>AHCCCS calculated</i>	230-238
Provider Attestation Type		X	1	<i>C- Board Certified; B-Board Certified Attested;6-60% Attested; 7-New Provider 60% Attested;N-Not Qualified</i>	239-239
PCP Indicator Begin		X	8		240-247
PCP Indicator End		X	8		248-255
PCP Indicator Last Modified Date		X	8		256-263
Vaccine Indicator		X	1	Blank - For Future Use	264-264
Total Encounter Count		D	8	Blank - For Future Use	265-272
Total Calculated PCP Rate Parity Amount		D	9	Blank - For Future Use	273-281