



Indian Health Services & Tribal 638 Providers Forum Fourth Quarter 2020

Provider Training Team
November 04, 2020
2:00pm – 3:30pm



Agenda for IHS 638 Forum on November 4, 2020

1. Tribal Consultation Updates	6. Billing for Vaccines under the VFC Program	11. AIR and IHS-638 SNF/NFs	16. EVV Training Reminders
2. COVID-19 CR Modifier Reminder	7. American Indian Medical Home (AIMH)	12. Behavioral Health Provider Types	17. ROPA Updates
3. Flu Vaccinations and Billing the AIR	8. Dental Hygienists and Therapy Services	13. Third Party Liability	18. Provider Participation Agreement (PPA)
4. Flu Vaccine Updates for EMS Providers	9. Alternate Care Sites (ACS)	14. Telehealth/Telephonic Reminders	19. NEMT Reminders
5. Flu Vaccine Administration For Members 3 to 18 Years Of Age	10. IHS/638 Ambulatory Surgery Center Billing Reminders	15. “Four Walls” Reminder	20. KidsCare Billing



Tribal Relations Update

Amanda Bahe, AHCCCS Tribal Liaison

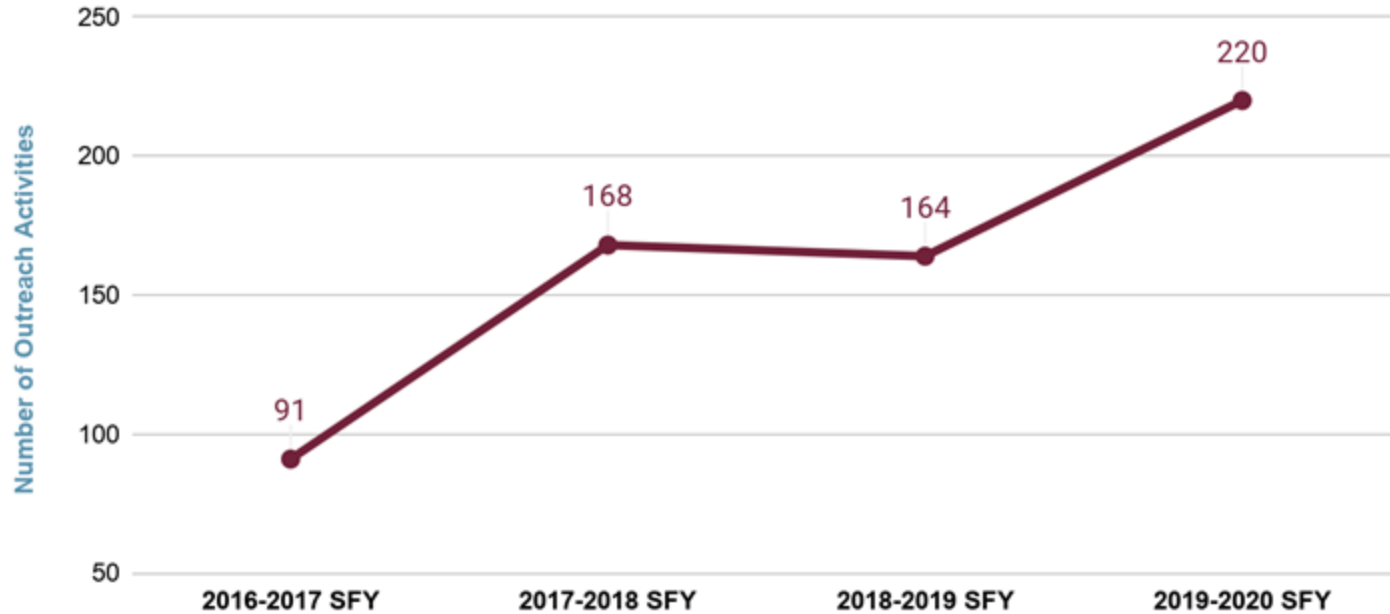
Arizona's Section 1115 Waiver Renewal Proposal: Public Notice & Comment Period

- Arizona must provide at least a 30-day public notice and comment period prior to submitting renewal application to CMS
- Arizona's draft application will be available for public review and comment: **October 2, 2020 - November 30, 2020**
- Submit written comments no later than **November 30, 2020**
- Arizona's renewal application can be found on the AHCCCS website: www.azahcccs.gov/WaiverRenewal

Tribal Consultation Annual Report

- Submitted annually to Governor's Office on Tribal Relations
- Documents AHCCCS Tribal Outreach and Engagement Activities
 - Goals: Derived from Tribal Consultation Policy (TCP)
 - Objectives: Defines reasons for conducting tribal outreach as defined by TCP
 - Measures: Describes actions taken by agency and any outcomes associated with action
- Link to Agency Reports:
<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/agencyreports.html>

Overview of Agency Tribal Activities



2019-2020 Activities

- Conducted by OOD, DCAIR, and DFSM and include:
 - Quarterly and Special Tribal Consultations: 11
 - Government-to-Government Meetings: 4
 - Trainings and Technical Assistance: 98
 - Statewide Presentations and/or Meetings: 71
 - AHCCCS Policy Distributions for Tribal Consultation: 40

Announcements

AHCCCS on the Road (Virtually!)

The Arizona Health Care Cost Containment System (AHCCCS) is hosting online forums to inform the community and gather feedback on the upcoming AHCCCS initiatives:

- The Future of Regional Behavioral Health Agreements (RBHA)
- Competitive Contract Expansion
- Whole Person Care Initiative
- Waiver
- AHCCCS COVID 19 Response

November 20, 2020

9:30 am - 11:00 am

Location: Webinar

Register in advance for this webinar:

https://ahcccs.zoom.us/webinar/register/WN_p6kwNk7nSPmNKUMph_CE0Q

After registering, you will receive a confirmation email containing information about joining the webinar.



Next AHCCCS Tribal Consultation:

November 5, 2020 at 1 pm

Please check [AHCCCS Tribal Consultation Webpage](#) for meeting information.

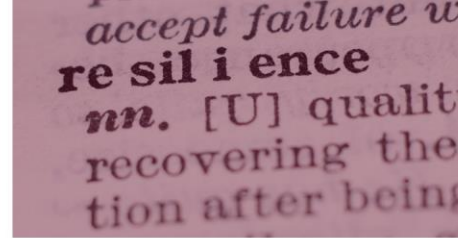


COVID -19 CR Modifier Reminder

Covid-19 Emergency Related Modifier CR – Catastrophe/Disaster

Modifier CR:

- AHCCCS has designated the CR modifier to be used on all claims for services provided as a result of, or related to COVID-19.
- Providers should begin utilizing modifier CR immediately in all appropriate instances in order for AHCCCS to identify the costs of services attributable to this emergency.
- All other guidance regarding use of modifiers continues to be applicable.



IHS/638 Providers, Flu Shots and the AIR

Can a Nurse Administer the Flu Shot, and the IHS/638 Facility be Reimbursed at the AIR?

An IHS/638 facility may bill the AIR for the flu vaccination when a nurse administers the vaccination in accordance with the following (these parameters also apply when billing the FFS rate):

- A RN or LPN may administer the flu vaccination when the vaccine has been ordered by a practitioner with prescriptive authority, which may be a standing order or an individual order.
- The ordering practitioner's NPI **must** be listed on the claim, which is required whether billing for the AIR on a medical or pharmacy claim.
- Please note that RNs and LPNs or other ancillary nursing staff are **not** independent billers in the AHCCCS system. Therefore they cannot be listed as the ordering provider.

Can a Nurse Administer the Flu Shot, and the IHS/638 Facility be Reimbursed at the AIR?

- Nurse Practitioners are independent providers/billers within the AHCCCS system and may be listed on the medical claim to bill the AIR for administration of the flu vaccine.
 - Please note that Nurse Practitioners are *different* from RNs and LPNs. RNs, LPNs or other ancillary nursing staff may **not** use their NPIs on these medical claims.
- Please note, the pharmacist, *assuming the pharmacist is certified as an immunizing pharmacist*, may run a community clinic; however, they cannot supervise a nurse giving injections nor bill through Optum for nurses giving injections.



EMS Providers and Flu Shots

EMS Providers and Flu Shots

AHCCCS continues to develop and expand the eligible providers that may offer and bill Medicaid for administering the flu vaccine. As a result of ongoing conversations with the Arizona Department of Health Services (ADHS), AHCCCS is allowing qualified emergency medical service providers, defined as ADHS licensed/certified AHCCCS registered provider types 06, 97 and TR, the opportunity to bill AHCCCS for the flu vaccine and the administration of the flu vaccine within their scope of practice effective October 1, 2020.

- Qualified emergency medical service providers will be given the ability to bill AHCCCS FFS for the codes specified in the following September 1, 2020 public notice for the flu vaccine and/or the flu vaccine administration

EMS Providers and Flu Shots

- The flu vaccine and administration codes shall be billed separately as a unique service. This means it shall be billed on a separate claim form.
- The administration of the vaccine shall not be delivered as part of a transport or be billed with a transport code such as ALS/BLS.
- The intent is that providers would deliver these as a separate service outside of transportation, such as at a flu vaccination drive or another stationary venue.
- For qualified emergency medical service providers, reimbursement is being made at the AHCCCS Capped FFS Fee Schedule.



Flu Vaccine Administration For Members 3 to 18 Years Of Age

Flu Vaccine

Access to the flu vaccine has been expanded as of September 1st, 2020. This expansion allows Fee-For-Service (FFS) members ages 3 through 18 years of to obtain their flu shot at an IHS, 638, or other OptumRX network pharmacy.

We recognize that IHS/638 Tribal pharmacists may not be registered with the Arizona State Board of Pharmacy; however, they are required to be trained to provide immunizations and emergency medications.

Vaccinations

Members ages 3 through 18 years of age, in need of other vaccines (beyond the flu shot), should be redirected to their primary care provider.

The primary care provider is required to obtain vaccines for this age group through the Vaccine For Children Program (VFC). For more information regarding the VFC program and billing requirements, please refer to the IHS/638 billing manual (page 146).

Flu Vaccines

The AIR may be billed by the pharmacy through Optum when the flu immunization is administered at the pharmacy. Due to COVID-19 and the urgency to immunize for the upcoming flu season, pharmacists that administer flu vaccines offsite, for example, for a mass immunization clinic, the pharmacy shall submit the AIR to Optum for enrolled Title XIX members who have received the flu vaccine at an offsite location.

Children ages 3 years through 18 years, that are seen in the clinic for a PCP appointment, must be immunized with a flu vaccine that has been obtained from or will be replaced by the VFC program.

Flu Vaccine

For additional information, including information for IHS and 638 pharmacies and billing the All- Inclusive Rate (AIR), please refer to the [Flu Vaccine Administration For Members 3 Years Through 18 years of age Memo](#)



Billing for Vaccines under VFC

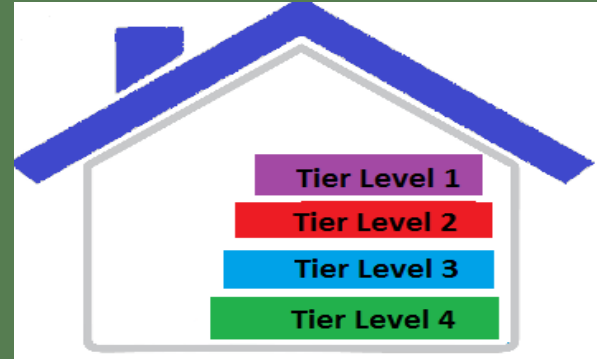
Billing under the Vaccines for Children Program

Providers:

- Must be registered with the **Vaccines for Children (VFC)** program;
- Must use only VFC vaccines;
- Shall be paid a capped fee for the administration of those vaccines to members 18 years old and younger;
- Shall bill the appropriate CPT code for the immunization, and shall use the “SL” (State Supplied Vaccine) modifier that identifies the immunization as part of the VFC program; and
- Shall include the CPT code for each vaccine administered with \$0.00 dollars.



American Indian Medical Homes



What is an American Indian Medical Home

- The American Indian Medical Home (AIMH) is a care management model that puts AHCCCS American Indian Health Program (AIHP) members at the forefront of care.
- AIMHs help address health disparities between American Indians and Alaskan Natives in Arizona by enhancing case management and care coordination through the use of Primary Care Case Managers (PCCM) and 24 hour access to the care team.

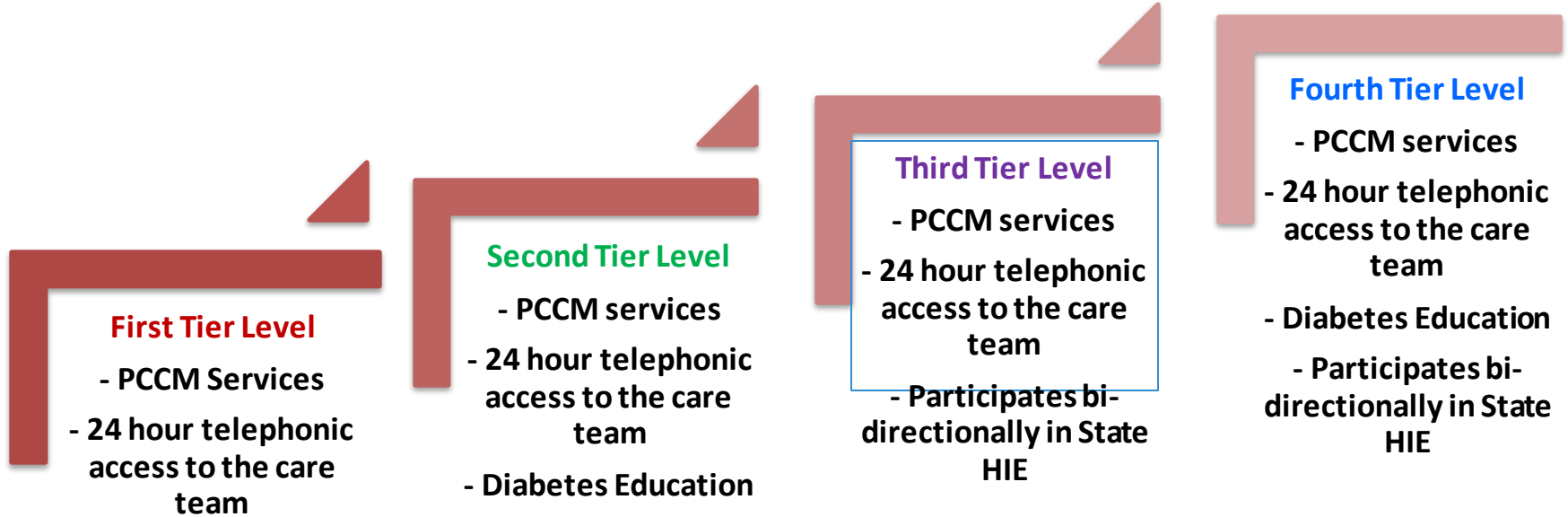
AIHM Provider Requirements

- Must be an IHS or Tribal 638 facility
- Enter into an AIMH Intergovernmental Agreement (IGA)
- Primary Care Medical Home (PCMH) accreditation
- Provide 24 hour telephonic access to the care team
- Dependent on selected Tier Level
 - Provide diabetes education
 - Participate bi-directionally in the State Health Information Exchange (HIE)

AIHM Medical Provider Types

Provider Type	Description
02	Hospital
05	Clinic (excluding Dental Providers)
IC	Integrated Clinic
C2	Federally Qualified Health Clinic (FQHC)
C5	638 Federally Qualified Health Clinic (FQHC)
29	Community / Rural Health Center

AIMH Services Per Tier Level



AIMH Reimbursement Rates

- Facilities who choose to become an AIMH will receive a Prospective Per Member Per Month (PMPM) rate for services provided by their medical home.
- Payments are dependent upon the AIMH tier level selected.
- Tier levels (4) include annual rate increases.

AIMH Reimbursement Rates

AIMH 4.6% rate increase calculation – 10 year forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
LEVEL 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
LEVEL 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
LEVEL 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
LEVEL 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

Active American Indian Medical Homes

- Chinle Comprehensive Health Care Facility
 - Tier 4
 - **13,108 members**
- Phoenix Indian Medical Center (PIMC)
 - Tier 2
 - **4,485 members**
- WhiteRiver Indian Hospital
 - Tier 2
 - **5,215 members**
- Winslow Indian Health Care Center
 - Tier 3
 - **3,401 members**
- San Carlos Apache Healthcare
 - Tier 4
 - **2,236 members**
- Fort Yuma Indian Health Center
 - Tier 1
 - **3 members**

AIMH Resources and Information

- IHS/638 Providers can send questions to:
 - AIMH@azahcccs.gov
- Review AIMH information at:
<https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/>
- State Plan Amendment (SPA)
<https://www.azahcccs.gov/Resources/StatePlans/StatePlanAmendments.html>



Dental Updates

Policy Update 310-D1

Dental Services for Members 21 Years of Age and Older

Dental Hygienist Services

Per AMPM 310-D1, dental hygienists may also practice within an inpatient hospital setting when under the general supervision of a licensed physician, so as to allow for the care of patients on a ventilator or who are physically unable to perform oral hygiene.

This allows for the coverage of dental cleanings, and these services are not subject to the \$1,000 adult emergency dental limit.

Policy Update 310-D1

Dental Services for Members 21 Years of Age and Older

Dental Hygienist Services

These dental services shall be billed under either the inpatient hospital (for claims for facility services) or under the supervising dental provider (for claims for professional services).

Dental hygienists may not bill as independent providers.

Policy Update 310-D1

Dental Services for Members 21 Years of Age and Older

Exception for Ventilator Cases

- If services are billed under the physician, then medical codes will be submitted and are not subject to the \$1000 adult emergency dental limit.

Dental Therapy Services

Dental Therapy Services

As of February 1st, 2020, dental services provided by dental therapists within their scope of practice that are consistent with statute may be billed to AHCCCS by facilities or supervising dentists.

Dental Therapy Services

Dental Therapy Services

Per [A.R.S. 32-1276.01](#) a dental therapist must be a licensed dental hygienist and have graduated from a dental therapy education program accredited by (or holding an initial accreditation from) the American Dental Association Commission on Dental Accreditation.

For information on licensing requirements and scope of practice, please refer to the Board of Dental Examiners website. Per [A.R.S. 32-1231](#) *there is an exception to state licensure (but not scope of practice requirements) for dental therapists who are employed in IHS and 638 facilities or Urban Indian Health programs.*

Dental Therapy Services

Dental Therapy Services

Dental therapists may not bill as independent providers or dispense narcotics, per [A.R.S. 32-1276-03](#).

Dental Therapy Services

Dental Therapy Services

Dental therapists may practice within the following practice settings or locations, including mobile dental units that are operated or served by any of the following, per [A.R.S. 32-1276.04](#) :

1. Federally Qualified Health Center (FQHCs);
2. Health Centers that have received a Federal Look-Alike Designation;
3. Community Health Centers;
4. Private dental practices that contract with FQHCs or provides dental care for community health center patients of record who are referred by the community health center; and/or
5. Nonprofit dental practice or a nonprofit organizations that provides dental care to low-income and underserved individuals.

Dental Therapy Services

Dental Therapy Services

Facilities or clinics owned or operated by the Indian Health Service, tribes or tribal organizations with a 638 agreement, and Urban Indian Health Programs that fall within one of the previously listed five practice settings and locations delineated in statute, may bill for dental therapist services, as long as the dental therapist meets the licensure requirements or exceptions to licensure requirements.



Alternate Care Sites

Purpose of Alternate Care Sites

In the event of a disaster or public health emergency, Alternate Care Sites (ACS) may be created to enable healthcare providers to provide medical care for injured or sick patients, or to continue care for chronic conditions in non-traditional environments.

These ACS may include locations that need to be converted (e.g., schools and stadiums) or they may include facilities like mobile field hospitals.

What is an Alternate Care Site (ACS)?

An ACS is an extension of a hospital or clinic that will treat members during a public health emergency.

The ACS that is set up must provide the required level of medical care necessary to meet the patient's medical needs.

An ACS can be established (owned and operated) by an individual hospital, a group or partnership of hospitals or health systems, a local community (such as the local health department), a state (such as a state health department), or the federal government.

Alternate Care Site Tools

The establishment of an ACS seeks to help address potential capacity gaps in healthcare systems, brought about by the 2020 SARS-CoV2 virus (COVID-19) pandemic.

For technical assistance regarding the setup of an ACS in your community, refer to:

- <https://files.asprtracie.hhs.gov/documents/acs-toolkit-ed1-20200330-1022.pdf>

Alternate Care Site Tools

For additional information on funding sources, refer to:

- <https://files.asprtracie.hhs.gov/documents/aspr-tracie-acsfunding-sources-establishment-and-operationalization.pdf>

For additional information on Alternate Care Sites, refer to:

- <https://asprtracie.hhs.gov/technical-resources/111/covid-19-alternate-care-site-resources/99>

Alternate Care Site Waiver Request

In June 2020, AHCCCS requested an 1135 Waiver from CMS to permit reimbursement for services offered by hospitals and clinics owned or operated by the Indian Health Service, tribes, or tribal organizations with a 638 agreement, in Alternate Care Sites (ACS), during the public health emergency.

CMS has indicated that an additional waiver is not required, since ACS are covered under the CMS blanket waiver.

Alternate Care Site Waiver Request

Federal and/or tribal entities will be required to attest that the ACS meets minimum standards consistent with reasonable expectations in the context of the current public health emergency to ensure health, safety and comfort to beneficiaries and staff.

ACS Attestation and Memo

Hospitals and clinics owned or operated by the Indian Health Services, tribes or tribal organizations with a 638 agreement, who have chosen to establish an ACS, shall sign an attestation form, which can be found at:

- https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2020/ACS_Attestation.pdf

ACS Attestation and Memo

Additional information regarding billing for services provided at an ACS can be found in the DFSM ACS Memo, located at:

- <https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2020/AlternateCareSitesMemo.pdf>

IHS/638 facilities with an attestation for an ACS shall be posted here:

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

ACS Covered Services

Reimbursement for medically necessary Title XIX and Title XXI AHCCCS covered services are permissible in an established IHS/638 ACS site, so long as the services are medically necessary, cost-effective, and federally and state reimbursable. Services for members being treated at an ACS site are subject to the same medical necessity requirements that apply to services provided within the associated hospital/clinic facility.

ACS Covered Services

Per the [CMS blanket waiver](#), CMS will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care or quarantine, provided the location is approved by the state (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's emergency preparedness or pandemic plan. This allows for increased capacity and promotes appropriate cohorting of COVID-19 patients.

ACS Covered Services

"Quarantine" per CMS refers to the concept of allowing treatment of COVID positive members (or potential positive members), who are receiving medically necessary hospital/clinic services (inpatient, observation, etc.), to occur in an environment secluded from the rest of the patient population.

ACS Reimbursement Guidelines

Per the 1135 Waiver submitted by AHCCCS, medically necessary Title XIX and Title XXI AHCCCS covered services will be reimbursed as follows:

- At either the inpatient or outpatient All-Inclusive Rate depending on the level of care provided to Title XIX eligible members; or
- At current FFS rates for Title XXI eligible members receiving services in an ACS.

Reimbursement Guidelines

Per the 1135 Waiver submitted by AHCCCS, professional services provided in the ACS will be consistent with current AHCCCS billing requirements, including AHCCCS registration of practitioners such as IHS/Tribal physicians and non-physician practitioners.

ACS and Clinic Services

Consistent with CMS guidance, AHCCCS is holding off on auditing compliance with the “Four Walls” component until January 31st of 2021.

CMS released FAQs on January 18, 2017, regarding the review of services furnished by IHS/Tribal clinic providers “outside the Four Walls” of the clinic prior to January 30th, 2021. This can be found in Question#13, in the FAQs at:

- <https://www.medicaid.gov/sites/default/files/federalpolicy-guidance/downloads/faq11817.pdf>

AHCCCS will continue to follow the “Four Walls” issue, since CMS is considering extending that timeline.

ACS Attestation and Memo

Hospitals and clinics owned or operated by the Indian Health Services, tribes or tribal organizations with a 638 agreement, who have chosen to establish an ACS, shall sign an attestation form, which can be found at:

- <https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2020/ACSAttestation.pdf>

Additional information regarding billing for services provided at an ACS can be found in the DFSM ACS Memo, located at:

- <https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2020/AlternateCareSitesMemo.pdf>

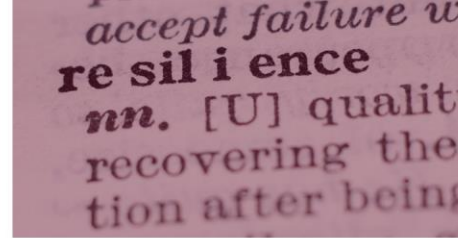
IHS/638 facilities with an attestation for an ACS shall be posted here:

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

Billing Services at an ACS

IHS/638 Providers/Facilities:

- When billing for reimbursement at the All Inclusive Rate (AIR):
 - Services will be billed on the UB-04 Institutional Claim Form.
- When billing for reimbursement at the Capped Fee-for-Service (FFS) Rate:
 - Services will be billed using the CMS 1500 Professional Claim Form.
 - Note: All services are subject to post payment review.



IHS/638 Ambulatory Surgery Center Billing Reminders

IHS/638 Ambulatory Surgery Center Billing for Title XIX Members

Ambulatory Surgical Centers will bill on the CMS 1500 with the appropriate CPT/HCPCS codes and modifiers. Reimbursement will be subject to the FFS ASC fee schedule.

- **Claim Form:** CMS 1500
- **Coding:** CPT / HCPCS Code
- **Modifiers:** If applicable
- **Place of Service:** 24
- **Reimbursement:** AHCCCS Capped FFS Rate

IHS/638 Ambulatory Surgery Center Billing for Title XIX Members

Surgeon and Anesthesiologist services:

- **Claim Form:** CMS 1500
- **Coding:** CPT / HCPCS Code
- **Modifiers:** If applicable
- **Place of Service:** 24
- **Reimbursement:** AHCCCS Capped FFS Rate



The AIR and IHS/638 Nursing Facilities & Skilled Nursing Facilities

IHS/638 Nursing Facilities & Skilled Nursing Facilities

On August 17, 2020, AHCCCS received CMS approval to reimburse Indian Health Service (IHS) /Tribally owned and/or operated (638) Nursing Facilities (NFs) and Skilled Nursing Facilities (SNFs) at the current All Inclusive Rate (AIR) as published in the Federal Register.

- This change will be effective October 1, 2020.

IHS/638 NFs and SNFs Reimbursement Rate Options

Per the Arizona Medicaid State Plan, IHS/638 NFs and SNFs may now be reimbursed at the outpatient All-Inclusive Rate (AIR)

- **NOTE:** Billing for reimbursement at the AIR is only an option for **Title XIX members**. Services provided to Title XXI members are not reimbursable at the AIR.

What has Changed?

Previously, the per diem rate (a daily rate paid for services provided to each member) for nursing facility stays was established based on four levels of care.

- Level 1
- Level 2
- Level 3
- Ventilator dependent, sub-acute and other specialty care

Billing for IHS/638 NFs & SNFs

For IHS/638 NFs and SNFs, now billing the outpatient AIR for services rendered to Title XIX members, they shall bill as follows:

- **Claim Form:** UB-04 Claim Form
- **Revenue Codes:** 0183, 0185, 0191, 0192, and 0193
- **Diagnosis Codes:** ICD-10
- **Reimbursement Rate:** The current outpatient AIR

Billing for IHS/638 NFs & SNFs

Coding

When billing for reimbursement at the AIR, providers should continue to use the appropriate Revenue Code and follow national coding standards.

Revenue Code	Description
0183	LOA/Therapeutic
0185	LOA/Nursing Home
0191	Subacute Care Level I
0192	Subacute Care Level II
0193	Subacute Care Level III

Billing for IHS/638 NFs & SNFs

Claim Form

There is *no change* to how the UB-04 Claim Form is filled out, except for the reimbursement rate requested. This will be reflected in the following fields:

- Field 42: Rev Code
- Field 47: Total Charges

For additional instructions on “how to” fill out a UB-04 Claim Form, please visit Chapter 5, Claim Forms, of the IHS/Tribal Provider Billing Manual at:

- <https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap05CImFormRequire.pdf>

Billing for IHS/638 NFs & SNFs

International Classification of Diseases (ICD) Diagnosis Codes

- **ICD-10** diagnosis codes are required on all claim forms. Services billed without an ICD-10 code, or that are billed with an ICD-9 code, will be denied.
- AHCCCS does not accept DSM-4 diagnosis codes. Services billed with DSM-4 diagnosis codes will be denied.

Billing for IHS/638 NFs & SNFs

Reimbursement

- The outpatient All-Inclusive Rate (AIR) for FFY 2020 is \$479. For the current year's outpatient AIR, please visit the Federal Register at:
 - <https://www.federalregister.gov/>

Fiscal Impact

The estimated aggregate fiscal impact to the Federal Budget of this update is as follows:

- **Federal Fiscal Year (FFY) 2021:** \$12,691,500
- **Federal Fiscal Year (FFY) 2022:** \$13,534,900

State Plan Amendment (SPA)

Please see below for the SPA submission and approval:

- Submission:
 - https://www.azahcccs.gov/Resources/Downloads/MedicaidStatePlan/Amendments/2020/SubmissionPacket_20-011.pdf
- Approval:
 - <https://www.azahcccs.gov/Resources/Downloads/MedicaidStatePlan/Amendments/2020/AZ20-0011Approved.pdf>



Behavioral Health Provider Types

Behavioral Health Professional (BHP)

Behavioral Health Technician (BHT)

Behavioral Health Paraprofessional (BHPP)

Behavioral Health Professional (BHP)

An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

- i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
- ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101,
 - b. A psychiatrist as defined in A.R.S. §36-501,

Behavioral Health Professional (BHP)

- c. A psychologist as defined in A.R.S. §32-2061,
- d. A physician,
- e. A behavior analyst as defined in A.R.S. §32-2091,
- f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
- g. A registered nurse with:
 - i. A psychiatric-mental health nursing certification, or
 - ii. One year of experience providing behavioral health services
 -

Behavioral Health Technicians (BHT)

As specified in A.A.C. R9-10-101, an individual who is not a BHP who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33, and
2. Are provided with clinical oversight by a behavioral health professional.

Behavioral Health Paraprofessionals (BHPP)

As specified in A.A.C. R9-10-101, an individual who is not a behavioral health professional who provides behavioral health services at or for a health care institution according to the health care institution's policies and procedures that:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, the individual would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
2. Are provided under supervision by a behavioral health professional.



Third Party Liability and Medicare Secondary Payer Claims

Third Party Liability

What is Third Party Liability?

Third party liability means that the recipient has another medical insurance plan that is the primary payer for their medical services.

Federal law 42 USC 1396a (a)(25)(A) requires Medicaid to take all reasonable measures to determine the legal liability of third parties for health care items and services provided to Medicaid members.

AHCCCS has liability for payment of benefits after Medicare and all other first- and third-party payer benefits have been paid. Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

Third Party Liability and AHCCCS as the “Payer of Last Resort”

AHCCCS is considered the “Payer of Last Resort”

- For members that have a primary insurance, AHCCCS will be the last payer to consider reimbursing the claim.
- A copy of the primary payer’s Explanation of Benefits (EOB) will be required for consideration of the claim.
- For members with Medicare as the primary coverage, Medicare will automatically transfer claims that have been approved for payment to AHCCCS for consideration.

Working Third Party Claim Denials

AHCCCS is considered the “Payer of Last Resort”

Providers must resolve claim denials with the primary payer first before AHCCCS can consider secondary payment.

- Claims denied for missing or inaccurate information.
- Common billing errors (incorrect member id)
- Incomplete information (date of service, coding, modifiers)

Fee Schedule Differences Between Payers

Fee Schedule Differences Between Payers

Insurance payers may have a different fee schedule or allowed amount assigned to each CPT/HCPCS code.

- Some payers allowed amount may be higher or lower than others.

AHCCCS will not issue a payment when the primary insurance payer's payment exceeds the AHCCCS allowable amount. If the primary insurance allowed amount is less than the AHCCCS allowed amount it is possible that a payment will be considered based on review.

Billing Secondary Claims

Billing Secondary Claims

Providers must adhere to the billing guidelines as identified by each insurance carrier including Medicaid.

Secondary payer claims refer to any claims for which Medicaid is the secondary payer, including third party insurance as well as Medicare crossover claims.

Medicare and TPL Guidelines

Medicare as the Primary Payer (Medicaid is Secondary)

- AHCCCS is secondary payer to Medicare.
- Medicare will automatically forward the approved claim to AHCCCS.
- Medicare does not crossover claims that are denied.
- Medicare does not crossover claims that have been adjusted.
- Providers must resolve Medicare denials (including following Medicare's claim reconsideration process) before AHCCCS can consider a claim as the secondary payer.
- The Medicare and AHCCCS remittance advice will have an indicator that will show the claim was an automatic cross over to Medicaid.

Medicare Secondary Payer Claims All Inclusive Rate

Medicare as the Primary Payer (Medicaid is Secondary)

For members who have Medicare as the primary payer, AHCCCS requires a Medicare Paid claim to be on file first before AHCCCS considers any additional OMB clinic visits for payment.

The Medicare approved claim does not have to be from the same AHCCCS provider.

Common Claim Denial; H189.1 Recipient has Medicare; Medicare must be indicated, is missing.

Medicare and TPL Guidelines

National Provider Identification (NPI) Numbers

Providers who qualify for Medicare payment, but have not applied to Medicare, must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

Timely Filing of Medicare Secondary Claims (MSP)

Timely Filing

The initial claim must be submitted to AHCCCS within **six months of the date of service**, even if payment from Medicare or another insurance payer has not been received.

Submitting the claim timely to AHCCCS allows the provider time to obtain any other information that may be required to finalize the claim within the 12 month time period.

Tribal Self-Insured Plans

Payment Rules

- Exception: If the recipient has primary coverage with a Tribal Self Insured plan then AHCCCS Medicaid assumes primary responsibility over the Tribal Self-insured plan.
- Tribal Self-Insurance. A health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator.



Telehealth Reminders

Telephonic Code Set (Temporary) Telehealth Services

AHCCCS has established two telephonic code sets that are available for use:

- a. Table I, **AHCCCS Telephonic Code Set (Temporary)** provides the lists of codes available on a temporary basis to be provided telephonically starting on dates of service March 17, 2020 until the end of the COVID-19 declared emergency.
- i. The **UD modifier** must be used when billing the applicable CPT or HCPCS code to designate **Telephonic Service**.
- ii. The Place of Service (POS) is the originating site (ie, where the member is located at the time of the telephonic service delivery).

Telephonic Code Set (Permanent) Telehealth Services

Table II, **AHCCCS Telephonic Code Set (Permanent)** are codes that have been available for use telephonically prior to the COVID-19 declared emergency and will continue to be available after the end of the emergency.

There is no change to the coding standards for these CPT/HCPCS codes. When providing these services *telephonically*, please continue to utilize ***POS 02 telehealth.***

Reminders: Billing Telehealth Modifiers

Modifier	Use
GQ	<i>Asynchronous telecommunications “store and forward” telehealth services.</i>
GT	Telehealth provided <i>Via “realtime” interactive audio and video telecommunications systems (Synchronous.)</i>
UD	Telephonic telehealth services.

Telehealth Services

- Telehealth services should otherwise continue to be billed in compliance with [AMPM Policy 320- I](#) Telehealth and the AHCCCS Telehealth Code List with POS criteria.



Four Walls Reminders

Four Walls

The “**Four Walls**” of an IHS/638 Clinic refer to the physical building the clinic operates within.

The CMS interpretation of section 1905(a)(8) of the Social Security Act, in 42 CFR 440.90, specifies that “clinic services” do not include any services delivered outside of the “four walls” of the clinic, except if services are provided to a homeless individual.

Under normal circumstances, the “Four Walls” applies as follows:

Four Walls Applicability and the AIR

Facility Type	Four Walls Rules Applicability
IHS/638 Free-Standing Clinics	“Four Walls” provision DOES apply.
IHS/638 hospitals	“Four Walls” provision DOES NOT apply.
IHS/638 hospitals or to their hospital-affiliated (provider-based) outpatient clinics	“Four Walls” provision DOES NOT apply.
Tribal 638 FQHC	“Four Walls” provision DOES NOT apply.

Telehealth Billing for IHS and 638 Providers

Reminder: Please Note that until January 30, 2021, that CMS will not review the “Four Walls” requirement for free-standing IHS/638 clinics.

For additional information regarding billing and the Four Walls we have provided the link to State Health Official Letter (16-002).

- [State Health Official Letter #16-002](#)



Electronic Visit Verification (EVV) Training Reminders

EVV Training

If you are a provider agency that is required to participate in EVV, you are required to take this training. It is important for you to know when and how to use this portal in order to avoid any issues with the EVV system including getting reimbursed for EVV services.

Who should participate in the training?

This training is intended for provider agencies (regardless of what EVV system is being used) and is concerning a new service authorization process required for EVV services that currently don't require prior authorization.

- This training is not intended for caregivers or Alternate EVV Vendors.
- In addition the agency's EVV Point of Contact, AHCCCS would recommend administrative personnel from the provider agency attend that are involved in receiving/managing authorizations as well as involved in the billing process. That said, provider agencies are welcome to invite administrative personnel at their discretion.

EVV Training

Background

The State's Electronic Visit Verification (EVV) system must comply with standards set forth by Centers for Medicare and Medicaid Services (CMS) to ensure the system meets the requirements of the 21st Century Cures Act. As part of the CMS certification process of the EVV system, the State must demonstrate the use of the EVV System supports the State to avoid payment for unauthorized or unapproved services by reconciling the linkage of providers, services, units and visits prior to claims payment.

The Service Confirmation Portal is being required by AHCCCS to ensure compliance with the CMS requirements for EVV.

EVV Training

What Does this Mean for You?

The AHCCCS Service Confirmation Portal will be required to be used by providers to submit information for services the provider is intending to render in the event a health plan does not require prior authorization for services. NOTE: If you are contracted to provide the same service for multiple health plans, you may have to adhere to different requirements and processes depending on the prior authorization requirements for each health plan.

If a service subject to EVV already requires prior authorization by a health plan, there is no change to that health plan's process. Providers are advised to continue to follow the specific prior authorization requirements and processes for the health plan.

If a service subject to EVV does not require prior authorization by the health plan, providers will use the AHCCCS Service Confirmation Portal to notify the health plan of their intention to provide a new service or continue providing an existing service.

EVV Training

What Does the Training Entail?

The training will be approximately two-hours in length and include a demonstration of the portal provided in a live-interactive webinar format.

While it is to the advantage of the provider to attend one of the live-interactive webinars, a recorded webinar will be posted to the AHCCCS website for viewing along with an FAQ document and technical companion guide.

During the training, you will learn:

- More about why this is required
- When you are expected to use the portal
- What information needs to be submitted
- How information can be submitted including the use of a file upload
- Timelines for compliance
- Resources for support and technical assistance

EVV Training

What do I do Next?

AHCCCS has scheduled training for the following dates/times along with information on how to connect to each of the training sessions. All training sessions will be the same so you only need to attend one of the sessions.

Monday, November 16th (8-10am)

https://ahcccs.zoom.us/webinar/register/WN_VMqIT5JfQcG9tJi-ZwNChQ

Thursday, November 19th (2-4pm)

https://ahcccs.zoom.us/webinar/register/WN_KDohMYJTeaildFNo33JLQ

Friday, November 20th (12-2pm)

https://ahcccs.zoom.us/webinar/register/WN_GiMeP5zQRpyxxkl2yVPhow

Monday, November 23rd (10-Noon)

https://ahcccs.zoom.us/webinar/register/WN_bDwFMdH8Slu9Dhk3KxTbig

AHCCCS EVV Billing Training

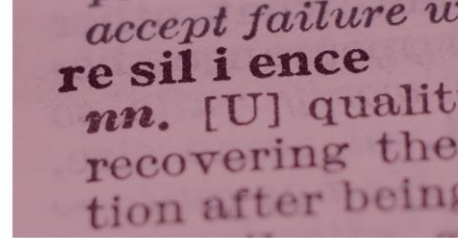
Electronic Visit Verification (EVV) Billing Training for IHS/638 Providers

The Division of Fee-for-Service Management (DFSM) will also be holding a series of provider trainings

for IHS 638 providers that are one of the provider types required to participate in EVV. It will cover an overview of billing information.

This training ***is not meant to replace the SanData training***. Providers MUST attend the SanData trainings. These DFSM trainings are designed just to cover billing items.

- Monday, November 9th, 2020 1:00 p.m. — 1:30 p.m. [Zoom Registration Link](#)
- Friday, November 20th, 2020 10:00 a.m. — 10:30 a.m. [Zoom Registration Link](#)
- Tuesday, December 8th, 2020 10:00 a.m. — 10:30 a.m. [Zoom Registration Link](#)



Referring, Ordering, Prescribing and Attending Providers ROPA Updates

Referring, Ordering, Prescribing, Attending Providers (ROPA)

- The [Patient Protection and Affordable Care Act \(ACA\)](#) and the [21st Century Cures Act \(Cures\)](#) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, or who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care, must be registered* as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA."
- Until these acts passed, referring, ordering, prescribing, and attending providers were required to obtain a National Provider Identifier (NPI), but were not required to be registered as an AHCCCS provider.

ROPA Registration Extension

In light of COVID-19 public health emergency and priority efforts it has demanded of public health systems, **AHCCCS has extended the ROPA registration deadline to June 01, 2021.**

The extension will help AHCCCS, our contracted managed care organizations, and all impacted providers determine who still needs to be registered and who does not; and ensure denials and access to care impacts are limited and/or negated.

Referring, Ordering, Prescribing and Attending (ROPA) Providers

Providers must be registered with AHCCCS by **June 01, 2021**, even if they have no intention of submitting claims to AHCCCS, if they intend to make any referrals, place any orders, prescribe any supplies/medications, or serve as an attending provider for any AHCCCS member. Failure to register ***may keep members from getting needed health care.***

If a rendering provider submits a claim to AHCCCS based on the order, referral, or prescription of a provider who is not registered with AHCCCS then that claim will be denied.

The ordering/referring/prescribing/attending provider must be both registered with AHCCCS and their NPI number shall be on the submitted claim.

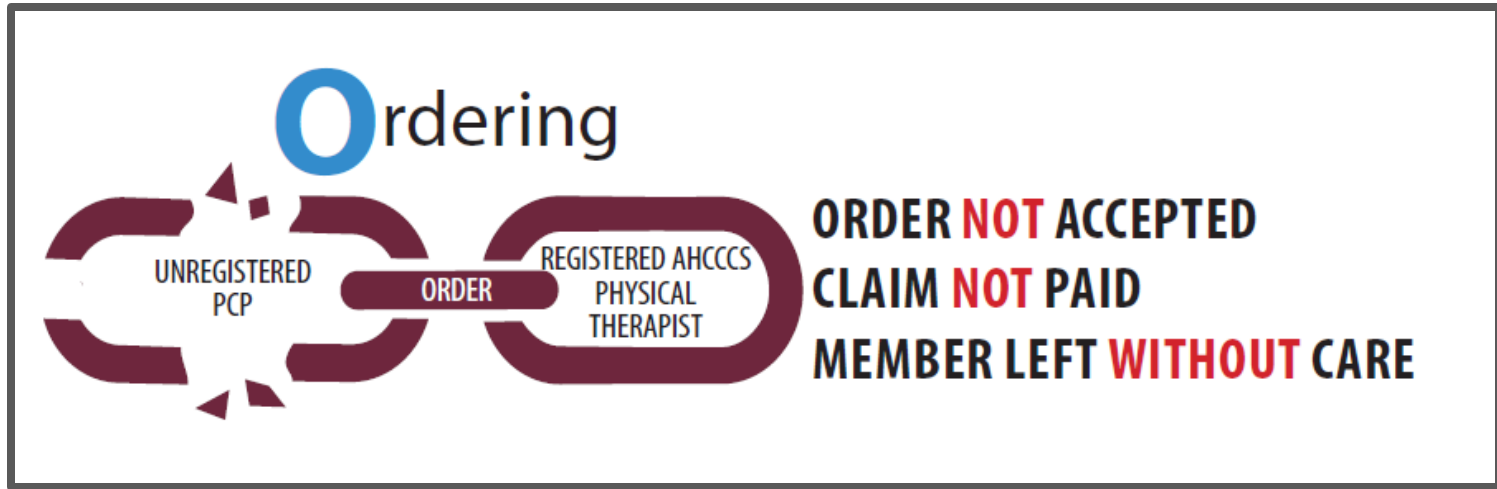
Referring, Ordering, Prescribing and Attending (ROPA) Providers

Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by **June 01, 2021**.



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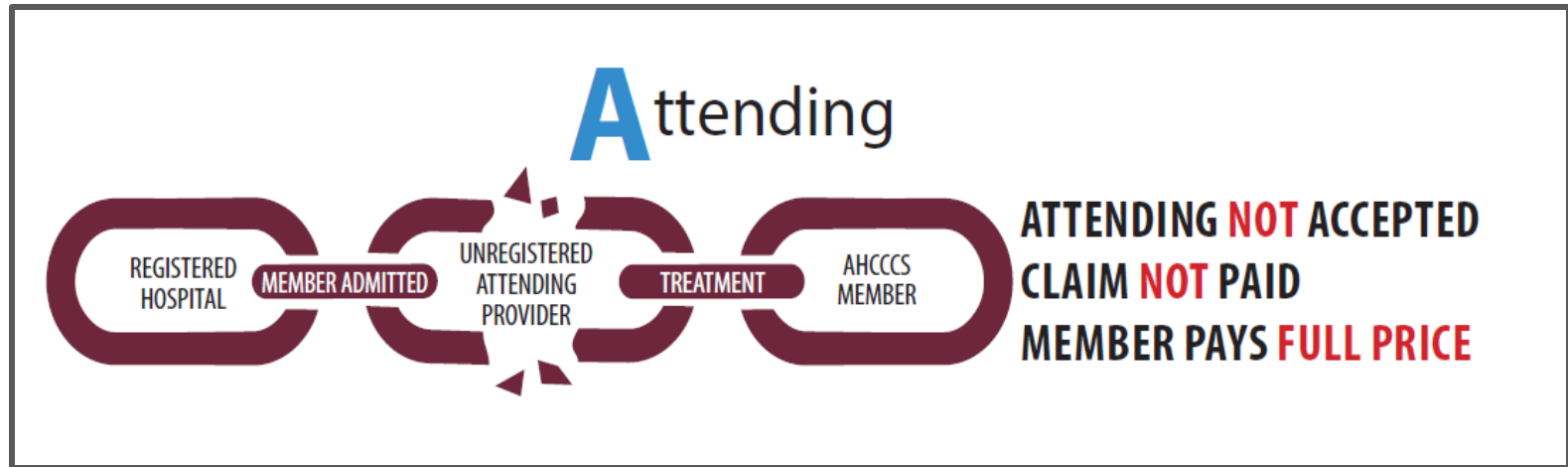
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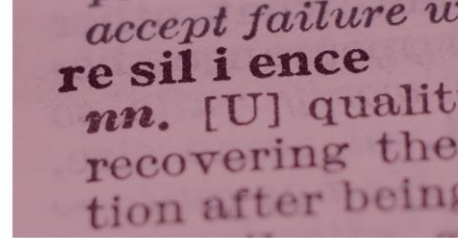
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Provider Participation Agreement (PPA)

Provider Location within the United States

Per the Provider Participation Agreement (PPA), “pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. 1396a(a)(80), AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institutions or entity located outside of the United States.”

Providers rendering services to an AHCCCS member must be located within the United States, or a territory of the United States, and also be an AHCCCS-registered provider, in order to be reimbursed.



Non-Emergent Medical Transportation Reminders

Non-Emergency Medical Transportation (NEMT)

- Prior authorization requirements have been temporarily waived for NEMT services over 100 miles.
- AHCCCS has waived the requirement for NEMT drivers to collect a passenger's signature, whether on paper or electronically at this time.
- The AHCCCS Daily Trip Report is the only acceptable document and will continue to be required (minus the member's signature) for NEMT trips.
- NEMT services must continue to meet coverage criteria and may be subject to post-payment review and/or audit.
- For FAQ NEMT COVID-19 information please visit:
<https://azahcccs.gov/AHCCCS/AboutUs/covid19FAQ.html>

Submission of Daily Trip Reports

AHCCCS provides 3 ways for providers to submit and attach the NEMT Daily Trip Report to the claim.

1. Upload online – electronic filing (automatic linking to claim submission).
2. Via Mail (defaults to a manual process which includes batching, sorting , scanning and manual linking and override).
3. Via Fax (defaults to a manual process which includes routing, manual linking and override).

Non-Emergent Medical Transportation (NEMT)

Question: What are the recommendations for Non-Emergency Medical Transportation (NEMT) providers to protect themselves?

- **Answer:** [This Arizona Department of Health Services flier](#) provides information to help NEMT providers understand the signs and symptoms of Coronavirus, how it spreads, the recommendations for how to protect yourself and others, when to use personal protective equipment (PPE), and where to request it.



Billing Information for KidsCare

Billing Medical Services for KidsCare (Title XXI)

- Medical services provided to Title XXI (KidsCare) members must be billed on the CMS 1500 (02/12) claim form with the NPI number for the rendering / servicing provider listed.
- Coding: CPT / HCPCS / Modifiers (if applicable).
- Reimbursement: AHCCCS Capped Fee-for-Service rate.
- The All Inclusive Rate (AIR) may not be billed for Title XXI (KidsCare) members.
- KidsCare claims that are submitted on the incorrect form type will deny.
- Denial Edit: (AD102 IHS/KidsCare must be bill on 1500, ADA or Point of Sale for pharmacy services).

Billing Dental Services for KidsCare (Title XXI)

- Dental services provided to Title XXI (KidsCare) members must be billed on the American Dental Association 2012 claim form using CDT-4 dental codes.
- Members that are enrolled in KidsCare, claims are reimbursed at the AHCCCS Capped Dental rate.
- The All Inclusive Rate (AIR) may not be billed for Title XXI (KidsCare) members.
- KidsCare claims that are submitted on the incorrect form type will deny.
- Denial Edit: (AD102 IHS/KidsCare must be bill on 1500, ADA or Point of Sale for pharmacy services).

KidsCare and Health Plan Enrollment

Claims for Title XXI (KidsCare) members must be submitted to the member's ***enrolled health plan***.

- KidsCare members that are enrolled in an AHCCCS Complete Care (ACC) health plan, submit the claim to that ACC plan.
- KidsCare members that are enrolled as Fee-for-Service or AIHP, submit the claim to AHCCCS using the appropriate claim form, CMS 1500 for medical services and the ADA dental form for covered dental services.

Thank You.

This concludes the presentation!

Questions?