ENCOUNTER KEYS

May-June, 2006

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Third Party Liability Changes

This is just a reminder that the Third Party Liability changes (addition of pharmacy and Medicare Supplemental coverage information to the verified TPL COB proprietary file) is in production. The communication e-mail of February 28, 2006 described in detail the changes to the file.

Simplification of changes for TPL:

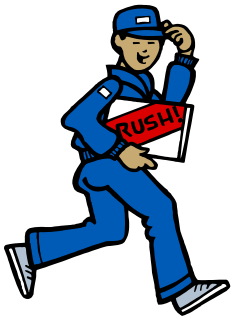
An additional field has been added to the end of TPL file, increasing the layout by **80 bytes.** This was done to accommodate Invalid Record Reason ('IRR') messages from Public Consulting Group, Inc. (PCG).

In addition, the field named "INSURANCE TYPE" has been changed. Additional values have been added. All applicable values are listed below. Information concerning these values can be found on the Technical Interface Guidelines on the AHCCCS website: http://www.azahcccs.gov/Publications/GuidesManuals/tig/CHAPTER2/hpTplLay.asp#ThirdPartyLiabilityDailyVerifieddataFileLayout

Insurance Type

Z – for Medicare
M – Medical for TPL
P – Pharmacy
S – Medicare Supplemental
V – Vision
D – Dental
B – Behavioral Health

The AHCCCS website will be updated to include the new file layout. Currently, AHCCCS is in the process of changing the website to include the current values that can be found in the 'INSURANCE TYPE' field.



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Adjudicated File

As part of AHCCCS' implementation of standardized files and transactions the final proprietary adjudicated file, ADMMDDYY.ZIP, will be produced at the end of encounter processing in September 2006. If you have not already, please complete your conversion to the new adjudication files, 277U and 277U Supplemental, prior to September 2006. The proprietary adjudicated file will not be produced after September 2006.

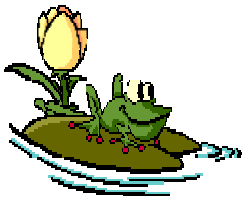
Encounter Financial Fields

Due to AHCCCS system modifications effective September 2006 encounter financial fields (such as billed charges, health plan allowed amount, health plan paid amount, coinsurance, deductible, and copay) will no longer be available for error correction using the pend correction process. Instead pended encounters due to invalid or incorrect financial information must be corrected using the replacement function.

Voids and Replacements

Original, void, and replacement encounters are all submitted in a new day file to AHCCCS. Plans should submit voids when the encounter was submitted in error to AHCCCS. Whereas a void should be a mirror image of an original or previous submission, a replacement does not have limitations on data field changes. A replacement means that something about the previous submission was incorrect or has been modified. [Voids and replacements may be used on pended, adjudicated, or denied encounters] When replacements are submitted to AHCCCS, the original or previous submission is "reversed" and is replaced by the new submission.

Encounters submitted in a new day file receive a unique AHCCCS CRN. Timeliness submissions are determined from the AHCCCS CRN. However, for replacements the calculation is based on the original AHCCCS CRN. For example, a replacement submitted to AHCCCS 360 days after the date of service will not be untimely if the original AHCCCS CRN was within the 240 day submission timeline. For voids or replacements, AHCCCS does not require a unique Health Plan CRN. Plans should be tracking voids or replacements either from a unique Health Plan CRN or from an internal tracking mechanism at the plan.



Health Plan Allowed and Paid for Capitated Services

In the previous proprietary format, the health plan paid amount field was used for either allowed or paid depending on the subcap code. For example, plans used the health plan paid field as health plan allowed when the service was capitated (01). With the newer standard formats, plans are required to report health plan allowed and health plan paid in unique fields. In the 837 transaction when providers are capitated (previously subcap 01 now contract type 05) the health plan paid will be $0 and the health plan allowed will be populated with the plan's fee schedule amount (what you would have paid if you were paying the claim as a FFS claim). There are other plan/provider arrangements where providers are not at risk. For those arrangements, e.g., flat fee, there would be an amount greater than $0 in the plan paid amount field and the plan's fee schedule amount would be in the health plan allowed amount field.

System Updates

Modifier

Effective with dates of service on or after January 1, 2001 the following codes can be reported with modifier 25:

99341 & 99343 Home Visit for the Evaluation and Management of a New Patient.

Hemophilia Factor Pricing

The current rates for Hemophilia Factor Pricing can be found on the AHCCCS website at: http://webdev-ahcccs04/RatesCodes/FFS/HemophiliaPricing07060906.asp

Therapeutic Classes

Effective with dates of service on or after January 1, 2006 the following drug therapeutic classes were added to the PMMIS reference table RF347 Medicare Part D excluded drugs. Pended encounters with these therapeutic classes for error code N027 (Drug Not Eligible for Medicare Coverage) will clear in the May cycle.

880000 Vitamins

880400 Vitamin A

880800 Vitamin B complex

881200 Vitamin C

882000 Vitamin E

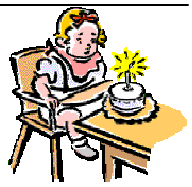
882400 Vitamin K Activity

940000 Devices

Age Change

Effective with dates of service on or after April 12, 2006, the CPT code 90633 Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use can be administered to children with a minimum age of 1 year.

Correction on Age Limit



The age limit that was listed in the communication e-mail of 04/24/2006 for the L codes should be **two (2).**

Code	Description
L1000	Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSON) (Milwaukee), Including model
L1010	Addition To Cervical-Thoracic-Lumbar-Sacral Orthosis (CTLSO) Or Scoliosis
L1020	Addition To CTLSO Or Scoliosis Orthosis, Kyphosis Pad
L1025	Addition To CTLSO Or Scoliosis Orthosis, Kyphosis Pad, Floating
L1030	Addition To CTLSO Or Scoliosis Orthosis, Lumbar Bolster Pad
L1040	Addition To CTLSO Or Scoliosis Orthosis, Lumbar Or Lumbar Rib Pad
L1050	Addition To CTLSO Or Scoliosis Orthosis, Sternal Pad
L1060	Addition To CTLSO Or Scoliosis Orthosis, Thoracic Pad
L1070	Addition To CTLSO Or Scoliosis Orthosis, Trapezius Sling
L1080	Addition To CTLSO Or Scoliosis Orthosis, Outrigger
L1085	Addition To CTLSO Or Scoliosis Orthosis, Outrigger, Bilateral
L1090	Addition To CTLSO Or Scoliosis Orthosis, Lumbar Sling
L1100	Addition To CTLSO Or Scoliosis Orthosis, Ring Flange, Plastic
L1110	Addition To CTLSO Or Scoliosis Orthosis, Ring Flange, Plastic
L1120	Addition To CTLSO, Scoliosis Orthosis, Cover For Upright, Each
L1499	Spinal Orthosis, Not Otherwise Specified
L1700	Legg Perthes Orthosis, (Toronto Type), Custom-Fabricated
L1710	Legg Perthes Orthosis, (Newington Type), Custom Fabricated
L1720	Legg Perthes Orthosis, Trilateral, (Tachdijan Type), Custom-Fabricated
L1730	Legg Perthes Orthosis, (Scottish Rite Type), Custom-Fabricated
L1755	Legg Perthes Orthosis, (Patten Bottom Type), Custom-Fabricated
L1843	Knee Orthosis, Single Upright, Thigh And Calf, With Adjustable Flexion
L1845	Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion
L1846	Knee Orthosis, Double Upright, Thigh And Calf, With Adjustable Flexion
L2037	Knee Ankle Foot Orthosis, Full Plastic, Single Upright,
L2106	Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Cast Orth
L2108	Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Cast Orth
L2112	Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis,
L2114	Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis,
L2116	Ankle Foot Orthosis, Fracture Orthosis, Tibial Fracture Orthosis,
L2126	Knee Ankle Foot Orthosis, Fracture Orthosis, Femoral Fracture Cast
L2128	Knee Ankle Foot Orthosis, Fracture Orthosis, Femoral Fracture Cast

L2180	Addition To Lower Extremity Fracture Orthosis, Plastic Shoe Insert
L2182	Addition To Lower Extremity Fracture Orthosis, Drop Lock Knee Joint
L2184	Addition To Lower Extremity Fracture Orthosis, Limited Motion Knee
L2186	Addition To Lower Extremity Fracture Orthosis, Adjustable Motion
L2188	Addition To Lower Extremity Fracture Orthosis, Quadrilateral Brim
L2190	Addition To Lower Extremity Fracture Orthosis, Waist Belt
L2192	Addition To Lower Extremity Fracture Orthosis, Hip Joint, Pelvic
L4000	Replace Girdle For Spinal Orthosis (CTLSO Or So)
L4040	Replace Molded Thigh Lacer, For Custom Fabricated Orthosis Only
L4045	Replace Non-Molded Thigh Lacer, For Custom Fabricated Orthosis
L4050	Replace Molded Calf Lacer, For Custom Fabricated Orthosis Only
L4055	Replace Non-Molded Calf Lacer, For Custom Fabricated Orthosis Only
L4350	Ankle Control Orthosis, Stirrup Style, Rigid, Includes Any Type I

Place of Service (POS)

- Effective with dates of service on or after July 1, 2005 the CPT code 92971, (Cardioassist-Method Of Circulatory Assist; External), can be reported with POS 11 (Office).

The POS 15 (Mobile Unit) has been removed from the following codes.

- 78459 - Myocardial perfusion imaging; (planar) single study, at rest or stress
- 78491 - Myocardial imaging, positron emission tomography (PET), perfusion; single study at rest or stress
- 78492 - Myocardial imaging, positron emission tomography (PET), perfusion; multiple studies at rest and/or stress
- 78608 - Brain imaging, positron emission tomography (PET); metabloic evaluation
- 78609 - Brain imaging, positron emission tomography (PET); perfusion evaluation
- G0219 - PET imaging whole body; initial staging; melanoma
- G0235 - PET imaging, any site, not otherwise specified
- G0252 -PET imaging, full and partial-ring pet scanners only, for initial diagnosis of breast cancer and/or surgical planning for breast cancer

Effective with dates of service on or after July 1, 2006 the following CPT Codes have been added to POS 15 (Mobile Unit):

- 99201-99205 Initial office visit
- 99211-99215 Office visit for an established patient
- 99241-99245 Initial office consultation

Provider Type

Effective with dates of service on or after January 1, 2006 provider type 08, (MD), can report the CPT code 97602 (Devitalized Tissue Removal).

Diaper Codes

Effective with dates of service on or after March 3, 2006 the following CPT Codes have the listed changes:

A4520	Incontinence Garment, Any Type, (E.G. Brief, Diaper),
T4521	Adult Sized Disposable Incontinence Product, Brief/Diaper, Small,
T4522	Adult Sized Disposable Incontinence Product, Brief/Diaper, Medium
T4523	Adult Sized Disposable Incontinence Product, Brief/Diaper, Large
T4524	Adult Sized Disposable Incontinence Product, Brief/Diaper, Extra
T4529	Pediatric Sized Disposable Incontinence Product, Brief/Diaper, Small
T4530	Pediatric Sized Disposable Incontinence Product, Brief/Diaper, Large
T4533	Youth Sized Disposable Incontinence Product, Brief/Diaper, Each
T4539	Incontinence Product, Diaper/Brief, Reusable, Any Size, Each

The changes include the following:

- Age - 3 thru 99
- Effective Date - 3/3/06 (date of court order)
- Limit - 240/month
- Modifier - NU (New Equipment) and CR (Catastrophe/disaster)
- Coverage Code - 01 (Covered Service/Service Available)
- Place of Service - 01 (Pharmacy), 12 (Home) and 99 (Other Unlisted Facility)
- Category of Service - 40
- Provider Types include: 03 (Pharmacy), 05 (Clinic), 23 (Home Health Agency), 24 (Personal Care Attendant), 30 (DME Supplier) and 40 (Attendant Care).

Clarification of H199

Drug encounters will fail for error code H199 when the health plan paid amount exceeds the ingredient cost paid plus the dispensing fee paid. That is, when plan paid > (ingredient cost paid + dispensing fee paid) an H199 pend error results. To correct H199 pends replacement encounters must be submitted.

Provider Inactivity

The following is a reprint from the *April, 2006 Claims clues*.

AHCCCS PROVIDER PARTICIPATION TO BE TERMINATED FOR INACTIVITY

An AHCCCS provider's participation in the AHCCCS program may be terminated for any of several reasons, including inactivity.

Provider participation may be terminated if the provider does not submit a claim to the AHCCCS Administration or one of the AHCCCS-contracted health plans or program contractors within the past 24 months. If AHCCCS has not received a claim or an encounter for the past 24 months, these providers will be terminated effective April 2006.

A new registration packet will be required to reactivate providers who reapply following termination for inactivity. Providers should refer to Chapter 3 of the AHCCCS Fee-For-Service Provider Manual for information on provider participation.

EDI Update

When Health Plans need assistance regarding EDI files, please submit your request to AHCCCSHIPAAWorkgroup@azahcccs.gov and copy your AHCCCS Encounter Technical Assistant with the following information:

- **General Summary of the Problem**
- **File Name**
- **ISA Ctrl #**
- **GS Ctrl #**
- **Date File Submitted**
- **Test or Prod File**
- **HP ID**
- **Contact Name**
- **Contact Phone #**
- **Contact Email Address**

Providing the above information will assist in troubleshooting problems and facilitate a quicker response. Health Plans should validate files prior to submission and should not rely on AHCCCS to verify if files are syntactically correct. Should you have any questions, please contact your assigned AHCCCS Encounter Technical Assistant.

NPI Tip

When providers are applying for their NPI, CMS urges them to include their legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated State name. This information is critical for payors in the development of crosswalks to aid in the transition to the NPI.

Revised EFI Materials

The EFI Summary, User Manual and Technical Companion Guide have all been revised. Please visit http://www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp to view and download these revised materials.

Encore Presentation of WEDI's NPI 101Audiocast
This presentation is scheduled for Thursday, April 27th. Please visit http://www.wedi.org/npioi/public/articles/dis_viewArticle.cfm?ID=476 for more information including scheduled times.

HIPAA Work Group Update

From: National Medicaid HIPAA Work Group [mailto:NAMEDIWORK-L@LIST.NIH.GOV] On Behalf Of SHUGART, ALAN R. (CMS/CMSO)
Sent: Monday, May 01, 2006 8:37 AM
To: NAMEDIWORK-L@LIST.NIH.GOV
Subject: NPI: Electronic File Interchange Now Available

**** National Medicaid EDI Healthcare (NMEH) Mailing List ****

Beginning today, May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) announces the capability for health industry organizations to submit health care providers' applications for National Provider Identifiers (NPIs) to the National Plan and Provider Enumeration System (NPPES) via Electronic File Interchange (EFI). With EFI, a CMS-approved health industry organization can submit a health care provider's NPI application data, along with the application data of many other health care providers, in a single electronic file in a CMS-specified format.

EFI is an alternative to health care providers having to apply for their NPIs via the web-based or paper application process. After the NPPES processes a file, it makes available to the organization a downloadable file containing the NPIs of the enumerated health care providers. Interested health industry organizations should avail themselves of the EFI materials available from the CMS NPI page (www.cms.hhs.gov/NationalProvIdentStand/) and from the NPPES page (https://nppes.cms.hhs.gov) before downloading and completing the Certification Statement (available at https://nppes.cms.hhs.gov) and registering as EFI Organizations. A completed Certification Statement must be approved by CMS before an interested health industry organization can participate in EFI.

Below is an updated vaccine list for the VFC Program.

90633	Hepatitis A vaccine, pediatric/adolescent dosage-2dose schedule
90647	Hemophilus Influenza B Vaccine (HIB), PRP-OMP conjugate (3 dose schedule)
90648	Hemophilus Influenza B Vaccine (HIB), PRP-T conjugate (4 dose schedule)
90655	Influenza virus vaccine, split virus, preservative, for children 6-35 months of age, for Intramuscular use
90656	Influenza virus vaccine, split virus, preservative, for use in individuals 3 years and above, for intramuscular use
90657	Influenza virus vaccine, split virus, 6-35 months dosage (covered under VFC only for high-risk children)
90658	Influenza virus vaccine, split virus, 3 years and above (covered under VFC only for high-risk children)
90660	Influenza virus vaccine, live, for intranasal use
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years
90680	Rotavirus vaccine, pentavalent, 3 dose schedule, live for oral use
90700	Diphtheria, tetanus toxoids, and acelllular pertussis (DTAP)
90702	Diphtheria and tetanus toxoids (DT) absorbed
90707	Measles, mumps and rubella virus vaccine (MMR)
90710	Measles, Mumps, Ruella, and Varicella Vaccine (MMRV)
90713	Poliovirus vaccine, inactivated (IPV)
90714	Tetanus and diphtheria toxoids (TD) absorbed, preservative free, 7 years or older, IM
90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (TDAP), 10 years or older, IM
90716	Varicella virus vaccine, live
90718	Tetanus and diphtheria toxoids (TD)
90721	Diphtheria, tetanus toxoids, and acelllular pertussis vaccine and Hemophilus influenza B vaccine (DTAP-HIB)
90723	Diphtheria, tetanus toxoids, acellular pertussis vacine, Hepatitis B, and poliovirus vac cine, inactivated (DTAP-HEPB-IPV)
90734	Meningococcal conjugate vaccine, serogroups A, C, and Y and W-135 (tetravalent), for IM use
90732	Pneumococcal polysaccharide, 23 valent
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)
90743	Hepatitis B vaccine, dolescent (2 dose schedule)
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)
90748	Hepatitis B and Hemophilus influenza B HEPB-HIB)

Part D

The PDF attachment is a clarification from CMS on the Part D status of prescription niacin products. There may be some differences in the coverage policies for niacin by the Part D plans. Therefore, AHCCCS will continue to allow coverage of prescription niacin products, as an excluded Part D drug, until January 1, 2007. For Contract year 2007 niacin products used at dosages much higher than appropriate for nutritional supplementation will be considered by CMS, for formulary inclusion, similar to all other Part D drugs.

PrescriptionNiacin_3 .pdf (104 ...

Clarification of S841 Error Code

Examples of procedure codes being submitted to AHCCCSA and pending for the error code S841 (ASC Procedure Code Is Not Covered) are listed below.

11750	Excision Of Nail And Nail Matrix, Partial Or Complete, (E.g., Ingrown)
67700	Blepharotomy, Drainage Of Abscess, Eyelid
69210	Removal Impacted Cerumen (Separate Procedure), One Or Both Ears
99070	Supplies And Materials (Except Spectacles), Provided By The Physician
99141	Sedation With Or Without Analgesia (Conscious Sedation); Intravenous

The AHCCCS Medical Review Team communicated that procedures done at an Ambulatory Surgical Center (ASC) must be on the Medicare approved ASC list to receive payment. Most procedures not on the Medicare ASC approved list should be done in an office setting or are too complex to be done in an ASC. If a provider wishes to have a procedure considered for inclusion on the ASC list medical documentation, that demonstrates medical necessity, would need to be submitted to Dr. Leib (AHCCCS Chief Medical Officer). Upon approval the procedure could be performed at an ASC.

Error Code Updates

- Effective with dates of service on or after January 1, 2006 the following error code Z870 (Elapsed Days Is Less Than Minimum for Refill) has been set to soft.

- Effective with dates of service on or after July 1, 2005 the following error code Z330 (1500 Near Duplicate) has been added to the online override table with an adjudication level of 50.