AHCCCS
MARCH-APRIL, 2008

Encounter Keys

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AHCCCS Technical Consortium Meetings

The AHCCCS NPI Consortium Meeting has been renamed to the AHCCCS Technical Consortium. Meeting topics and discussion will be expanded to include all technical areas (HIPAA, NPI, system changes, etc). These meetings will be scheduled quarterly, and the first meeting is currently scheduled for May 14th, 2008.

If you are interested in attending these meetings and did not receive a notice regarding the May 14th meeting or did not previously attend the NPI Consortium meetings, please contact Lori Petre at lori.petre@azahcccs.gov

Out Patient Fee Schedule (OPFS) Processing

The procedure code values contained on reference screen RF739 (Limit Override Procedures) with an action code of 05 (Override Bundling) apply only the those OPFS claims where the bundling of revenue codes (as outlined on RF796 (OPFS Bundled Revenue Codes)) are triggered by surgery and/or surgery and ER on the claim.

If bundling for the OPFS claim is triggered only by ER, these bundling exceptions do not apply. Please let us know if you have any questions.

Out Patient Fee Schedule (OPFS) CCI table

Please note the update below for the Out Patient Fee Schedule (OPFS) CCI table to disallow infusion codes billed with Emergency Room visits.

Primary	Compont			MOD			
Procedure	Procedure	Form	Ind	Pol	Begin Date	X End Date	Last Modified
99281	90760	B	0	P	02/01/2008	99/99/9999	02/04/08
99281	90761	B	0	P	02/01/2008	99/99/9999	02/04/08
99282	90760	B	0	P	02/01/2008	99/99/9999	02/04/08
99282	90761	B	0	P	02/01/2008	99/99/9999	02/04/08
99283	90760	B	0	P	02/01/2008	99/99/9999	02/04/08
99283	90761	B	0	P	02/01/2008	99/99/9999	02/04/08
99284	90760	B	0	P	02/01/2008	99/99/9999	02/04/08
99285	90760	B	0	P	02/01/2008	99/99/9999	02/04/08
99285	90761	B	0	P	02/01/2008	99/99/9999	02/04/08

Codes

- Effective for dates of service on or after April 1, 2008 the following codes have been end dated:

  J7602 (Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)).

  J7603 (Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)).

- Effective for dates of service on or after January 1, 2008 the Provider Type 43 (Ambulatory Surgical Center) and Place of Service 24 (Ambulatory Surgical Center) has been added to the following codes:

  C9237 (INJECTION LANREOTIDE ACETATE, 1 MG.)
  C9240 (INJECTION, IXABEPILONE, 1 MG.)
  C9354 (VERITAS COLLAGEN MATRIX, CM2)
  C9355 (NEUROMATRIX NERVE CUFF, CM)

- Effective with dates of service on or after 04/08/2008 for code 90736 (Zoster (Shingles) Vaccine, Live, For Subcutaneous Injection) the Medicare indicator has been changed to “N”.

Place of Service (POS)

- Effective for dates of service on or after September 1, 2007 the POS 15 (Mobile Unit) has been added to the code R0075 (Transportation of Portable X-Ray Equipment and Personnel to Home or Nursing Home).

- Effective for dates of service on or after September 1, 2007 the POS 22 (Outpatient hospital) has been added to the code 87220 (Tissue examination by KOH slide of samples from skin, hair or nails).

- Effective with dates of service on or after January 1, 2008 the HCPCS codes Q9953 (Injection, iron-based magnetic resonance contrast agent) and Q9954 (Oral magnet resonance contrast agent, per ml) can be reported at POS 11 (Office).

- Effective with dates of service on or after July 1, 2007 the CPT code 90658 (Influenza virus vaccine, split virus, when administered) can be reported at POS 60 (Mass immunization center)

- Effective for dates of service on or after January 1, 2008 the POS 49 (Independent Clinic) has been added to the following:

  - 95810 (Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist)
  - 95811 (Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bi-level ventilation, attended by a technologist)

- Effective for dates of service on or after January 1, 1995 the POS 22 (Outpatient Hospital) can be reported on the following codes:

  49255 (Omentectomy, Epiploectomy, Resection of Omentum (Separate Procedure)
  44005 (Enterolysis (Freeing Of Intestinal Adhesion) (Separate Procedure

- Effective immediately the POS 22 (Outpatient hospital) has been added to the CPT code 51530 (Cystotomy; for excision of bladder tumor).

Modifier(s)

- Effective for dates of service on or after December 31, 2007 the following modifiers have been end dated.

  QA (FDA investigational device exemption)
  QR (Item or service provided in a Medicare specified study)
  QV (Item or service provided as routine care in a Medicare qualifying)

- Effective with dates of service on or after January 1, 2006 the modifier Q5 (Services furnished by a substitute physician under a reciprocal billing arrangement) has been added to the following HCPCS codes:

  90767 (Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (list separately in addition to code for primary procedure))

  90775 (Therapeutic, prophylactic or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/ drug (list separately in addition to code for primary procedure))

- Effective for dates of service on or after March 20, 2008 the W (CLIA waived) Lab indicator was added.

  80047 (Basic Metabolic Panel (Calcium, Ionized))
  80048 (Basic Metabolic Panel (Calcium, Total))
  80051 (Electrolyte Panel)
  80053 (Comprehensive Metabolic Panel)
  80178 (Lithium)

- Effective for dates of service on or after January 1, 2008 the modifier QW (CLIA waived) can be reported with the code 80047 (Basic Metabolic Panel (Calcium, Ionized), refer to RF122 (Valid Procedure Modifiers).

- Effective for dates of service on or after October 30, 2007 the modifier QW (CLIA waived) can be reported with the code 80051 (Electrolyte Panel).

- Effective for dates of service on or after January 16, 2008 the modifier QW (CLIA waived) can be reported with the code 80053 (Comprehensive Metabolic Panel).

Age

Effective with dates of service on or after February 19, 2008 the age limit has been lowered to 0 for the following codes:

- L1930 (Ankle foot orthosis, plastic or other material, prefab)
- L1686 (Hip orthosis, abduction control of hip joint, postoperative hip abduction type, prefabricated, includes fitting and adjustment)

Daily Maximum Limits

- Effective with dates of service on or after January 1, 2008 the CPT code 97110 (Therapeutic procedure, one or more areas, each 15 minutes) has a procedure daily maximum of 4.

- Effective with dates of service on or after February 20, 2008 the CPT code 27756 (Percutaneous skeletal fixation of tibial shaft fracture) has a procedure daily maximum of 2.

- Effective for dates of service on or after March 3, 2008 the procedure daily maximum for CPT code 25295 (Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon) has been changed to 5.

- Effective for dates of service on or after March 3, 2008 the procedure daily maximum for the CPT codes listed below has been changed to 60:

  15003 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; each additional 100 sq cm or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure))

  15005 (Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm or each additional 1% of body area of infants and children (list separately in addition to code for primary procedure)).

"Earth laughs in flowers."
Ralph Waldo Emerson

Provider Type

- Effective with dates of service on or after January 1, 2007 the provider type 12 (Certified Registered Nurse Anesthetist) can report service 94002 (Ventilation assist and management, initiation of pressure).

- Effective with dates of service on or after January 1, 2008 the provider type 40 (Attendant care) can report the HCPCS code A0130 (Non-emergency transportation: wheel-chair van).

- Effective for dates of service on or after March 1, 2008 the following codes may be reported by provider type 48 (Nutritionist):

    - 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes)
    - 97803 (Medical nutrition therapy; re-assessment and intervention individual, face-to-face with the patient, each 15 minutes)
    - 97804 (Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes)
    - G0270 (Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes)
    - G0271 (Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes)

- Effective for dates of service on or after January 1, 2003 the Provider Type 77 (BH Outpatient Clinic) can now report the following code:

    T1016 (Case management, each 15 minutes)
    Modifier HN (Bachelors Degree Level/AMB HSP 2 SKLD NURS Facility)
    Place of Service 11 (Office)

- Effective for dates of service on or after July 1, 2007 the provider 500670 (St. Luke's Behavioral Hospital) Provider type 77 (Psychiatric Hospital) can now report the revenue code 0204 (ICU/psych stay).

- Effective with dates of service on or after April 1, 2008 the following provider types A5 (Behavioral Health Therapeutic Home) and F1 (Fiscal Intermediaries) can report the services:
    S5110 (Home Care Training, Family; Per 15 Minutes)
    S5115 (Home care training, non-family; per 15 minutes)

- Effective with dates of service on or after April 1, 2008 the provider type 39 (Habilitation Provider) can report the services:
    S5108 (Home care training to home care client, per 15 minutes)
    S5115 (Home care training, non-family; per 15 minutes)

- Effective with dates of service on or after April 1, 2008 the code S5115 (Home care training, non-family; per 15 minutes) has been added to the following provider types:

  23 (Home Health Agency)
  37 (Homemaker)
  40 (Attendant Care)
  77 (BH Outpatient Clinic)
  81 (EPD HCBS)

- Effective with dates of service on or after 04/07/2008 the code C9241 (Injection, doripenem, 10mg.) has been removed from the following provider types.

  08 (MD-Physician)
  18 (Physicians Assistant)
  19 (Registered Nurse Practitioner)
  31 (DO-Physician Osteopath)

Revenue Code

Effective with dates of service on or after January 1, 2007 the HCPCS code G0260 (Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography) has been added to the revenue code 0490 (Ambul Surg) on the PMMIS screen RF773 (Revenue-Codes-To Procedure Codes).

Coverage Code(s)

- Effective with dates of service on or after January 1, 2008 the coverage code has been changed to 09 (Medicare only) for the following:

  99406 (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes)
  99407 (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes)

- Effective with dates of service on or after 03/31/2007 the coverage code has been changed from 01 (Covered service/code available) to 04 (Not covered service/Code not available) for J7319 (Hyaluronan (sodium hyaluronate) or derivative, intra-articular injection, per injection).

- Effective with dates of service on or after January 1, 2008, the CPT code 99477 (Initial hospital care, per day, for the evaluation and management) has been changed from coverage code 04 (Not covered service/code not available) to 01 (Covered service/code available).

Category of Service (COS) Change

Effective for dates of service on or after January 1, 2007 the code S5109 (Home Care Training To Home Care Client, Per Session) has been changed from COS 35 (Adult Foster Care) to COS 47 (Mental Health Services).

Medicare Coverage Indicator

Effective with dates of service on or after March 26, 2008 the Medicare coverage indicator on PMMIS screens RF113 (Procedure code indicators and values) and RF127 (Procedure OPFS indicators and values) has been changed to "N" for the following codes:

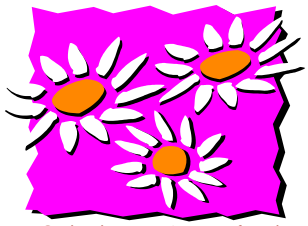
T4521 (Adult sized disposable incontinence product, brief/diaper, small,)
T4522 (Adult sized disposable incontinence product, brief/diaper, medium)
T4523 (Adult sized disposable incontinence product, brief/diaper, large,)
T4524 (Adult sized disposable incontinence product, brief/diaper, extra)
T4529 (Pediatric sized disposable incontinence product, brief/diaper, small)
T4530 (Pediatric sized disposable incontinence product, brief/diaper, large)
T4531 (Pediatric sized disposable incontinence product, protective underwear/pull-on, small/medium size, each)
T4532 (Pediatric sized disposable incontinence product, protective underwear/pull-on, large size)
T4533 (Youth sized disposable incontinence product, brief/diaper each)

Capitated Encounters

As a reminder, AHCCCS assigns a value to each encounter submitted. These values help us determine impacts on changes to fee-for-service rate schedules, capitation rates, reinsurance and other supplemental payments to plans. The AHCCCS value is based on the health plan paid amount, health plan approved/allowed amount (what the plan would have paid if you were paying the service as a fee-for-service claim) and the CN1 value. When the plan fully capitates provider services, CN1 = '05', AHCCCS expects the health plan paid amount to be $0.00 and the health plan approved/allowed amount to be greater than $0.00. AHCCCS relies on the accuracy of these fields for valuation. To receive appropriate AHCCCS valuation, it is important for plans to correctly populate the health plan allowed amount on all encounters.

For your reference a cross-walk of the CN1 values to AHCCCS internal subcapitated codes is listed below.

CN 1 Code	Definition	Subcap Code	Description
Not Used		00	No subcapitated payment arrangement *When subscriber exception code is 25 subcap code is 05*.
01	Diagnosis Related Group (DRG)	00	DRG arrangement *When subscriber exception code is 25 subcap code is 05.*
02	Per Diem	00	Per diem arrangement *When subscriber exception code is 25 subcap code is 05.*
03	Variable Per Diem	00	Variable per diem arrangement *When subscriber exception code is 25 subcap code is 05.*
04	Flat	00	Flat fee arrangement *When subscriber exception code is 25 subcap code is 05*.
05	Capitated	01	Full subcapitation arrangement *When subscriber exception code is 25 subcap code is 05.*
06	Percent	00	Percentage arrangement *When subscriber exception code is 25 subcap code is 05.*
09	Other	08	Negotiated settlement *Used to report services that are included in a negotiated settlement, for example, claims paid as part of a grievance settlement, when subscriber exception code is not 25.*



Spring is nature's way of saying, "Let's party!"

-Robin Williams

AHCCCS, DIVISION OF HEALTH CARE MANAGEMENT
DATA ANALYSIS & RESEARCH, ENCOUNTER UNIT
Revised Encounter File Processing Schedule
April 2008 - June 2008

	April	April	May	May	June	June
FILE PROCESSING ACTIVITY	2008	2008	2008	2008	2008	2008
Deadline for Corrected Pended Encounter and	Fri	Fri	Fri	Thurs	Thurs	Thurs
New Day File Submission to AHCCCS by **6:00 PM Thursday**	04/04/08	04/18/08	05/09/08	05/22/08	06/05/08	06/19/08
Work Days for AHCCCS	7	7	7	8	8	8
Encounter Pended and Adjudication Files	Fri	Fri	Fri	Fri	Fri	Fri
Available to Health Plans by Friday at 5:00 PM	04/11/08	04/25/08	05/16/08	05/30/08	06/13/08	06/27/08

AHCCCS, DIVISION OF HEALTH CARE MANAGEMENT
DATA ANALYSIS & RESEARCH, ENCOUNTER UNIT
Revised Encounter File Processing Schedule
July 2008 - Sept 2008

	July	July	Aug	Aug	Sept	Sept
FILE PROCESSING ACTIVITY	2008	2008	2008	2008	2008	2008
Deadline for Corrected Pended Encounter and	Thurs	Thurs	Thurs	Thurs	Thurs	Thurs
New Day File Submission to AHCCCS by **6:00 PM Thursday**	07/03/08	07/17/08	08/07/08	08/21/08	09/04/08	09/18/08
Work Days for AHCCCS	8	8	8	8	8	8
Encounter Pended and Adjudication Files	Fri	Fri	Fri	Fri	Fri	Fri
Available to Health Plans by Friday at 5:00 PM	07/11/08	07/25/08	08/15/08	08/29/08	09/12/08	09/26/08

NOTE: 1. This **schedule is subject to change.** If untimely submission of an encounter is caused by an AHCCCS schedule change, a sanction against timeliness error will not be applied.

2. Health Plans are required to correct each pending encounter within 120 days.

3. On deadline days, encounter file(s) must arrive at AHCCCS by 6:00 P. M.

4. Contractors are encouraged to submit files immediately following their claims adjudication process. Contractors may be required to submit files for one or both encounter adjudication cycles.

5. Adjustments to the schedule may be necessary until AHCCCS and its contractors have sufficient experience with multiple adjudication cycles. The plan availability dates are only estimates. Adjustments to these dates may be necessary based on the number of files submitted and processed.

Encounter Logic

The encounter logic system changes scheduled for our production environment are noted below. Items marked as deferred were moved to another quarter. Please note that the financial/unit field expansion modification has been moved to the December.

March promote (SR610-090101 release number) schedule was March 20th.

SSR#	Task #	Ticket #	Description	Location
20060302	1		Financial/unit field expansion	Deferred
20060351	3		Change encounter read for coverage code 08 to emulate 04	Deferred
20060381	1		Modify R580 to read TPL coverage types, e.g., dental, drug	Deferred
20070145	3		Change encounter reads for modified RF774/773 tables	Deferred
20070146	1		Disable logic setting data fields to spaces	Deferred
20070180	1		Create duplicate logic module for 1500	Deferred
20070223	1		Add missing NPI edits on dental services	Approved
20070224 20070255 20070309	1 4 1		Allow DX 799.9 for COS 14 services 1 to many NPI display Add sorts to select encounter screens	Approved Approved Deferred

Key: Deferred = logic change was deferred to a later production promote
Approved = logic change was moved into production

June promote (SR610 - 090201 release number) scheduled June 19th

SSR #	Task #	Ticket #	Description	Location
20050189	3		Status code clean up	Development
20060156	1		Financial Balancing	Development
20060302	1		Financial/unit field expansion (UB)	Deferred
20060302	2		Financial/unit field expansion (1500)	Deferred
20060381	1		Modify R580 to read TPL coverage types, e.g., dental, drug	Development
20070109	1		Correct transaction travel for screens	Development
20070180	1		Create duplicate logic module for 1500	Development
20070200	1		Modify reads for revenue code coverages to RF774	Development
20070205	1		Remove all conditions that bypass A950	Development
20070278	1		Allow occurrence code '40' to bypass U350	Development

Key: Development = in programming development
Testing = testing logic change(s)
Deferred = logic change was deferred to a later production promote
Approved = logic change was moved into production