Claims Clues

A Monthly Publication of the AHCCCS Claims Department August, 2001

New, Modified Programs Outlined

Measures approved by the Arizona Legislature earlier this year created some new AHCCCS programs and modified some existing programs.

Here are some highlights of the new and modified programs. Future issues of *Claims Clues* will provide details about the programs.

Breast/Cervical Cancer

House Bill 2194 created a new eligibility category for women who meet the following criteria:

- Under 65 years old,
- Screened for breast or cervical cancer through the Arizona Department of Health Services
- Need treatment for breast or cervical cancer, and
- Have no other insurance.

Beginning Jan. 1, 2002, eligible women will receive full services for as long as they require treatment for breast or cervical cancer. Recipients will be enrolled in an AHCCCS health plan.

Freedom to Work

HB 2585 allows AHCCCS to implement a program called Freedom to Work on or after Jan 1, 2002. Freedom to Work is the AHCCCS name for the Medicaid Buy-In groups under the Ticket to Work and Work Incentives Improvement Act.

The legislation requires AHCCCS to request approval for a new eligibility group for persons who meet the following criteria:

- Age 16 through 64 who meet SSI eligibility criteria and have earned income below 250 per cent ($1,790 per month) of the Federal Poverty Limit (FPL), and
- Employed individuals with a medically improved disability with earned income under 250 per cent of FPL. AHCCCS must adopt a process to determine the definition of medically improved disability.

Unearned income is not counted, and work-related expenses are deducted before comparing the individual's income to 250 percent of FPL.

Eligibile recipients will pay a premium not to exceed two per cent of adjusted income.

Prescription Insurance Pilot

Senate Bill 1118 appropriated money for a two-year Prescription Insurance Pilot targeted for implementation on Nov. 1, 2001. The program assists people with high prescription drug costs who live in counties without a Medicare HMO that offers prescription coverage (The program will not be available in Maricopa, Pima, and Pinal counties).

To be eligible, a person must:

- Be eligible for Medicare
- Have monthly income between 100 per cent ($716) and 200 percent ($1,432) of FPL.

Eligible persons will be approved for 12 months.

Individuals with monthly incomes up to 150 per cent ($1,074) of the FPL must meet a $500 deductible, and persons with incomes between 150 and 200 per cent of the FPL must meet a $1,000 deductible. Once the deductible is met, the program will pay 50 per cent of a person's prescription costs for the remainder of the 12-month period.

KidsCare

SB 1087 made changes to the KidsCare program, including:

- Adding non-emergency transportation, removing eye exam and eyeglass limitations, and making behavioral health services the same as the state employees benefit package. The services package is the same as the Medicaid services package.
- Reducing the time a child must be without health insurance before being eligible from six months to three months. AHCCCS is required to develop rules to waive this requirement for a seriously or chronically ill child.
- Establishing a hardship exemption when a family can't pay a premium so the child is not disenrolled.

Premium Sharing Program

HB 2585 made the Premium Sharing Program permanent and

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Specialty Air Transport Reimbursement Revised

Effective Aug. 1, 2001, AHCCCS has changed its reimbursement methodology for air ambulance specialty care transports.

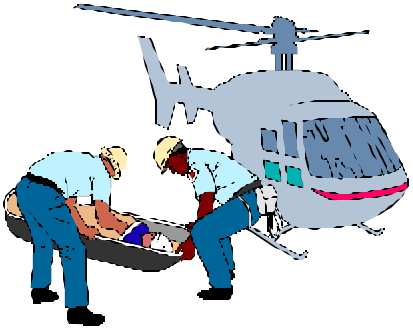
Specialty care transports are services for high-risk members through the maternal transport program (MTP) and the newborn intensive care program (NICP) administered by the Arizona Department of Health Services (ADHS). ADHS provides special education and training in the care of maternity and newborn emergencies during transport to a perinatal center.

The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only providers with MTP or NICP contracts with ADHS may provide specialty care transport services for AHCCCS recipients.

All air ambulance providers receive the same reimbursement for non-specialty care transports.

A provider will receive the specialty care transport reimbursement rates when the following conditions are met:

- The provider must have a current MTP/NICP contract with ADHS, and AHCCCS must have a copy of that contract.
- The provider must use high-risk transport team and equipment for the transport.



- The provider must send supporting documentation. The documentation must include either:
  - A completed Request for Participation Form for all neonatal flights with approval from an ADHS contracted perinatologist or neonatologist with privileges at an Arizona tertiary perinatal center, or
  - A completed Request for Maternal Transport Form for all maternal flights with approval from an ADHS-contracted perinatologist with privileges at an Arizona tertiary perinatal center.

To receive specialty care reimbursement, specialty care transport providers must bill the "TH" modifier with one of the following transportation codes:

- A0430 Ambulance service, conventional air service, transport, one-way, base rate
- A0435 Air ambulance, Fixed-wing mileage, per statute mile
- A0888 Non-covered ambulance mileage, per mile (Limited to air ambulance services for members with dual Medicare/Medicaid eligibility).
- A0431 Ambulance service, air, helicopter service, transport, base rate
- A0436 Air ambulance, helicopter mileage, per statute mile

If this specialty modifier is used by a non-specialty care provider, the claim will be denied.

In addition, code A0225 (Ambulance service, neonatal transport, base rate, emergency transport, one way) will be used for the maternal/neonate transport team ground ambulance. This code may only be used by specialty care providers, but it does not require the “TH” modifier. The code replaces Z3660. ❒

Non-Ambulance Waiting Time Requires PA

Effective Aug. 1, 2001, non-ambulance waiting time (Z3717) requires prior authorization for all fee- for-service recipients.

The AHCCCS Prior Authorization Unit will authorize the service for acute care recipients, and Arizona Long Term Care System (ALTCS) case managers will authorize for the ALTCS recipients.

Also effective Aug. 1, the capped fee for this service is $4.85 per unit (1 unit = 30 minutes).

Providers who have questions should contact the AHCCCS PA Unit at:

(602) 417-4400 (Phoenix area)
1-800-433-0425 (in state)
1-800-523-0231 (out of state) ❒

Behavioral Health FFS Rates Revised

Fee-for-services rates for certain behavioral health services have been revised effective July 1, 2001.

The changes are the result of an analysis performed by consultants to the Arizona Department of Health Services/Division of Behavioral Health (ADHS/BHS). AHCCCS reviewed and approved the changes. The rates are posted on the ADHS/BHS Web site: www.hs.state.az.us/bhs/matrix.pdf.

There will also be changes to the array of covered behavioral health services effective Oct. 3, 2001. These changes are designed to provide a more flexible service package, to support development of individual/family centered delivery models, and to recognize and reimburse support services provided by certain non-licensed providers such as community service providers.

The new service descriptions, codes, and allowable provider types also will be available on the ADHS/BHS Web site by Oct. 1, 2001. ❐

AHCCCS Awards 5 ALTCS Contracts

Five long term care program contractors have been awarded contracts to serve the ALTCS elderly and physically disabled (EPD) populations outside of Maricopa County. The contracts are effective Oct. 1.

Each of the 14 counties will be served by one program contractor. Contracts were awarded to:

- Pima Health System for Pima and Santa Cruz counties. Lifemark Health Plans is the current program contractor for Santa Cruz County.
- Yavapai County Long Term Care for Yavapai County
- Cochise Health Systems for Cochise, Graham, and Greenlee counties. Lifemark is the current program contractor for Greenlee County.
- Lifemark for Apache, Coconino, La Paz, Mohave, Navajo, and Yuma counties.
- Pinal County Long Term Care for Pinal and Gila counties. Lifemark is the current program contractor for Gila County.

Last year, AHCCCS awarded contracts to three program contractors to serve the EPD population in Maricopa County, marking the first time ALTCS members had a choice of program contractors. The three program contractors are Maricopa Long Term Care Plan, Mercy Care Plan, and Lifemark. ❐

New, Modified AHCCCS Programs Outlined

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expanded it statewide effective Oct. 1, 2001. Currently it is available only in Maricopa, Pima, Pinal, and Cochise counties.

The program covers uninsured individuals with gross household incomes at or below 250 per cent of the FPL. Premiums are based on income and household size.

Individuals with a chronic illness and monthly income up to 400 per cent of the FPL ($2,864) also are eligible.

Eligible individuals must not have or have had any health insurance for the past month, unless the loss was involuntary.

Individuals cannot be covered by Medicare or Medicaid or be eligible for medical services through the Veterans Administration. ❐

Need Help with a Claim?

Contact Claims Customer Service
(602) 417-7670 (Phoenix area)
(800) 794-6862 (In state)
(800) 523-0231 (Out of state)

Hours: 7:00 a.m. – Noon
12:30 – 4:00 p.m.

Did you know that many common claim errors can be fixed with a simple phone call? Contact Claims Customer Service for more information.

Guidelines Offered for Submitting Documentation

The AHCCCS Claims Medical Review Unit is offering guidelines to providers for submitting documentation with fee-for-service claims.

While it is impossible to offer specific guidelines for each situation, the tables below are designed to give providers some general guidance regarding submission of documentation. Also, not all fee-for-service claims submitted to AHCCCS are subject to Medical Review.

What to submit …

HCFA 1500 Claims		
Billing For	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report	
Missed abortion /Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Emergency room visits	Emergency room record	Billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, History and physical, office records, discharge summary, consult reports	Documentation should be specific to code billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.

UB-92 Claims		
Billing for	**Documents Required**	**Comments**
Observation	All documents required by statute and observation records	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, pathology report	Information must substantiate fetal demise
NICU/ICU tier claims	All documents required by statute	MD orders and MD progress notes to substantiate level of care billed
Outlier	All documents required by statute	

And what not to submit …

Providers should *not* submit the following unless specifically requested to do so:

- Emergency admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- Ultrasound/X-ray *films*
- Medifax information
- Nursing care plans
- Medication administration records (MAR)
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays
- Entire medical records ❐