AHCCCS

CLAIMS CLUES

A Publication of the AHCCCS Claims Department

November 2011

MEMBER PHOTOS TO BE ADDED AS VERIFICATION TOOL

Effective December 15, 2011, AHCCCS will be adding photos to its on-line verification tool that providers use to verify member eligibility. This new feature is one of many efforts by AHCCCS to help protect members and prevent fraud. For all AHCCCS members who have an Arizona driver's license or a State issued Identification (ID) Card, AHCCCS will obtain photos from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers use the online member verification system and enter a member's social security number, the member's photo, if available from MVD, will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The added photo image will assist AHCCCS providers to quickly validate the identity of a member.

Members will be informed about the addition of MVD photos on their AHCCCS ID card carriers as well as in the Welcome Back letters. In addition, current and future AHCCCS members will be notified of this change through the applicant and member portals on the AHCCCS internet website

Providers are reminded of their continuing obligation to comply with all requirements of the AHCCCS Provider Participation Agreement signed by providers as a condition of participating in the AHCCCS Program. Paragraph 25 of the Agreement states "*If Provider or any employee or contractor of Provider discovers, or is made aware, that an incident of potential fraud or abuse has occurred, the Provider shall report the incident to the AHCCCS Office of Inspector General (AHCCCS OIG) in accordance with state statutes and AHCCCS policy.*" In addition, Arizona Laws ARS §§ 36-2905.04 and 2918.01 require providers to cooperate with AHCCCS to prevent and discover eligibility fraud and to immediately notify AHCCCS of any cases of suspected fraud or abuse

IMPORTANT FES CHANGES

Effective 10/01/11:
AHCCCS will no longer be covering ER codes **99281** and **99282** when billed for services rendered to FES members.

In addition to the above change: pursuant to ARS R9-22-217 **effective 9/1/11** AHCCCS DFSM will no longer require concurrent review for inpatient FES member admissions. DFSM may only reimburse for emergencies and complete retrospective review will be necessary to determine whether assessment and treatment meet federal criteria for emergency status.
For purposes of this rule, an emergency medical or behavioral health condition for a FES member means:
A medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

"Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition.
Clinical documentation for FES members should be submitted directly to the FFS Claims Department, along with the FES claim.

FEE FOR SERVICE EDITING

AHCCCS Fee for Service has implemented a CMS mandate that all states initiate a process of Correct Coding Initiative (CCI) editing and Medically Unlikely Edits (MUE) editing.

Although AHCCCS already does a rather extensive CCI editing process some changes have been made to conform to the new requirements.

Claims regardless of the date of service will utilize the CCI and MUE editing.

IDENTIFICATION OF ORDERING PROVIDER TO BE REQUIRED

Effective 1/1/12 the AHCCCS Administration will require the identification of the ordering provider, for certain CPT/HCPCS codes, when submitting CMS 1500 claim forms. Ordering providers can be an M.D., D.O., Optometrist, Physician Assistant, Registered Nurse Practitioner, Dentist, Podiatrist, Psychologist or Certified Nurse Midwife.

Claim submissions will be edited to ensure that the ordering provider is present for the following types of services:

Laboratory
Radiology
Medical and Surgical Supplies
Respiratory DME
Enteral and Parenteral Therapy
Durable Medical Equipment
Drugs (J-codes)
Temporary K codes
Orthotics
Prosthetics
Temporary Q codes
Vision codes (V-codes)
97001-97546

Fee for Service claims submitted to the AHCCCS Administration for dates of service 1/1/12 for the above mentioned services will be **denied** if the ordering provider is not submitted.

Paper claim submissions:

Providers submitting paper claims should identify the ordering provider in form locator 17, with the providers NPI in form locator 17b.

Electronic claim submissions:

Providers submitting electronic claims (837P) should identify the ordering provider in the 2310A loop (referring provider).

Web claim submissions:

Providers submitting claims via the AHCCCS on-line system should identify the ordering provider name and NPI in the spaces provided on the 1500 claims drop down menu.

PERM UPDATE

The Arizona PERM Claims samples have not been selected to date. For this reason we have scheduled the payment reviews to be conducted by the Federal Contractor the weeks of April 16th through the 27th. While the payment reviews won't begin until April, the Fee-For-Service medical reviews could begin soon after the sample is pulled. You will be notified by letter if you have selected claims in the sample. Be watching for further updates.

If you have any questions regarding PERM, please contact us:

Kim Sanchez, PERM Project Manager (602) 417-4563
kim.a.sanchez@azahcccs.gov
Kyra Westlake, Claims Manager (602) 417-7532
kyra.westlake@azahcccs.gov
Carol Nilson, Medical Review Manager (602) 417-4505
carol.nilson@azahcccs.gov

FEE FOR SERVICE BILLING REMINDER

As a reminder when submitting claims the appropriate beginning and end date of service **MUST** be submitted.

Chapter 4 of the AHCCCS FFS Provider Manual states:

GENERAL AHCCCS BILLING RULES—

Most of the rules for billing AHCCCS follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by AHCCCS.

- Billing span
  - Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

As an example when a DME provider is billing for the monthly rental of a piece of equipment the service date should span all of the dates the item is being provided/rented.

AHCCCS-SECURE- FTP-NOTIFICATION

Providers may now sign up for the AHCCCS-Secure-FTP-Notification listserv at http://listserv.azahcccs.gov

835/MREP CHANGES

The 835/MREP process has changed, **for step by step instructions on the new process, please go to the link below:**

http://www.azahcccs.gov/commercial/Downloads/FFSTechnicalAssistance/TAD835Remits.pdf

The MREP process will remain the same.