CLAIMS CLUES

A Publication of the AHCCCS Claims Department

DECEMBER 2010

AHCCCS ADMINISTRATION OFFICES TO CLOSE FOR FURLOUGH DAYS

Recently the Arizona State Legislature, in the seventh special session, passed HB2003 which requires mandatory furlough days for many State offices and agencies. AHCCCS Administration will be closed on the following furlough days in FY2011 & FY2012:

December 23, 2010
June 10, 2011
July 22, 2011
August 19, 2011
September 16, 2011
November 25, 2011
December 23, 2011
June 15, 2012

All web site services will still be available during this time.

FFS PROVIDER TRAINING SCHEDULED

AHCCCS FFS has scheduled 2 "open forum" provider training meetings:

January 21, 2011
AHCCCS Administration Office
701 E. Jefferson Street, Phoenix
Gold Room 10:00am-12:00pm

Seating is limited; please email kyra.westlake@azahcccs.gov to reserve your place for this session. Agenda topics or questions, regarding the FFS program, for the session are appreciated.

Flagstaff Area FFS Provider Meeting

Monday, February 7, 2011
11:00 AM to 1:00 pm
Flagstaff Public Library Meeting Room
300 West Aspen Avenue
Flagstaff
Seating is limited
RSVP - kyra.westlake@azahcccs.gov

ALTCS FFS FOR AMERICAN INDIANS LIVING ON-RESERVATION

Elderly and/or Physically Disabled American Indians who are living "on-reservation" or who were living on a reservation prior to admission into an off-reservation Nursing or Assisted Living Facility are enrolled with an ALTCS Tribal Contractor when they become eligible for the ALTCS program. When a provider verifies AHCCCS enrollment for an ALTCS FFS member, both the AHCCCS ID card and AHCCCS Online may reflect that the ALTCS member is enrolled in one of the following:

- Gila River Indian Community ALTCS FFS
- Hopi Tribe ALTCS FFS
- Navajo Nation ALTCS FFS
- Pascua Yaqui Tribe ALTCS FFS
- San Carlos Apache Tribe ALTCS FFS
- Tohono O'odham Nation ALTCS FFS
- White Mountain Apache Tribe ALTCS FFS
- Native American Community Health Center (NACHC)

Technically speaking, the above enrollment assignments are <u>not</u> health plans; they are case management programs. Therefore, AHCCCS-registered providers do not need a contract with these programs in order to deliver services to ALTCS FFS members. When a service is delivered by an AHCCCS-registered provider to an ALTCS FFS member, the claim is sent directly to AHCCCS. AHCCCS is responsible for claims payment, so any AHCCCS registered provider can be reimbursed for medically necessary covered services delivered to members enrolled with the above Tribal Contractors.

The Tribal Contractors, through assigned tribal case managers, are responsible for providing case management services and for authorizing certain services, including most ALTCS HCBS and institutional services. It is important for providers to coordinate with the assigned case managers to ensure continuity of care and to ensure that the members' long term care needs are met.

To clarify, ALTCS members with Gila River, Pascua Yaqui, White Mountain, San Carlos, Navajo Nation, Tohono O'Odham, Hopi or NACH on their AHCCCS ID cards are FFS members, and any AHCCCS registered provider may bill AHCCCS and be reimbursed for medically necessary covered services for these members.

PRIOR AUTHORIZATION CHANGES IN AHCCCS FEE FOR SERVICE

In an effort to reduce the unnecessary burden of prior authorizations for services which are typically determined to be medically necessary, the AHCCCS Division of Fee for Service Management will stop requiring prior authorization for the following services, **effective 1/1/11**:

1. Apnea management and training for premature babies up to one year of life

2. Professional and facility component for dialysis shunt placement (including FESP members on Extended Services for ESRD)

3. Professional and facility component for outpatient arteriovenous graft placement for dialysis (including FESP members on Extended Services for ESRD)

4. Professional and facility component for outpatient thrombectomies of dialysis shunts (including FESP members on Extended Services for ESRD)

5. Professional and facility component for outpatient thrombectomies of arteriovenous grafts for dialysis (including FESP members on Extended Services for ESRD)

6. Professional and facility component for outpatient angioplasties of dialysis shunts or grafts (including FESP members on Extended Services for ESRD)

7. Professional and facility component for outpatient eye surgery for the treatment of diabetic retinopathy CPT codes 67028, 67210, 67220, and 67228

8. Professional and facility component for outpatient eye surgery for the treatment of glaucoma CPT codes 65855 and 66761

9. Professional and facility component for outpatient eye surgery for the treatment of macular degeneration CPT codes 67028 and 67210

10. Outpatient wound debridement prior authorizations by the facility

11. Physical therapy outpatient visits for adult acute members

12. Physical therapy visits for adult acute care members in subacute SNFs with up to 90 day stays

13. Family stay at provider types 55 and 56 which includes Ronald McDonald House, Ronald McDonald House-SA, Casa Esperanza, Hospital Traveler, Banner Good Samaritan-Hotel, and University Medical Center when associated with a medical service

14. Oral Supplements for ALTCS members will need to be entered on the member's service plan by the case manager but will no longer require medical oversight by the FFS prior authorization department.

These changes apply to all FFS members excluding the FES population except where specifically delineated above. Stay tuned for future additions to this list.

REMINDER ALERT!

New Mandatory Forms for AHCCCS Fee-For-Service Prior Authorization

Effective 5/1/2010 the AHCCCS FFS Prior Authorization Unit implemented the requirement for providers to use new mandatory forms. There are three different forms. Select the appropriate form and **complete all mandatory fields**. You only need to use one form. Your entire fax will be returned if mandatory fields are not completed.

The correct form must be the 1st or 2nd page of your fax or it will be returned. You must fax only one patient's information at a time. Do not combine faxes or they will be returned.

Medical Documentation Form: Use this form to send in medical documentation for clinical review.

Prior Authorization Request Form: Use this form to obtain initial authorization for any service that requires authorization.

Prior Authorization Correction Form: Use this form to submit corrections for a previously issued authorization.

USING YOUR REMITS AND RECEIVING QUICKER PAYMENTS

Yes, there is a connection!

Claim status and payment information is just a "Click Away". Using the AHCCCS online web portal to status claims, make corrections and to review your electronic remittance notices will **INCREASE YOUR PRODUCTIVITY** and **DECREASE** non-productive work time waiting for your call to be answered. We at AHCCCS are here to help you with claim problems and due to the increasing call volumes we would like to be able to assist you with those claims that are the most complex. By using your remits, you will be able to find answers to questions such as: claim status, payment amounts, date of payment and check numbers. Correcting simple billing errors or checking claim status using our web tools will increase your payment turn around time and help us to focus on your needs when you do have a complex claim problem.

Please use the web tools listed below:

Claims Status

https://azweb.statemedicaid.us/Home.asp

Electronic Claim Submission (837)

https://azweb.statemedicaid.us/Home.asp

Electronic Documentation Attachments (275)

http://www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSTechnicalAssistance.aspx#Uploading_275_Claim_Attachments_Technical_Assistance_Document

Electronic Remits (835)

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

PERM UPDATE

AHCCCS hosted employees of CMS and the Federal Contractors last month for a PERM kick-off meeting. At the meeting we discussed in detail how Arizona processes claims and managed care payments. For Federal Fiscal Year 2011, which began on October 1, 2010, the CMS Federal Contractor will be randomly sampling claims and managed care payments for review. A portion of this review will include requesting medical records from providers. We were excited to note that the amount of time providers have to provide medical records has increased from 60 to 75 days. If all information pertaining to a claim is not provided and the contractor needs to request additional information, only 15-days will be allowed to submit information on the second request. The payments will be selected on a quarterly basis so look for the medical records requests in early 2011!

For more information regarding PERM, contact:

Kim Sanchez, PERM Project Manager	(602) 417-4563
Kyra Westlake, Claims Manager	(602) 417-7532
Carol Nilson, Medical Review Manager	(602) 417-4505

"DOC TALK"

A Message from the AHCCCS MSBC Program Manager

Melinda Hollinshead, Ph.D.

Medicaid School Based Claiming
AHCCCS Members Receiving Services in School

What happens when a child needs help with a medical condition or disability in order to better perform in the classroom, or to attend school at all? Their local school provides the services necessary to ensure that child's ability to participate in the learning environment. In many cases, the services the child receives in school are the same, or similar, to the services they are receiving outside of the school

In 1975 Congress passed the Education for All Handicapped Children Act to protect the rights of, and meet the needs of, students with disabilities. The Act was amended and renamed in 1997 to become what we now refer to as IDEA, or the Individuals with Disabilities in Education Act. IDEA is intended to ensure that students with special medical needs or disabilities receive the services needed to participate in school and further their education. As part of the Medicare Catastrophic Coverage Act in 1988, Congress created the opportunity for services provided to Medicaid eligible students in the schools to be reimbursed by Medicaid. In 2000, AHCCCS entered into an

Intergovernmental Agreement with the Arizona Department of Education (ADE) to serve as the program administrator for schools wanting to submit claims for reimbursement of medical services provided in the schools.

Claiming for services provided in schools, also referred to as Local Education Agencies (LEAs), is administered as a fee-for-service program called Direct Service Claiming (DSC). In order for services to be reimbursed they must meet four main criteria; (1) the student/member must be Title IXX eligible, age 3 through 21 and registered with AHCCCS at the time the service is delivered, (2) they must be enrolled in special education and the services must be outline in the student's Individualized Education Program (IEP), (3) the services must be medically necessary, prescribed in the IEP and delivered by a qualified, AHCCCS registered provider, (4) be one of the package of services identified for school based claiming.

Services approved for reimbursement include:

- Nursing
- Health Attendant Care
- Behavioral Health
- Therapies (PT, OT, SLT)
- Audiology
- Transportation

For each of the services eligible for reimbursement, there are a limited number of procedure codes available for use by the LEAs based on the limited scope of services eligible for reimbursement, but they are the same procedure codes used by all AHCCCS providers.

Although participation in School Based Claiming is not mandatory, approximately 200 LEAs choose to participate in the program. Those LEAs participating account for about 90% of the students who meet the program criteria statewide, or about 23,000 students with claims reimbursed each year. Those students represent AHCCCS acute care and long term care members enrolled with our Health Plans and Program Contractors. Although the services provided by the LEA are reimbursed through a fee-for-service program administered by the AHCCCS Administration, the services they receive are often the same as those they receive from AHCCCS medical providers outside of school. As a result, coordination of care between the school staff and the child's PCP is an important component of ensuring our members are receiving the most appropriate services to meet their needs. The coordination may be facilitated by the members' Heath Plans or Program Contractor.