CLAIMS CLUES

A Publication of the AHCCCS Claims Department
December 2011

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.

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

99281 and 99282 NO LONGER A COVERED SERVICE FOR FES

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

AHCCCS Provider Training Schedule for 2012

701 E Jefferson, Phoenix 85034
Aspen Conference Room 1:00-3:00 pm

ILinc/Teleconference information will be emailed via ListServe prior to each training (dates/times/location are subject to change)

Jan 9	Non-Emergency Transportation
Jan 23	Void and Replacement on AHCCCS Website
Feb 6	Provider Registration
Feb 27	Medicare Remit Easy Print (MREP)
Mar 5	On-Line Claim Submission
Mar 19	Telemedicine Billing for IHS
Apr 16	Non-Emergency Transportation
Apr 30	Void and Replacement on AHCCCS Website
May 14	Medicare Remit Easy Print (MREP)
May 21	Prior Authorization on Website & Inquiry
Jun 11	Non-Emergency Transportation
Jun 25	On-Line Claim Submission
July 9	Medicare Remit Easy Print (MREP)
July 23	To Be Announced Training
Aug 6	Void and Replacement on AHCCCS Website
Aug 20	Medicare Remit Easy Print (MREP)
Sept 10	Prior Authorization on Website & Inquiry
Sept 17	To Be Announced Training
Oct 15	On-Line Claim Submission
Oct 29	Medicare Remit Easy Print (MREP)
Nov 5	Void and Replacement on AHCCCS Website
Nov 26	Prior Authorization on Website & Inquiry
Dec 10	Non-Emergency Transportation

PERM MEDICAL DOCUMENTATION NOTIFICATION LETTERS

PERM is right around the corner. We anticipate receiving our claims sample selection after the first of the year. If one or more of your submitted claims is selected for PERM audit AHCCCS will send you a notification letter. Once you are notified by AHCCCS that one or more of your claims was selected it is vital that you work with the Federal Review Contractor (RC), A+ Government Solutions, Inc., and submit the claims medical documentation requested in a timely manner. The RC will make initial contact by phone to verify the mailing address for requesting medical documentation. For the initial request you will have 75 days to submit your documentation. Once you have submitted documentation the 75 day time frame stops. If while reviewing the medical claim they determine that the documentation furnished is not adequate, they will send you a request for additional documentation and provide an additional 14 days to provide the additional requested information.

If the RC does not receive documentation to support the medical claim timely or they receive inadequate documentation, the claim will count as an error for the State. When a claim is determined to be an error the State is required to recoup the dollars paid to the provider and reimburse the Federal Government for their share.

If you have any questions or concerns regarding this process please feel free to contact us:

Kim Sanchez, PERM Project Manager (602) 417-4563
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ALL GENETIC TESTING REQUIRES PRIOR AUTHORIZATION

All codes for genetic testing now require authorization. Please view the coverage criteria listed below:

Genetic Testing Provisions:

Genetic testing **is only covered** *when the results of such testing are necessary to differentiate between treatment options*.

Testing for other medical conditions (e.g., renal disease, hepatic disease, etc.) that may be associated with an underlying genetic condition *is covered when medically necessary*.

Genetic testing is not covered to determine specific diagnoses or syndromes when such diagnoses would not definitively alter the medical treatments of the member.

Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future.

Genetic testing is not covered as a substitute for ongoing monitoring or testing of potential complications or sequellae of a suspected genetic anomaly.

Genetic testing is not a covered service for purposes of determining current or future family planning.

Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases.

Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

You may also view this criteria in the Policy Manual which is available online at:

http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf

5010 CHANGE MADE TO THE WEB

Effective **11/30/11** a change to "Claim Status" was made to the web.
The denial codes/reasons are now located under the "**Other Claim Info**" section. To navigate to that section, click on the "**Other Claim Info**" link on the upper right corner of the page and scroll down to the "**Denial Reason**" section.
The on-line manual has been updated to reflect this change.

A REMINDER ABOUT MEDICARE EOMB'S

As a reminder…..AHCCCS requires a Medicare explanation of benefits to properly adjudicate any claim, with the exception of dental and non-emergency transportation, for a Medicare recipient. This would include any claim for services that benefits have been exhausted. Please note a copy of the recipients Health Insurance Query Access (HIQA) will not be acceptable as a formal determination of benefits and will result in a denial of your claim.