CLAIMS CLUES

A Publication of the AHCCCS Claims Department

June 2011

COMING SOON!

PHOENIX FEE FOR SERVICE PROVIDER MEETING

September 13th, 2011
10 AM - 12 NOON
701 East Jefferson, Phoenix
Gold Room

If you have topics that you would like us to address at this meeting, please send those to kyra.westlake@azahcccs.gov.
Health Plan representation will be available also.

RECORD KEEPING REQUIREMENTS FOR NON-EMERGENCY TRANSPORATION PROVIDERS

The AHCCCS Provider Participation Agreement states in part, "the provider shall maintain all records in compliance with all specifications for record keeping established by AHCCCS. All books and records shall be maintained in such detail as shall reflect each service provided for which payment is made to the provider. Such material shall be subject to inspection, audit or copying by the State. The provider shall preserve and make available records for a period of 5 years from the date of payment. The provider shall comply with all applicable AHCCCS Rules relating to audits of the Provider's records. The Provider Participation Agreement also states that AHCCCS shall be entitled to offset against any amounts due the provider, any overpayments discovered."

AHCCCS conducts random audits of various provider types on an ongoing basis to ensure that providers are maintaining appropriate records of the services they are providing and billing to AHCCCS for payment.

CMS also conducts several audits continually on claims submitted to AHCCCS for payment to ensure that AHCCCS is adhering to State Rules and Regulations and spending Medicaid funds appropriately.

Therefore, record keeping is of the utmost importance.

Each claim submitted to AHCCCS for payment must be supported with the following documentation (trip log/run sheet, etc.).....

1. Complete Service Provider's Name and Address
2. Name and signature of the driver who provided the service
3. Vehicle Identification (car, van, wheelchair van, etc.)
4. Recipient (being transported) name
5. Recipient's AHCCCS ID
6. Complete date of service, including month, day and year
7. Complete address of the pick up site
8. Complete address of drop off destination
9. Odometer reading at pick up
10. Odometer reading at drop off
11. Type of trip - Round trip or one way
12. Escort (if any) must be identified by name and relationship to the member being transported
13. Signature of recipient, verifying services were rendered

It is the provider's responsibility to maintain documentation that supports each transport provided. Transportation providers put themselves at risk of recoupment of payment IF the required documentation is not maintained or covered services cannot be verified.

SYSTEM UPDATES

Please note the following system updates:

Modifiers

The modifiers 80 (Assistant Surgeon) and AS (PA SVCS for Assistant/At Surgery) have been removed from the following CPT Codes:

62252 Reprogramming Of Programmable Cerebrospinal Shunt

62368 Electronic Analysis of Programmable, Implanted Pump For Intrathecal Or Epidural Drug Infusion (Includes Evaluation Of Reservoir Status, Alarm Status, Drug Prescription Status); With Reprogramming

NEW INFORMATION POSTED TO AHCCCS WEB SITE

There have been some new postings to the AHCCCS website that might be of interest and help to providers…..

Claims Customer Service Hours
http://www.azahcccs.gov/commercial/ClaimsCustomerService.aspx

FAQs for American Indian Health Program (AIHP)
http://www.azahcccs.gov/commercial/ProviderBilling/indianproviders/indianproviders.aspx

http://www.azahcccs.gov/tribal/default.aspx

FAQs for Non-Emergency Transportation (NEMT)
http://www.azahcccs.gov/commercial/ProviderBilling/manuals/NEMT.aspx

http://www.azahcccs.gov/commercial/ProviderBilling/manuals/NEMT.aspx

IMPORTANT PRIOR AUTHORIZATION INFORMATION

Before Submitting a Claim, Please Check the Prior Authorization First.

Many Prior Authorization disputes can easily be resolved by checking the status of the Prior Authorization on-line https://azweb.statemedicaid.us/Home.asp before the claim is submitted. If a correction needs to be addressed then either fax the change request form to: http://www.azahcccs.gov/commercial/FFSclaiming/priorauthorization/PARequest.aspx or call the DFSM Prior Authorization Department (602-417-4400).

When Filing a Reconsideration of a Prior Authorization:

Often a dispute does not require the filing of a grievance and could easily be resolved by the reconsideration process. This could include a change in tier status, missing documentation, incorrect CPT/HCPCS codes or units or date of service change
When filing reconsiderations, please include the following information:

- Any additional documentation required including medical records.

- A brief note describing what correction is needed. If the provider is unwilling to justify in writing why a legitimately denied claim deserves reconsideration, it will be difficult for AHCCCS to reverse its decision.

Each Prior Authorization should be identified clearly with the word "reconsideration".

Mail all reconsideration requests to:

AHCCCS Prior Authorization
Attn: Reconsideration
701 E. Jefferson MD 8900
Phoenix, AZ 85034

Providers have 12 months from the date of service to request a reconsideration of the claim, so prior authorizations must be updated prior to the submission of a claim resubmission.

A request for review or reconsideration of a claim does not constitute an appeal or Provider Claim Dispute (see Chapter 28 in the FFS Provider Manual and Chapter 19 in the IHS/Tribal Provider Manual).

When Filing a Grievance of a Prior Authorization Denial:

When a claim dispute is filed to request a review of a prior authorization that a provider feels was incorrectly denied, it is helpful when the provider filing the claim dispute provides the following:

- Any additional documentation that may be required to substantiate the providers claim that the services were denied incorrectly e.g.: History & Physical, MD Orders & Progress notes, Surgery & Procedure Reports, IV Medications and actual frequencies, Therapy Notes, Consults, or any other documentation that might be needed to substantiate the grievant's claim.
- A brief note describing what correction is needed. If the provider is unwilling to justify in writing why a legitimately denied claim deserves reconsideration, it will be difficult for AHCCCS to reverse its decision.

REMINDER …….

AHCCCS FFS CLAIMS RE-REVIEW PROCESS

In order to streamline requests for FFS resubmissions and reconsiderations the Division of Fee for Service Management has developed a new process for providers to submit these claims re-reviews.

Claims:

A "**Resubmission"** is defined as a claim originally denied because of missing documentation, incorrect coding, etc., which is now being resubmitted with the required information.

A "**Reconsideration"** is defined as a request for review of a claim that a provider feels was incorrectly paid or denied because of processing errors.

When filing resubmissions or reconsiderations, please include the following information:

- ✓ An updated copy of the claim
- ✓ A copy of the original claim (reprint or copy is acceptable)

- ✓ A copy of the remittance advice on which the claim was denied or incorrectly paid
- ✓ Any additional documentation required
- ✓ A brief note describing what correction is needed. If the provider is unwilling to justify in writing why a legitimately denied claim deserves reconsideration, it will be difficult for AHCCCS to reverse its decision.

Each claim should be identified clearly with the words "resubmission" or "reconsideration".

Mail all resubmission and reconsideration requests to:
AHCCCS Claims Department
Attn: Resubmission & Reconsideration
701 E. Jefferson MD 8200
Phoenix, AZ 85034

You have 12 months from the date of service to request a resubmission or reconsideration of the claim.

A request for review or reconsideration of a claim does not constitute an appeal or Provider Claim Dispute (see Chapter 28 in the FFS provider manual and Chapter 19 in the IHS/638 provider manual).

UPDATED GUIDELINES FOR BILLING OF ARIZONA DEPARTMENT OF CORRECTIONS CLAIMS TO AHCCCS

- Medical/Dental claims should be billed either in a HIPAA-compliant 837 transaction OR by using the On-Line Claims submission tool available on the AHCCCS website –**http://azweb.statemedicaid.us/Home.asp**

- If the claim is for INPATIENT (both institutional and professional) services, check the AHCCCS eligibility to determine if the inmate was deemed a Medicaid Eligible Inmate. If the eligibility indicates Medicaid Eligible Inmate for the **dates of service of the INPATIENT services**, bill the claim to AHCCCS using the AHCCCS ID

- If the claim is for INPATIENT (both institutional and professional) services, and the AHCCCS eligibility is **NOT showing for those dates of service**, bill the claim to AHCCCS using the Inmate ID# (P00_____, nine digits). If a Prior Auth is required – contact the Arizona Department of Correction (**602-364-2925**) for the authorization for this stay.

- All OUTPATIENT (both institutional and professional) services are to be billed to AHCCCS using the Inmate ID# (P00_____, nine digits).

- If you have questions regarding claims payment etc., you may contact

  Lorrie.Adams@azahcccs.gov
  Kyra.Westlake@azahcccs.gov