CLAIMS CLUES

Publication of AHCCCS Claims Department

March 2007

TUCSON PROVIDER "ASK AHCCCS" SESSION SCHEDULED

AHCCCS will conduct an "ASK AHCCCS" meeting in the Tucson area on **TUESDAY, MAY 1st, 2007** from **9:30 am – 12:00 noon.**
The meeting will be held at;

Northwest Medical Center
Event Center
6060 Fountain Plaza Drive, Suite 130
Tucson, AZ 85704

This meeting is open to Hospital and physician billers in the Tucson and surrounding areas. Seating is limited, so reserve your seat early. To reserve a seat at this meeting or submit topics you would like AHCCCS to address, you may email kyra.westlake@azahcccs.gov

Phoenix area meetings will be held later in the year. Information regarding the upcoming session in Phoenix will be provided in later Claims Clues publications.

NOTICE FOR REIMBURSEMENT OF INCONTINENCE BRIEFS IN CLASS ACTION CONCERNING CHILDREN UNDER AGE 21 (Article Revised 4/18/2007)

The Consent Decree in the **Ekloff vs. Rodgers** litigation regarding incontinence briefs (diapers) was signed in November 2006. This settlement provides for coverage of incontinence briefs (diapers) to class members as described below:

Coverage: Incontinence briefs (diapers), including all pull-ups, are covered for AHCCCS members who have a documented disability, in order to prevent skin breakdown, and to enable participation in social, community, therapeutic, and educational activities. Coverage shall be determined by:

a. Documentation of a disability that causes incontinence of bowel and/or bladder; and
b. A prescription from the PCP or attending physician ordering the incontinence briefs (diapers).

Age Limit: Coverage for incontinence briefs (diapers) is limited to members over age three (3) and under age twenty-one (21).

Number of Briefs (diapers) per Month: The benefit is limited to 240 briefs (diapers) per month, except in cases involving members who are diagnosed with chronic diarrhea and/or spastic bladder. In these cases, more than 240 briefs (diapers) shall be authorized when evidence of medical necessity is provided by the prescribing physician.

Prior Authorization: Prior Authorization will be permitted to ascertain that:

a. the member is over age three (3) and under age twenty-one (21);
b. the member has a disability that causes incontinence of the bladder and/or bowel;
c. a physician has prescribed incontinence briefs (diapers) as medically necessary; and
d. the prescription is for 240 briefs (diapers) or fewer per month, unless evidence of medical necessity for over 240 briefs (diapers) is provided.
e. A physician prescription supporting medical necessity may be required for specialty briefs (for instance, hypo-allergenic briefs (diapers)) or for briefs different from the standard briefs supplied by the health plan.

Number of Prior Authorizations Per Year: AHCCCS health plans may require a new prior authorization to be issued every twelve (12) months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member, rather than an in-person physician visit.

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NOTICE FOR REIMBURSEMENT OF INCONTINENCE BRIEFS IN CLASS ACTION CONCERNING CHILDREN UNDER AGE 21 *cont.*

Obtaining Supplies: Members will be required to obtain incontinence briefs (diapers) from the in-network providers contracted with the health plans. AHCCCS health plans and in-network providers will be required by contract to provide standard adequate types of briefs (diapers), including pull-ups.

Dispute Resolution: Any disputes regarding prior authorization will be addressed through the existing administrative appeal system (A.A.C. R9-34-101 et seq.) If an AHCCCS health plans denies a request for prior authorization, the health plan shall provide a notice in writing outlining (1) the specific reason for the denial, citing to the particular prior authorization criteria, in paragraph above, that it believes are not met, and (2) the citation to the relevant policy or regulation supporting the denial.

Policy and Rule Revisions: All AHCCCS policies and rules shall be modified to conform with the Settlement Agreement***. (Article revised 4/18/2007)***

AHCCCS Dental Codes and Fees Updated

New dental fees were effective with dates of service beginning October 1, 2006. These fees can be found on the AHCCCS website at www.azahcccs.gov. Please review this carefully as many previously available codes are no longer available for reimbursement.

In addition, the CDT 2007/2008 coding updates will be made to our system. Effective with January 1, 2007 dates of service and later, you must use the updated dental codes. In particular, please note that CDT codes **D1201** and **D1205** will be deleted. This effectively eliminates the combined billing of topical application of fluoride and oral prophylaxis. The services must now be billed separately. Please refer to ADA CDT 2007-2008 for this and other code changes.

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AHCCCS Dental Codes and Fees Updated *cont.*

The following are some new rates effective 1/1/2007……..

D0145	$ 35.00
D0273	$ 30.00
D1206	$ 16.00
D1555	$ 34.00
D2970	$105.00
D8693	$ 46.00
D9120	$ 52.00
D9612	$ 30.00

Dental Hygienists with an Affiliated Practice Agreement

Effective 4/1/2007, dental hygienists with an Affiliated Practice Agreement may register as an AHCCCS provider, as allowed by State law, A.R.S. §32-1281 and §32-1289 and described in the AHCCCS Medical Policy Manual, and may provide dental hygiene services to AHCCCS members eighteen years of age and younger. AHCCCS covers dental hygiene services provided by Arizona licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist. Each affiliated dental hygienist, when practicing under an affiliated practice relationship may perform only those specified duties within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication and consultation with the affiliated practice dentist.

** Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.

** The affiliated practice dental hygienist must maintain individual patient records of AHCCCS members in accordance with the Arizona State Dental Practice Act. At a minimum this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, patient medical history and documentation of services rendered.

Emergency Dialysis Service Provided to Federal Emergency Service (FES) members with End Stage Renal Disease (ESRD) (Article REVISED 4/18/2007)

As a result of the Padilla v. Rodgers lawsuit, the AHCCCS Administration will reimburse providers for emergency dialysis services provided to patients with End Stage Renal Disease (ESRD) under the FES program.

Emergency services include both inpatient and outpatient dialysis services and will be covered when dialysis treatments are prescribed by the patient's physician at least three times weekly. When dialysis services are needed for the first time, the provider must submit an "Initial Dialysis Case Creation" form to the AHCCCS Administration Prior Authorization Unit.

Dialysis services will be covered on a monthly basis when the patient' physician signs a monthly certification stating that the patient requires dialysis services at least three times a week. This form is called a "Monthly Certification of Emergency Medical Condition." It must be maintained by the provider in the patient's medical records. *The provider is not required to submit the monthly certification form to the AHCCCS Administration.*

The monthly certification serves as prior authorization for the emergency dialysis services received during the month. The dialysis services will continue to be covered on a monthly basis as long as the patient remains eligible, and the provider completes and maintains the monthly certification form. The AHCCCS Administration may retrospectively audit patient medical records to ensure compliance with this monthly requirement.

More information about this process will soon be available in policy and rule.

If you have difficulty obtaining emergency dialysis treatment for a patient under the FES program or have questions, please contact:

AHCCCS Prior Authorization Unit, 701 East Jefferson, Phoenix, AZ 85034, 602-417-7548.

AHCCCS Provider Assistance Unit, 701 East Jefferson, Phoenix, AZ 85034, 602-417-7670, 1-800-794-6862

Sally Hart at William E. Morris Institute for Justice, 2033 East Speedway Boulevard, Suite 200, Tucson, AZ 85719, 520-322-0126.
Ellen Sue Katz at William E. Morris Institute for Justice, 202 E. McDowell Road, Suite 257, Phoenix, AZ 85004, (602) 252-3432.
Ms. Hart and Ms. Katz are the attorneys who brought the Padilla lawsuit.

CMS revises Medicare Crossover process

The new Coordination of Benefits Agreement (COBA) Program establishes a nationally standard contract between CMS and other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data. CMS will transfer the claims crossover functions from individual Medicare contractors to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This consolidation will allow for the establishment of unique identifiers (COBA Ids) to be associated with each contract and create a national repository for COBA information.

AHCCCS has now tested and implemented this revised Medicare Crossover process. During the transition to this revised process AHCCCS did not process any crossover claims received September 2006 through current. Processing of those Medicare Crossover Claims has now begun. Providers will begin to see a large number of these crossover claims appear on your remits.

NATIONAL PROVIDER IDENTIFIER
NPI

***** AHCCCS will require the NPI number to be used as the healthcare provider identifier in all claim submissions beginning May 2007. *****

AHCCCS has established an electronic mailbox for providers to forward a copy of their NPI notification via email. **This email address can only accept copies of the statement mailed to the provider from the NPI enumerator.** The AHCCCS provider ID number must also be included in the email for identification purposes. The email address is, **NationalProviderID@azahcccs.gov.**

Other options for providers to submit a copy of their NPI number notification include mailing or faxing a copy of the enumerator statement to**,**

AHCCCS
Provider Registration Unit
P O Box 25520
Phoenix, AZ 85002
FAX: (602) 256-1474

The provider's name and AHCCCS provider ID number must be written on the copy.

NPI numbers will also be accepted via written notification. Notification must include the AHCCCS provider's name, AHCCCS provider ID number, NPI number and signature of the provider or authorized signer.
AHCCCS will accept claims and encounters including the NPI beginning January 1, 2007. ***Effective May 23, 2007, ALL claims and encounters must be submitted with an NPI. Claims submitted on May 23rd or after without an NPI number will be denied by AHCCCS.***

There is additional NPI information on the AHCCCS website at www.azahcccs.gov. Click on Plans and Providers, then scroll down to National Provider Identifier (NPI) documents for reference. Providers may also access additional information regarding NPI at www.cms.hhs.gov/hipaa/hipaa2. This site contains Frequently Asked Questions and other information related to NPI and other HIPAA standards.

Effective March 1, 2007, ALL new registrations, if applicable, will require inclusion of the provider's NPI number prior to completion of registration process.

Correcting Claim Errors

All claims submitted to AHCCCS Administration are extensively edited by the AHCCCS claims system. When a claim fails and edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed in the Denied Claims section of the Remittance Advice with an edit number, decimal point, and a single digit that further defines the problem.

Providers should use the *Claims Correction Request Form* to correct many common errors without resubmitting the claim. The *Claims Correction Request Form* should be faxed to the AHCCCS Claims Research Unit at 602-417-4430. The completed Claims Correction Request Form must include the provider's name and AHCCS ID Number and a contact person's name, signature and date the request was sent. The recipient's name and AHCCCS ID, claim date of service, billed amount, The Claim Reference Number (CRN) of the claim to be corrected, and the fields to be changed must also be included.

Resubmission of claims - when resubmitting a denied claim, the provider must submit a new claim containing all previously submitted lines. **The original AHCCCS Claim Reference Number (CRN)** must be included on the resubmission to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame. Providers do *not* need to resubmit documentation unless specifically requested to do so.

Who do I call/contact at AHCCCS?

Claim Status – AHCCCS has developed a Web application that allows providers to check status of claims using the Internet, https://azweb.statemedicaid.us. Customer support for this Web application is at 602-417-4451.
If a provider does not have access to the Internet, they may call Claims Customer Service at 602-417-7670 (option 4), 1-800-654-8713 (In state), or 1-800-523-0231, Ext. 77670 (Out of State).

Electronic claim submissions or electronic remittance advice SETUP help – call the Electronic Claim Submission Unit –
602-417-7986 or 602-417-4334.

Information regarding submitting claims via the Web – AHCCCS allows providers to submit Professional, Institutional and Dental claims via the AHCCCS website. Go to https://azweb.statemedicaid.us. AHCCCS registered providers will need to establish a username and password for login purposes if you have not already established one.

Information regarding status or other issues with electronic TRANSMISSION of claims –
call the AHCCCS Customer Support Unit at 602-417-4451.

Information regarding receipt of Remittance Advice or "Credit Memo" -
Call AHCCCS Division of Business and Finance at 602-417-4052.

Information regarding Medicare Crossover claims -
Call 602-417-4105

Is a specific service covered?
Call the Office of Medical Policy at 602-417-4053.

AHCCCS Modifier Files

A few months ago, AHCCCS discovered that the modifier reference file in the Pre-Paid Medical Management Information System (PMMIS) did not include all modifiers that could correctly be attached to a specific code. To correct this problem, AHCCCS purchased a download file from Ingenix containing a complete inventory of modifiers and loaded it into PMMIS. AHCCCS will continue to use Ingenix to validate our modifier files. Identified missing modifiers were given an effective date of 7/1/2005 or the actual effective date of the modifier, whichever is later.

The reason for back-dating the effective dates in this situation is that a correct and complete modifier file is necessary for appropriate outpatient claims payment. If a previously processed outpatient claim inappropriately disallowed due to this modifier issue, AHCCCS has reprocessed that claim allowing appropriate payment.

News from AHCCCS Fee for Service Medical Review

It has come to the attention of the Medical Review Department that AHCCCS has received several Claim Disputes in the recent past for provider's failure to use Modifiers 76 and 77, **WHEN APPROPRIATE.**

Modifier 76 – Repeat Procedure by the Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

Modifier 77 – Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

Appropriate use of these modifiers could prevent a need for a Claim Dispute.

News from AHCCCS' Chief Medical Officer, Marc Leib, M.D.

It has come to the attention of AHCCCS that one or more manufacturers of electronic optical screening devices have been advising primary care physicians and others that they can submit claims for the use of these devices under CPT code 92015 (determination of a refractive state). CPT code 92015 describes services by an ophthalmologist or optometrist during which the exact prescription for eyeglasses or contact lenses is determined and provided to the patient in the form of a written prescription that may be filled at an optical dispensary. This code should NOT be used to describe a screening examination that determines whether a referral to an ophthalmologist or optometrist may be warranted. Although the screening devices may give approximate refractory values for a particular patient, they do not provide an exact prescription by which eyeglasses or contact lenses can be dispensed. Professional associations, including the American Academy of Ophthalmologists, state that the use of electronic measuring devices does not meet the requirements for submitting claims for CPT code 92015. If currently doing so, please cease submitting claims under CPT code 92015 for electronic screenings of visual acuity.