CLAIMS CLUES

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AHCCCS PROVIDER MANUALS ARE AVAILABLE ON WEB

You can access the Arizona Health Care Cost Containment (AHCCCS) Fee-For-Service Provider Manual and the IHS/Tribal Billing Manual via the AHCCCS website at **www.ahcccs.state.az.us.** These manuals are publications of the AHCCCS Claims Department, Division of Fee-For-Service Management.

The manuals contain basic information concerning AHCCCS, Arizona's Medicaid program and the state's health care program for persons who do not qualify for Medicaid. The manuals are to furnish providers' billing staff and contracted billers with information about AHCCCS, coverage of specific services, and requirements for completion and submission of fee-for-service claims to the AHCCCS Administration.

Referencing these manuals will help reduce questions about coverage of services, recipient eligibility, and proper billing procedures (including timely filing requirements) and expedite the claims process by ensuring that claims are filed correctly the first time.

Changes and updates to these manuals will be made to the on-line version as they occur. You are encouraged to utilize the on-line versions for your reference needs as it will always contain the most updated information available.

AHCCCS NOW ACCEPTS 4 DIGIT REVENUE CODES

Beginning in February AHCCCS accepts 4 digit Revenue Codes. Please use 4 digit Revenue codes on all UB-92 billings.

CLAIM SUBMISSION TIMEFRAMES

An AHCCCS registered provider shall initially submit a claim for covered services to the AHCCCS Administration not later than:
Six months from the date of service, or six months from the date of eligibility posting, whichever is later. For hospital inpatient claims, "date of service" means the date of the discharge of the patient. **Any claim initially received beyond the 6-month time frame, except retro-eligibility claims, will be denied.**

If the claim is originally received by the Administration within the 6-month time frame, the provider has up to 12 months from the date of service to resubmit the claim in order to achieve a clean claim status or to adjust a previously processed claim, unless that claim is a retro-eligibility claim. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months from date of service, **AHCCCS is not liable for payment.**

A **"clean claim"** is a claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation from fraud or abuse or claims under review for medical necessity.

A **"retro-eligibility"** claim is a claim where no eligibility was entered in the AHCCCS system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

If a claim for payment under Medicare as primary coverage has been **initially filed with the AHCCCS Administration in a timely manner** as written above, the Administration may pay a Medicaid claim relating to the same services within 6 months after the date of the Medicare EOMB.

EXPANSION OF WEB BASED PRIOR AUTHORIZATION (PA) INQUIRY TOOL NOW AVAILABLE

Beginning in November of 2005, providers were able to view the status of their prior authorization via the web. AHCCCS has extended this service to include providers like DME, home health, nursing homes, therapy, and HCBS. This expanded web based tool allows providers to verify the service plan line items. This web based tool will provide the same level of service as a phone call to verify the service plan line items while being accessible 24-7. The application allows providers to search for a particular request then display all relevant data for that service plan. The site functionality includes searching by case number, AHCCCS ID number, or provider ID number. Begin and end date criteria will also be available with these options. Providers with current accounts can log in at **https://scertsrv.ahcccs.state.az.us.**
Additionally, providers without current accounts are able to create new accounts at this site. Once a provider reaches the prior authorization screen please select "Long Term Care" in the "Search System" drop down menu.

RECEIVE YOUR REMITTANCE ADVICE ELECTRONICALLY

Using the upgraded AHCCCS Remit process, you can download your remittances directly from a secure AHCCCS Internet website and store them in either electronic or hardcopy format, depending on your preference.

In order to access the AHCCCS Online website, you will need a user name and password approved by AHCCCS.

If you do not currently have an active account, you can sign up for one in the following manner:

- Access the AHCCCS website: https://scert.ahcccs.state.az.us/Home.asp
- Click on the "Create a New Account" link in the "New Account" section of this page.
- Read and agree to the AHCCCS End User Agreement
- Enter your provider number and tax ID number into the fields as requested.
- Create your user profile (including your user name, password, hint question and answer, account type selection, and contact information)

Successful completion of the web based account request process will be followed by a letter sent to you via US mail containing your account activation code. You cannot access the website without first completing your account setup with this activation code.

To access your Remittance once you have established an active account:

- Use the username and password from your activated account to gain access to the AHCCCS Online website.
- Access the Remittance site functionality by clicking on the "Remits" link on the left side of the page (bottom link available in the Main Menu on the left side of the page).
- If you have no available remittance files, you will instead receive a message advising you of the lack of available files.
- If you have available remittance files, they will be listed.
- To download a remittance file, click the "download file" link to the right of the filename corresponding to the file that you wish to download. You will then see a pop up box asking "Would you like to open the file or save it to your computer?"
- Click the "Save" button. You will then be provided a window in which to specify where you wish the remit file saved.
- Specify a location and click the "Save" button. The file has been saved and can be accessed directly from there, and displayed in any text editor (Notepad, Wordpad, Winword, etc.)

***Note: Remittance files are retained by AHCCCS Online for 2 weeks. After 2 weeks, they will no longer be available via AHCCCS Online.

IHS/TRIBAL PROVIDERS OF SERVICE

Any person or company may participate as an IHS/Tribal AHCCCS provider if the person or company is qualified to render a covered service and complies with AHCCCS policies and procedures for provider participation.

Individual providers eligible to provide services for reimbursement to AHCCCS are registered under one of 14 provider types:

- MD – Physician
- DO – Physician Osteopath
- Podiatrist
- Dentist
- Psychologist
- Optometrist
- Physician Assistant
- Nurse Practitioner
- Certified Nurse Mid-wife
- Speech Therapist
- Occupational Therapist
- Physical Therapist
- Certified Registered Nurse Anesthetist
- Respiratory Therapist

Each IHS Area Office or IHS/Tribal facility must maintain a roster of its AHCCCS-registered individual providers. As staff changes occur, including both staff additions and deletions, each IHS Area Office or IHS/Tribal facility must notify AHCCCS of those changes. Each IHS Area Office or IHS/Tribal facility is responsible for informing AHCCCS when one of its AHCCCS-registered providers terminates IHS employment.

Each physician and mid-level practitioner must complete a Provider Application packet and AHCCCS Provider Agreement.

AN AHCCCS registered IHS facility or a tribal facility or organization wishing to act as the financial representative for a provider or group of providers who have authorized this arrangement may register as a group billing provider. ***Group billers may not provide services or bill as the service provider. The service provider's AHCCCS provider ID number MUST appear on each claim submitted, even though a group billing number may be used for payment.***

According to Arizona Administrative Code (R9-22-714), The AHCCCS Administration shall not reimburse a covered service provided to a member unless the provider has signed a provider agreement with the Administration that establishes the terms and conditions of participation and payment under A.R.S. § 36-2904

Hopefully, this reiteration of the IHS/Tribal Provider Manual will help facilities determine which services can be billed to AHCCCS for reimbursement.

OUTPATIENT HOSPITAL REIMBURSEMENT

There appears to be some confusion regarding billing of Observation Services on an Outpatient claim submission.

Observation services, without labor, billed on the UB claim form must be billed with a 762 revenue code (Treatment/Observation Room – Observation Room) **AND** the appropriate observation CPT procedure code 99218, 99219 or 99220 (Please note that 99217 is not appropriate for outpatient hospital billing). Each hour or portion of an hour that a recipient is in observation status must be indicated as one unit of service (CPT code).

Observation services, with labor, billed on the UB claim form must be billed with a 721 revenue code (Labor Room Delivery – Labor) **AND** the appropriate CPT procedure codes (see above scenario). Each hour or portion of an hour that a recipient is in observation status must be billed as one unit of service (CPT code).

According to the Outpatient Reimbursement guidelines established by AHCCCS, CPT/HCPCS are *required* when billing these revenue codes (762 and 721). AHCCCS is gathering data to establish an hourly reimbursement rate for observation in the future. Revenue code 762 and 721 are each considered a "bundled" revenue code for reimbursement purposes.

VACCINES FOR CHILDREN (VFC) PROGRAM

As a reminder, providers who bill for administration of vaccines under the federal Vaccines for Children (VFC) program must bill the appropriate CPT code for the immunization with "SL" (State supplied vaccine) modifier.

Under the VFC program, providers are paid a capped fee for administration of vaccines to recipients 18 and younger. Because the vaccine is made available to providers free of charge, they must not bill for the vaccine itself. Providers must not use the immunization administration CPT codes of 90471, 90472, 90473 and 90474 when billing under the VFC program. An **updated listing** of vaccines covered under the VFC program is attached for your reference. This information will also be updated in the Fee For Service Provider Manual and the IHS/Tribal Provider Manual available via the AHCCCS website.

It is important to note that CPT code 90715's description per the AMA is listed "….for use in individuals 7 years and older", however the FDA's description states, "for children 10 years and older." AHCCCS is following the FDA description for age.

Vaccines Covered Under the VFC Program	
90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule
90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule
90645	Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule)
90646	Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only
90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule)
90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule)
90655	Influenza virus vaccine, split virus, preservative free, 6 – 35 months of age, (intramuscular use only)
90656	Influenza virus vaccine, split virus, preservative free, 3 years of age and above, (intramuscular use only)
90657	Influenza virus vaccine, split virus, 6 - 35 months of age (covered under VFC only for high-risk children)
90658	Influenza virus vaccine, split virus, 3 years of age and above (covered under VFC only for high-risk children)
90669	Pneumococcal conjugate vaccine, polyvalent, for children under 5 years
90698	Diptheria, tetanus toxoids, acellular pertussis vaccine, hemophilius influenza b and poliovirus vaccine, inactivated (DTap-Hib-IPV), (intramuscular use only)
90700	Diphtheria, tetanus toxoids, and acellular pertussis (DTaP)
90701	Diphtheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)
90702	Diphtheria and tetanus toxoids (DT) adsorbed
90707	Measles, mumps and rubella virus vaccine (MMR)
90710^	Measles, mumps, rubella and varicella vaccine (MMRV), live, (subcutaneous use only)
90713	Poliovirus vaccine, inactivated (IPV)
90714*	Tetanus and diphtheria toxoids (Td) absorbed, preservative free, 7 years or older, IM
90715*	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), 10 years or older, IM
90716	Varicella virus vaccine, live
90718	Tetanus and diphtheria toxoids (Td)
90720	Diphtheria, tetanus toxoids and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib)
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DtaP-Hib)
90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV)
90734+	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for IM use
90732	Pneumococcal polysaccharide, 23 valent
90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule)
90743	Hepatitis B vaccine, adolescent (2 dose schedule)
90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule)
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule)
90748	Hepatitis B and Hemophilus influenza b (HepB-Hib)

*** Effective Date of July 1, 2005**
+ Effective Date of June 1, 2005
^ Effective Date of December 21, 2005

BILLING AHCCCS ELIGIBLE MEMBERS

On April 18, 2005 Governor Janet Napolitano signed into Law, Senate Bill (SB) 1249. This law prohibits Providers from billing Arizona Health Care Cost Containment System (AHCCCS) eligible members and authorizes AHCCCS to impose civil penalties (of three times the amount of the billing) upon AHCCCS registered Providers who bill members, after notification from AHCCCS.

In order to comply with the SB 1249, we recommend that before any AHCCCS registered Provider submits a claim to a collection agency, they make one last attempt to verify the member's eligibility for dates of service(s) by using the AHCCCS Communication Center (602-417-7000), Interactive Voice Response system (IVR) at (602-417-7200 or 1-800-331-5091), Medi-Fax or the AHCCCS website at (*http://www.ahcccs.state.az.us/PlansProviders/CheckElig.asp*).

SB 1249 also establishes procedure for the correction of improper requests for collection. It requires a health care Provider who has improperly contacted any collection agency or credit reporting agency regarding a member's outstanding bill, to request that the collection efforts be terminated and that any affected credit report be corrected. The effective date for this law is August 18, 2005.

The AHCCCS Office of Program Integrity will investigate allegations regarding violations of SB1249, which has been incorporated into Arizona Revised Statute 36-2903.01.L.

NATIONAL PROVIDER IDENTIFIER (NPI)

Effective January 23, 2004, the final rule regarding the National Provider Identifier (NPI) was published. CMS started assigning NPI numbers to providers last May. AHCCCS will require the NPI to be used as the healthcare provider identifier in all claim submissions starting in May 2007.

An electronic mailbox has been established for providers to forward a copy of their NPI notification via email. The AHCCCS provider ID number also needs to 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. The provider's name and AHCCCS provider ID number needs to be written on the copy. The information can be mailed or faxed to:

AHCCCS
Provider Registration Unit
P. O. Box 25520 Mail Drop 8100
Phoenix, AZ 85002

Fax: (602) 256-1474

NPI numbers will also be accepted via written notification. Notification must include the AHCCCS provider's name, AHCCCS provider ID number, and signature of the provider or authorized signor.

The agency is targeting January 1, 2007 as the optional claims and encounter submission date. Effective May 23, 2007 all claims and encounters must be submitted with the NPI when applicable.

Providers can obtain additional information about NPI at ***www.cms.hhs.gov/hipaa/hipaa2***. This site contains Frequently Asked Questions and other information related to the NPI and other HIPAA standards.

AHCCCS RECIPIENT ELIGIBILITY AND ENROLLMENT

Eligibility determination is not performed under one roof but by various agencies, depending on the eligibility category. For example, pregnant women, families, children and many individuals usually enter AHCCCS by way of Department of Economic Security. The blind, aged or disabled who receive Supplemental Security Income enter through the Social Security Administration. Eligibility for categories such as ALTCS, SSI-Medical Assistance Only (aged, blind and disabled who do not qualify for Supplemental Security Income cash payment), KidsCare, AHCCCS for Parents of KidsCare Children (HIFA Parents), Freedom to Work, and Medicare Cost Sharing Programs is handled by the AHCCCS Administration. Each eligibility category has its own income and resource criteria.

ON-LINE CMS 1500 CLAIM SUBMISSION NOW AVAILABLE

AHCCCS registered providers may now submit CMS 1500 claims via the AHCCCS website, ***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 to view claim status or verify recipient eligibility.

Once you have successfully logged in, the user can select to *enter new claims* or *view the status of previously submitted claims.* Much of the information required (such as, Billing provider name (based on user id and password), Billing provider Tax ID, Service provider name, Service provider Tax ID, Recipient Name, Date of Birth, and Gender) for the claim completion will be extracted from AHCCCS Claims Processing System populating fields. "Find" options are provided for this purpose.

The recipient's eligibility will be verified prior to AHCCCS' acceptance of the claim. If a recipient is not eligible at the time of the service, then a message will display to the user indicating the claim cannot be accepted due to ineligibility.

The process will include a Claim Entry Confirmation page used to show status of the claim just submitted. The Transmission Status will indicate either a "Successful" or "Failed" transmission. The user will also be allowed to modify data entered if incorrect information was submitted.

A Batch process will be submitted to the AHCCCS mainframe **nightly** for processing. Any Batch submitted after 4:00 PM will be processed the following day.

For additional information regarding this process, contact Kyra Westlake at 602-417-4152.