



AHCCCS

CLAIMS CLUES

Publication of the AHCCCS Claims Department

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CHANGE IN IHS REFERRAL POLICY

Effective ***with dates of services 10/1/2008***, a referral from an IHS/638 Tribal program will no longer be required for our fee for service members enrolled in AHCCCS American Indian Health Program (formally IHS/AHCCCS), to receive services by non-IHS/638 Tribal fee for service providers. This change will be reflected in the AHCCCS Billing Manual for IHS/Tribal Providers and the Fee for Service Billing Manual.

This IHS referral policy change does not affect or change our current Prior Authorization requirements for medical services that require a Prior Authorization.

CORRECTION – COLLECTION OF CAPILLARY BLOOD SPECIMEN

Effective 10/1/2008, AHCCCS will no longer allow providers to bill for 36416 (Collection of capillary blood specimen (EG, finger, heel, or ear stick) when billed in conjunction with an E&M service billed on the same day.

NEW VACCINES ADDED TO VFC PROGRAM

For effective dates on or after January 1, 2008 the following vaccines have been added to the Vaccine For Children (VFC) program:

90861 (rotavirus vaccine, human, attenuated, 2 dose schedule, live, for oral use) – minimum age 6 weeks, maximum age 32 weeks

90698 (Diphtheria, Tetanus Toxoids, Acellular Pertussis Vaccine, Haemophilus Influenza Type B, and Poliovirus Vaccine, Inactivated (DTAP – HIB – IPV), for intramuscular use) – minimum age 6 weeks, maximum age 208 weeks

90696 (Diphtheria, Tetanus Toxoids, Acellular Pertussis Vaccine and Poliovirus Vaccine, Inactivated (DTAP-IVP), when administered to children 4 years through 6 years of age, for intramuscular use) – minimum age 4 years and maximum age to 6 years

MODIFIER UPDATES

Effective for dates of service on or after October 1, 2008 the modifiers AS and 80 have been end dated for the following codes:
15002 – 15005

Effective for dates of service on or after October 23, 2008 the modifier 80 has been removed from CPT code 64405 for provider type 18 (Physicians Assistant).

BEHAVIORAL HEALTH CLAIMS

For behavioral health services received by American Indian Health Program members at an IHS/638 facility – the AHCCCS Administration is responsible for payment of claims. Therefore, providers must submit claims to the AHCCCS Administration. Any disputes regarding these claims would be submitted to the AHCCCS Administration also.

For behavioral health services received by American Indian Health Program members who are enrolled in a TRBHA, the AHCCCS Administration serves as a TPA (Third Party Administrator) for ADHS. Therefore, the AHCCCS Administration processes the behavioral health claims for this population (as a TPA). Any disputes regarding these claims should be submitted to ADHS for consideration.

For behavioral health services received by Acute Care Fee for Service members who are enrolled in a RBHA, ADHS (or its subcontracted RBHA) is responsible for the processing claims for this population. Any disputes regarding these claims should be submitted to ADHS for consideration.

For behavioral health services received by a Health Plan enrolled member, the Health Plans are responsible for UP TO (no more than) 72 hours of **inpatient emergency behavioral health services**, depending upon when the member has been determined eligible for behavior health service by the RBHA. ADHS (and its RBHAs) are responsible for everything else with the exception of 1.) BH screening and evaluation services which are the responsibility of the COUNTY as specified in State Statute and 2.) BH services received by Health Plan members during prior period coverage which are responsibility of the acute care Health Plan.

Provider Manuals are being updated to reflect this clarification.

MATERNITY ONE-DAY OUTLIER CONSIDERATIONS

AHCCCS has recently received a number of questions related to Maternity one-day outlier considerations.

Effective with dates of admission 10/1/2007 and >

ROUTINE MATERNITY stays, Maternity tier qualified stays of one-day DO NOT qualify for outlier consideration UNLESS the patient delivers three (3) or more babies related to that stay. Routine maternity stays will be reimbursed at tier.

REVISED RATES

AHCCCS has revised its rates for some of the Ambulatory Surgery Codes (ASC) that had been priced as less than 80% of the current CMS rate. These rates were increased to the lesser of 80% of the CMS ASC rate or 90% of the AHCCCS OPFS rate **effective 11/1/2008**. Additionally, two codes (41899 and 58565) were identified as missing from the ASC Fee Schedule implemented 10/1/2008. These codes have been added to the tables effective 10/1/2008.

OUTPATIENT REFERENCE TABLE UPDATES

AHCCCS has reviewed and restructured the RF773 (Revenue Code to HCPCS) and the RF774 (Revenue Code to Bill Type) tables to ensure correctness and to accommodate single code to code relationships. This restructuring resulted in all pre-existing open-ended segments being end dated as of 9/30/2008 dates of service, and a new single code to code segment being added for dates of service on or after 10/1/2008.

ARIZONA GROUND AMBULANCE SERVICE RATE SCHEDULE UPDATE

Ambulance companies received rate adjustments from ADHS. Rates are available at <http://www.azdhs.gov/bems/ambrates.htm>.

PERM (PAYMENT ERROR RATE MEASUREMENT) PROGRAM

The Improper Payments Information Act of 2002 directs Federal agency heads, in accordance with the Office of Management and Budget (OMB) guidance, to annually review its programs that are susceptible to significant erroneous payments and report the improper payment estimates to Congress. OMB identified the Medicaid and State Children's Health Insurance Program (SCHIP) as programs at risk for significant erroneous payments.

The Centers for Medicare and Medicaid Services (CMS) will measure the accuracy of Medicaid and SCHIP payments made by States for services rendered to recipients through the Payment Error Rate Measurement (PERM) program. Under the PERM program, CMS uses 3 national contractors to measure improper payments in Medicaid and SCHIP. Provider interactions in this process will be primarily with the documentation/database contractor (DDC), Livanta, who will collect medical policies from the State and medical records from providers either in hard copy or electronic format.

Medical records are needed to support required medical reviews for PERM so that the review contractor can review the fee for service Medicaid and SCHIP claims to determine if the claims were correctly paid. If a claim is selected in a sample, the DDC will contact the provider identified as receiving the payment for those services for medical records to support the medical review of the claim selected.

PERM (PAYMENT ERROR RATE MEASUREMENT) PROGRAM

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Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a)(27) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by a provider for rendering services. The furnishing of this information includes medical records. AS for SCHIP, section 2107(b)(1) of the Act requires an SCHIP State Plan to provide assurances to the Secretary that the State will collect and provide to the Secretary any information required to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of the States' SCHIP plans. In addition, the collection and review of protected health information contained in individual-level medical records for payment review purposes IS PERMISSABLE by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

The DDC will be contacting providers to verify the correct name and address information and to determine how providers want to receive the request (i.e., facsimile or US Mail) for medical records.

ONCE PROVIDERS RECEIVE A REQUEST FOR MEDICAL RECORDS, RECORDS MUST BE SUBMITTED TO THE DDC EITHER ELECTRONICALLY OR HARDCOPY WITHIN 60 DAYS. Please note that it will be the responsibility of the provider who is identified on the claim to receive payment, to ensure that any and all supporting medical records are submitted in a timely manner. During this 60 day timeframe, the DDC will follow up to ensure that you submit the documentation before the timeframe has expired. AHCCCS may also contact you to assist in identifying the required documentation for submission.

PERM (PAYMENT ERROR RATE MEASUREMENT) PROGRAM

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It is important that providers cooperate with submitting the requested documentation in a timely manner because no response or insufficient documentation will be deemed an error. Past studies have shown that the largest cause of error in medical reviews is no documentation or insufficient documentation. As such, it is important that information be sent in a timely and complete manner.

If you have questions regarding this PERM audit, please contact Kim Wilson, AHCCCS Quality Compliance Administrator at 602-417-4563 or kim.wilson@azahcccs.gov.

Thank you for your support of the PERM program.

Just as a note to providers who have outstanding medical records requests. The requests for records are time-sensitive. Please respond quickly to the contractor request for records.

QUESTIONS REGARDING MEDICARE CROSSOVER CLAIMS?

Call Jeanne at 602-417-7980

NOTES.....

1. AHCCCS Claims Administration will act as a TPA (Third Party Administrator) for Juvenile Corrections beginning October 1, 2008
2. ***CLAIMS CORRECTION FORMS - Be sure to include a contact name and number on ALL CCR (Claim Correction Request) forms sent to AHCCCS. Be specific with your comments on what you are expecting the claims department to correct.***

5% Fee for Service Rate Reduction Effective February 1, 2009

The State of Arizona is currently facing a projected budget deficit of \$1.2 billion in State Fiscal Year 2009 and an estimated shortfall of at least twice that State Fiscal Year 2010. To address this shortfall, the Executive has developed a Budget Management Plan which includes fund transfers, budget savings measures, and other actions. Executive Branch agencies are moving forward with select budget savings measures which do not require statutory changes. As part of the Governor's Budget Management Plan, the Arizona Health Care Cost Containment System (AHCCCS) proposes to revise specified Fee for Service payment rates for services provided to members enrolled in the AHCCCS Fee for Service program, the Medicaid Scholl Based Claiming (MSBC) program the Comprehensive Medical and Dental Program (CMDP) for dates of service **on or after February 1, 2009**. AHCCCS has established the Fee for Service Program Capped Fee Schedule and rates contained therein will be reduced by 5%.

Rates contained in the Fee For Service Program Capped Fee Schedule shall include the Physician Fee Schedule (also DME, radiology, and drugs administered in a physician's office), Dialysis (Free Standing), Transportation, and Behavioral Health services (including counseling, crisis, rehabilitation/supportive services, residential treatment and services in psychiatric facilities not paid for by ADHS/BHS or their subcontractors). Please refer to the fee schedules on our web site at www.azahcccs.gov/RatesCodes.

Affected rates can be identified under each category of service by "FFS Program Capped Fee Schedule" effective February 1, 2009.

The February 1, 2009 "FFS Program Capped Fee Schedule" **will not** impact rates for the following services: hospital, nursing facility, pharmacy, home and community based services, dental, ambulatory surgical centers, and hospice.

AHCCCS has also established the "MCO Capped Fee Schedule" for claims for members enrolled in Managed Care Organizations (except CMDP).

Fee For Service Rate Reduction..... cont.

At this time, rates contained in the “MCO Capped Fee Schedule” remain unchanged from rates effective October 1, 2008 (with some updates as of January 1, 2009). Please refer to the fee schedules on our web site at www.azahcccs.gov/RatesCodes. Rates can be identified under each category of service by “MCO Capped Fee Schedule” effective October 1, 2008 or January 1, 2009.

90882 Non-Covered Service Effective 3/1/2009

Procedure Code 90882 (Environmental intervention for medical management purposes on a psychiatric patient’s behalf with agencies, employers, or institutions) will be an AHCCCS Non-Covered Service beginning with dates of service March 1, 2009 and after.

New Hospital

American Regional Medical Center is a new hospital with an official CMS certification effective 10/30/2008.

Modifier “QW” (CLIA Waived Test)

Effective for dates of service on or after January 1, 2009, the modifier “QW” (CLIA waived test) has been added for use with the CPT Code 87905 (infectious agent enzymatic activity other than virus (e.g., Sialidase activity in vaginal fluid)).

Attendant Care Modifiers

Providers of Attendant Care (S5125) should be aware that modifiers may be required when submitting claims for this service. ALTCS case managers have been instructed to add appropriate modifiers to their service authorizations. If the authorization contains a modifier but the provider does not include that modifier on the claim, the claim will deny for “No Prior Authorization”. The modifiers and their descriptions are listed below.

- ✓ U3 – Attendant Care provided by the ALTCS member’s spouse
- ✓ U4 – Attendant Care provided by a family member who does not live with the ALTCS member
- ✓ U5 – Attendant Care provided by a family member who does live with The ALTCS member

S5125 **with no modifier** indicates Attendant Care provided by a non-family member of the ALTCS member.

“Family Member” includes the following:

- ❖ Adult children of the member
- ❖ Son/Daughter-in-law of the member
- ❖ Adult grandchildren of the member
- ❖ Siblings of the member
- ❖ Parents of members >18 years (parents of members <18 years cannot be paid caregivers)
- ❖ Grandparents of the member
- ❖ Mother/Father-in-law of the member
- ❖ Brother/Sister-in-law of the member

UPCOMING AHCCCS Provider Meetings

AHCCCS Fee for Service Provider Meeting (Flagstaff Area)

Tuesday, March 17th, 2009

**Flagstaff Public Library – 300 West Aspen – Flagstaff
Community Room**

10:00 am – 12:00 NOON

***Limited seating – please email your RSVP to
Kyra.westlake@azahcccs.gov**

AHCCCS Fee for Service Provider Meeting (Phoenix Area)

Friday, March 20th, 2009

701 East Jefferson - Phoenix

GOLD ROOM

10:00 AM – 12:00 NOON

AHCCCS Claims staff will conduct these meetings for Fee for Service providers. It is a great forum to get together to discuss topics of concern for providers and receive updates on AHCCCS Fee for Service Claims.

We are also planning meetings for Tucson and Yuma areas - watch for announcement in future Claims Clues.

Should you have questions regarding these scheduled meetings, please email Kyra.westlake@azahcccs.gov