



AHCCCS

CLAIMS CLUES

A Publication of the AHCCCS Claims Department
SEPTEMBER 2011

IMPORTANT FES CHANGES

Effective 10/01/11:

AHCCCS will no longer be covering ER codes 99281 and 99282 when billed for services rendered to FES members.

In addition to the above change: pursuant to ARS R9-22-217 effective 9/1/11 AHCCCS DFSM will no longer require concurrent review for inpatient FES member admissions. DFSM may only reimburse for emergencies and complete retrospective review will be necessary to determine whether assessment and treatment meet federal criteria for emergency status.

For purposes of this rule, an emergency medical or behavioral health condition for a FES member means:

A medical condition or a behavioral health condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy,
2. Serious impairment to bodily functions,
3. Serious dysfunction of any bodily organ or part, or
4. Serious physical harm to another person.

"Emergency services for a FES member" mean those medical or behavioral health services provided for the treatment of an emergency condition.

Clinical documentation for FES members should be submitted directly to the FFS Claims Department, along with the FES claim.

PRIOR AUTHORIZATION CHANGES FOR AHCCCS FEE FOR SERVICE

In an effort to reduce the unnecessary burden of prior authorizations for services which are typically determined to be medically necessary, the AHCCCS Division of Fee for Service Management will stop requiring prior authorization for the following services **effective 8/1/2011**.

- C-section delivery admissions that do not exceed 96hrs.
- Vaginal delivery admissions that do not exceed 72hrs.
- Home Health visits-up to the first 5 visits following an acute hospitalization.
- Hysteroscopy -up to 2 (one before and one after, when associated with a family planning diagnosis code, and when done within 90 days of hysteroscopic sterilization.)

BENEFIT LIMITS & PA POLICY

Due to the upcoming benefit limits, including the 25 day limit on inpatient hospital days for adults, it is important to reiterate the FFS policy regarding prior authorization. Please keep in mind that prior authorization is not a guarantee of payment. DFSM will continue to prior authorize some inpatient days even when the member has already reached the 25 day limit. This will allow a hospital to be paid for those days in the event that prior days must be recouped. Therefore, it is important to remember that while prior authorization is required for most inpatient stays, prior authorization is performed to confirm medical necessity and it does not guarantee that the claim will be paid.

AHCCCS RESPITE BENEFIT CHANGE EFFECTIVE OCTOBER 1, 2011

BACKGROUND

On March 15, 2011, Governor Brewer presented her plan to preserve Arizona's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State's General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget. The Medicaid Reform Package includes changes to the AHCCCS member benefit package and can be found on the AHCCCS website at the following Address:

<http://www.azahcccs.gov/shared/news.aspx#GovernorBrewersMedicaidReformPackage>

BENEFIT CHANGE

Beginning October 1, 2011, the annual limit of covered respite hours will be 600 hours during each October 1 through September 30 time period. (Prior to October 1, 2011, the annual limit is 720 hours per benefit year.) The respite benefit change will impact adults and children who are:

- Enrolled in the Arizona Long Term Care System (ALTCS). ALTCS members include individuals who are elderly and/or physically disabled as well as individuals with developmental disabilities, or
- Receiving respite services through the behavioral health system.

If 1) respite services were prior authorized before October 1, 2011, and 2) the authorized respite services will be provided on or after October 1, 2011, the authorization and the amount of services may need to be adjusted to ensure that the annual limit is not exceeded. For additional information providers are encouraged to contact the appropriate Contractor or, for questions concerning FFS members, the AHCCCS Administration.

The proposed AHCCCS Rule may be found at:

<http://www.azahcccs.gov/reporting/state/proposedrules.aspx#Respite> .

NON-COVERED SERVICES & MEMBER BILLING

Providers may charge AHCCCS members for services which are excluded or provided in excess of AHCCCS limits if the provider obtains the member's written agreement to pay for the services in advance of providing the service. However, providers are still prohibited from charging members for non-excluded services provided within the limit when a claim is denied or payment is reduced due to the provider's failure to comply with billing requirements

such as timely claim filing, lack of authorization, or lack of clean claim status. AHCCCS rule R9-22-702 has been revised to clarify the circumstances when registered providers may bill AHCCCS members. The Final AHCCCS Rule may be found at:

<http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx> .

Additional information about the benefit changes can be found at <http://www.azahcccs.gov/shared/news.aspx#Benefits>. Questions regarding the benefit changes can be e-mailed to LegislativeBenefitChange@azahcccs.gov.

AHCCCS BENEFIT CHANGES EFFECTIVE OCTOBER 1, 2011: ANNUAL LIMITS FOR INPATIENT DAYS AND RESPITE SERVICES

BACKGROUND

On March 15, 2011, Governor Brewer presented her plan to preserve Arizona's Medicaid program with reforms that will drive down costs by an estimated \$500 million in the State's General Fund for the partial first year. The plan was approved by the Legislature as part of the FY 2012 budget. The Medicaid Reform Package includes changes to the AHCCCS member benefit package and can be found on our website at the following address:

<http://www.azahcccs.gov/shared/news.aspx?ID=reporting#GovernorBrewersMedicaidReformPackage>

The benefit changes addressed in this memo are the annual limits on the number of hospital inpatient days and the number of hours of respite services available. The inpatient hospital limit will **not** impact AHCCCS members under 21 years of age¹. The change in annual respite hours impacts both adults and children. Benefit changes are effective October 1, 2011.

BENEFIT CHANGES

Inpatient Day Hospital Limit (Adults Only)

The annual inpatient hospital limit impacts individuals 21 years and older and only applies to facility (not professional) services. Members in the acute and long term care programs are subject to the limits, regardless of whether they

¹ AHCCCS is awaiting final approval from CMS.

receive services through managed care or fee for service.² No inpatient limits are placed on persons under 21 years of age.

For persons age 21 and older, AHCCCS will pay hospitals a maximum of 25 days of hospital inpatient care per benefit year (October 1 of each year through September 30 of the following year). Each 24 hours of paid observation services also counts as 1 inpatient day. There are certain exceptions to the annual 25 day inpatient hospital limit such as: inpatient days for behavioral services, transplant services which are reimbursed under component pricing, or certain Medicare beneficiaries for whom AHCCCS is responsible for co-pays and deductibles. Physician services provided to inpatients beyond the 25-day limit will continue to be covered as an AHCCCS benefit.

Refer to Attachment A regarding coordination of benefits.

Respite (Adults and Children)

The decrease in the number of hours of annual respite services available to AHCCCS members will impact both adults and children receiving respite services through the Arizona Long Term Care System (ALTC) or through the Behavioral Health System. Effective October 1, 2011, the number of respite hours paid for by AHCCCS or its Contractors will be reduced to a maximum of 600 hours per benefit year. The benefit year time period is from October 1 through September 30 of the following year. Since respite is not a Medicare covered service, AHCCCS is not responsible for co-pays and deductibles. (Prior to October 1, the annual limit for respite services is 720 hours per benefit year.)

NON-COVERED SERVICES & MEMBER BILLING

Providers may charge AHCCCS members for services which are excluded from AHCCCS coverage or which exceed AHCCCS limits if the provider obtains the member's written agreement to pay for the services in advance of providing the service.

Providers are still prohibited from charging members for non-excluded services provided within the limits when a claim is denied or reduced due to the provider's failure to comply with billing requirements such as timely claim filing, lack of authorization, or lack of clean claim status. For more information, please review AHCCCS rule R9-22-702 which has been revised to clarify the circumstances when registered providers may bill AHCCCS members. As previously mentioned, medically necessary professional services will continue to be covered even when payments to hospitals for inpatient

²At this time, these limits also apply to American Indians regardless of where they receive services. AHCCCS will provide notice if there are any changes.

admissions are not paid by AHCCCS or its Contractors after the limits have been met.

Additional information about the benefit changes can be found at <http://www.azahcccs.gov/reporting/legislation/2011/BenefitChanges.aspx> and <http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx>

Questions regarding the benefit changes can be e-mailed to LegislativeBenefitChange@azahcccs.gov.

**IN-PATIENT LIMIT: MEMBER & CONTRACTOR RESPONSIBILITY
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER
(MEDICAID ONLY, QMB DUAL AND NON-QMB DUAL STATUS)**

CONDITION	CONTRACTOR IMPLEMENTATION (Fiscal Implications)
Member is Medicaid only and is not Medicare eligible. (Also known as non-dual)	Contractor is responsible for payment limited to the first 25 inpatient days per contract year. Contractor is not responsible for payment of inpatient days beginning with the 26 th inpatient day in a contract year. The first 25 inpatient days are the first 25 inpatient days (with dates of service during the contract year) that are paid by the Administration or the member's Contractor-irrespective of whether the date of payment was during or after the contract year. For more information about counting the 25 day inpatient limit and exclusions, refer to the “Adult Inpatient limits and member billing rule: http://www.azahcccs.gov/reporting/state/unpublishedrules.aspx
Member is Dual Eligible (Also known as Medicare Primary, non-QMB dual)	Contractor is responsible for Medicare cost sharing (co-pay, coinsurance, and deductible) associated with all admissions through the admission in which the 25 th inpatient day of the contract year occurs. (Example: a non-QMB dual with 23 prior inpatient days during the contract year is admitted and remains in the hospital for 10 days. Since the admission occurs before the 25-day limit is reached, Contractor is responsible for Medicare cost sharing associated with the 10 days even though the member exceeds the 25-day annual limit during that admission.) Contractor is not responsible for Medicare cost sharing (co-pay, coinsurance and deductible) related to admissions occurring after the first 25 inpatient days per contract year.
Member is QMB Dual	Contractor is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year.
Member is QMB Only	AHCCCS FFS program is responsible for all Medicare cost sharing (co-pay, coinsurance, and deductible) regardless of the number of inpatient days in contract year.

DEFINITIONS:

- **Inpatient Setting** – Acute Care hospital including Specialty Care Hospital and Rehabilitation Hospital (in-state and out of state)
- **Dual Eligible (Non-QMB Dual)** - An individual who is Medicare and Medicaid eligible with income above 100% FPL. The individual does not qualify for QMB.
- **QMB Dual** - An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL.

- **QMB Only** – An individual who is Medicare only who qualifies to have Medicare premiums, co-payments, and deductibles paid by the AHCCCS program.

EXCLUSION

The following inpatient days are not included in the inpatient hospital limitation:

- a. Days reimbursed under specialty contracts between AHCCCS and a transplant facility that are included within the component pricing referred to in the contract³;
- b. Days related to Behavioral Health:
 - i. Inpatient days that qualify for the psychiatric tier under R9-22-712.09 and reimbursed by the Administration or its contractors, or
 - ii. Inpatient days with a primary psychiatric diagnosis code reimbursed by the Administration or its contractors, or
 - iii. Inpatient days paid by the Arizona Department of Health Services Division of Behavioral Health Services or a RBHA or TRBHA.
- c. Days related to treatment of conditions with diagnoses of burns or burn late effect at a governmentally-operated hospital located in an Arizona county with a population of more than 500,000 persons with a specialized burn unit in existence prior to 10/1/2011;
- d. Same Day Admit Discharge services are excluded from the 25 day limit; and Subject to approval by CMS, days for which the state claims 100% FFP, such as payments for days provided by IHS or 638 facilities.

¹ Examples include the following:

- **Evaluation** (Limited to inpatient days directly associated with the evaluation)
- **Harvest** (Tissue harvesting for autologous bone marrow transplants; The related costs/in-pt days for live donors; Note: if the donor is a Medicaid member this will not be included as part of their 25 day limit)
- **Total Body Irradiation** (Limited to the inpatient days associated with the series of conditioning regimens prior to bone marrow or peripheral blood stem cell transplantation)
- **Preparation and transplant** (10 days post transplant care for kidney transplants)
- **Post transplant care** (Up to 60 days for other covered transplants)
- **Placement of Circulatory Assist Devices (CADs)** also known as Ventricular Assistive Devices (VADs) and Total Artificial hearts (TAHs) (Limited to day of surgery; Inpatient days before and after the placement of the CADs are to be counted towards the 25 day limit)

Note: Inpatient days while “wait listed” are to be counted towards the 25 day limit. This is the period of time after a member has been determined to be a candidate for transplant, by the transplant facility, and is waiting for an available organ.

CLAIM TIPS & REMINDERS...

Emergency Services Claims: On the UB-04 claim form, the Admit Type field (field 19) must be "1" (emergency) or "4" (newborn) on all emergency inpatient and outpatient claims. **All other admit types, including "2" (urgent) designate the claim as non-emergent and will be denied.**

Claim Reference Number Fields: The correct fields for documenting an original CRN number on a paper claim, for adjustment or correction, are:

UB-04: #64- "Document Control Number
CMS 1500: #22- "Original Reference Number

"DOC TALK"

A Message from the AHCCCS Medical Director

Jennifer Heaton Amen MD.

Flu Season is Around the Corner

As the temperature starts to give us a break, it's time to start thinking about flu season again. Flu season in Arizona typically runs from October through early May, with the number of cases usually peaking in January or February. October is a great time to start vaccinating because antibodies need at least a couple of weeks in adults to rise to protective levels. In children, this process can take even longer, especially if they are naïve to the flu virus. Children who have never received the flu vaccine may require 2 doses given at least 28 days apart.

This year, there is a new flu vaccine available called Fluzone Intradermal, and it is administered subcutaneously. This vaccine may be given to people ages 18-64 years and contains less antigen than the intramuscular preparations. While studies have indicated that this injection may initially be less painful than the traditional flu shot, the incidence of mild adverse reactions including erythema, swelling, and pruritis at the injection site did appear to be slightly greater. At this time, the CDC is not recommending one method of vaccine administration over another. Because of this and the significant cost differential between the intradermal and traditional flu shot, AHCCCS will not be reimbursing for the cost and administration of the intradermal flu vaccine.

The 2011-2012 flu virus strains that are present in this year's flu vaccine are identical to the strains in the vaccine from 2010-2011. The CDC is still recommending administration of the vaccine to persons who were vaccinated

last season due to studies which indicate that there is a post-vaccination decline in antibody levels over the course of a year.

If you have further questions or concerns about this year's flu vaccine, please see the CDC's full report at <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6033a3.htm>

PERM MEDICAL REVIEW JUST AROUND THE CORNER

It won't be long until the PERM Medical Review Contractor, A+ Government Solutions, Inc will receive the Arizona PERM claims random sample. On Fee-For-Service claims a review of medical documentation for medical necessity is also conducted. If the claims you have submitted are selected in the random sample, A+ Government Solutions, Inc will be sending you a request for medical documentation (heading shown below). Please provide all of the documentation requested to ensure that Arizona has the lowest error rate possible.



Payment Error Rate Measurement Program
c/o A+ Government Solutions, Inc.
CMS PERM Review Contractor
1300 Piccard Drive, Suite 205
Rockville, MD 20850

PERM – INITIAL REQUEST FOR RECORDS

Provider#: <Provider ID>

PERM ID: <PERM ID>

<Provider Name>

Attn: <Medical Record Contact Name>, <Medical Record Contact Title>

<Medical Record Contact Address 1> <Medical Record Contact Address 2>

< Medical Record City>, < Medical Record State> < Medical Record Zip>

Dear Medicaid and/or CHIP Provider:

Date: <Date Sent>

**Please send ASAP but
no later than the due date**

Due Date: <Date send>+74 days

The PERM "Provider Page" can be found at:

http://www.cms.gov/PERM/07_Providers.asp#TopOfPage

If you have any questions regarding PERM, please contact us:

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