





IHS/638 Tribal Providers Quarterly Billing Forum

Second Quarter 2023

Wednesday, May 17, 2023

Time: 2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

Agenda

- Quarterly Tribal Consultation
- IHS/638 Billing Forum
- Mental Health Awareness Month
- Billing Information BH Claims
- The End of the Covid PHE
- 2023 All Inclusive Rate
- American Indian Medical Home (AIMH)
- End of Additional Pharmacy AIR
- Stand Alone Visits
- Attending Provider
- Date Span Requirement (PT 77 and IC)
- Participating Provider Reporting Requirements
- NEMT Reporting Pick Up/Drop Off Addresses
- KidsCare Title XXI Billing Reminders
- Billing Third Party Liability Claims
- Billing Medicare Secondary Claims
- FFS Medicaid Travel Services
- NEMT Services for Attendant Care (Provider Type 40)
- Alternate Care Site (ASC)
- PHE FAQs
- IHS Unlimited Dental Benefits




Upcoming
Quarterly Tribal Consultation Events

AHCCCS
Arizona Health Care Cost Containment System

Upcoming Quarterly Tribal Consultation Events

Quarterly Tribal Consultation Session	June 22, 2023 (Thursday)	1:00 p.m. - 5:00 p.m. (Arizona Time) REGISTER FOR SESSION
Quarterly Tribal Consultation Session	August 10, 2023 (Thursday)	1:00 p.m. - 5:00 p.m. (Arizona Time) REGISTER FOR SESSION
Quarterly Tribal Consultation Session	November 09, 2023 (Thursday)	1:00 p.m. - 5:00 p.m. (Arizona Time) REGISTER FOR SESSION

Please check AHCCCS Tribal Consultation web page for meeting information.




Upcoming
IHS/638 Tribal Billing Forums

AHCCCS
Arizona Health Care Cost Containment System

Upcoming IHS/638 Tribal Billing Forums

IHS/638 Tribal Billing Forum	August 15, 2023 (Tuesday)	2:00 p.m. - 3:30 p.m. (Arizona Time)
IHS/638 Tribal Billing Forum	November 15, 2023 (Wednesday)	2:00 p.m. - 3:30 p.m. (Arizona Time)

Zoom information will be emailed via Constant Contacts at least 5 days prior to the IHS/638 Quarterly Billing Forum.

To sign up to receive information directly via Constant Contacts regarding IHS/638 forums click on Subscribe to DFSM News




Mental Health Awareness Month

May is Mental Health Awareness Month

Mental Health Month was established in 1949 to increase awareness of the importance of mental health and wellness and to celebrate recovery from mental illness. Mental health is essential for a person's overall health.

Make a difference, make an impact!




Clarification of Billing Requirements for Behavioral Health Outpatient Claims

AHCCCS
Arizona Health Care Cost Containment System

Clarification of Billing Requirements for Behavioral Health Outpatient Claims

Effective with claims received on and after May 3, 2023, Fee-For-Service providers billing more than 8 units of any of the following HCPCS codes in one day are required to provide the following documentation with the submission of the claim;

- A copy of the most recent comprehensive assessment,
- A copy of the Treatment plan, and
- The medical record documentation for the service billed on the service date.

Behavioral Health Billing Codes

- H0004 (Behavioral Health Counseling and Therapy)
- H0038 (Self-Help/Peer Services)
- H2011 (Crisis Intervention Service)
- H2014 (Skills Training and Development)
- H2015 (Comprehensive Community Support Services)
- H2017 (Psychosocial Rehabilitation Services)
- H0025 (Behavioral Health Prevention Education Service)
- H2027 (Psychoeducational Service)
- S5150 (Unskilled Respite Care, Not Hospice)
- T1016 (Case Management)
- T1019 (Personal Care Services)

Clarification of Billing Requirements for Behavioral Health Outpatient Claims (cont)

In addition, when billing more than 4 units of **H0034** in one day, providers are required to provide documentation with the submission of the claim including a copy of the most recent comprehensive assessment, treatment plan, and the medical record documentation for the service billed on the service date.

Clarification of Billing Requirements for Behavioral Health Outpatient Claims (cont)

Prior authorization or medical review of services does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the program.

*Failure to submit the required documentation will result in denial of the claim.

Clarification of Billing Requirements for Outpatient BH Claims

Clarification of Billing Requirements for Behavioral Health Outpatient Claims (cont)

- When billing behavioral health claims, each service must be billed on a single line to include the date of service, CPT/HCPCS Code and applicable Units. A claim line with multiple dates of services on a single line is not allowed and will result in a denial of the claim.
- Claim Instruction: This change is applicable to claims submitted Electronically Data Interchange 837P (EDI), paper submissions and via the AHCCCS Online Provider Portal.
- Providers are reminded to bill procedures with the correct modifier combinations, units of service provided and correct code combinations.




Transaction Insight Portal for Outpatient Behavioral Health Providers How to Attach Documentation for Specific BH Service Codes

AHCCCS
Arizona Health Care Cost Containment System

Using the Transaction Insight Portal To Attach Documentation to the BH Claim

Providers that are rendering services to members enrolled in the AHCCCS Fee-for-Service and the American Indian Health Program (AIHP), can submit required documentation to an existing FFS claim using the Transaction Insight Portal (TIBCO) application.

How to Request a Transaction Insight Portal Account

Each member of your team who has a service need to use the Transaction Insight Portal must send an individual email requesting a user account, if they do not have an active account.

The TIBCO log-in credentials will be sent to the email address provided on the service desk request.

Note: Regardless of how the claim was initially submitted, paper, EDI or on the AHCCCS Online portal, the Transaction Insight Portal is the most effective way to attach required documentation to a FFS claim.

Requesting a Transaction Insight Portal Account

To request a Transaction Insight Portal account, FFS providers can email servicedesk@azahcccs.gov you must include the following information:

- Name of your organization,
- Provider Identification Number,

  If you have a NPI number this will be your primary ID number. Providers that are only assigned a six digit AHCCCS provider number the 6 digit ID is your primary number.

- Your full name, and
- Correct (work) email address.

Requesting a Transaction Insight Portal Account

Once you receive your login information, you can access the Transaction Insight Portal at:

https://tiwebprd.statemedicaid.us/AHCCCS/default.aspx?ReturnUrl=%2fAHCCCS%2f




End of the Covid-19 Public Health Emergency (PHE)

End of the Covid-19 Public Health Emergency (PHE)

Effective May 11, 2023, marks the end of the federal COVID-19 PHE declaration.




2023 All-Inclusive Rate

2023 All Inclusive Rate (AIR)

The Federal Register has published the 2023 All Inclusive Rates (AIR).

- CY 2023 Inpatient rate is now $4,333.00, increased from $4,239.00
- CY 2023 Outpatient rate is now $654.00, increased from $640.00

https://www.federalregister.gov/documents/2023/02/27/2023-03896/reimbursement-rates-for-calendar-year-2023




American Indian Medical Home (AIMH)

What is an American Indian Medical Home

The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP).

The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

American Indian Medical Homes help address health disparities that exist between American Indians and other populations in Arizona by offering services and supports which improve access to critically needed care.

Learn more about DFSM's efforts on the AIMH web page.

American Indian Medical Home Provider Requirements

- Be an IHS or Tribal 638 facility,
- Enter into an AIMH Intergovernmental Agreement (IGA),
- Primary Care Medical Home (PCMH) accreditation,
- Provide 24-hour telephonic access to the care team,
- Dependent on selected Tier Level,
  - Provide diabetes education, or
  - Participate bi-directionally in the State Health Information Exchange (HIE).

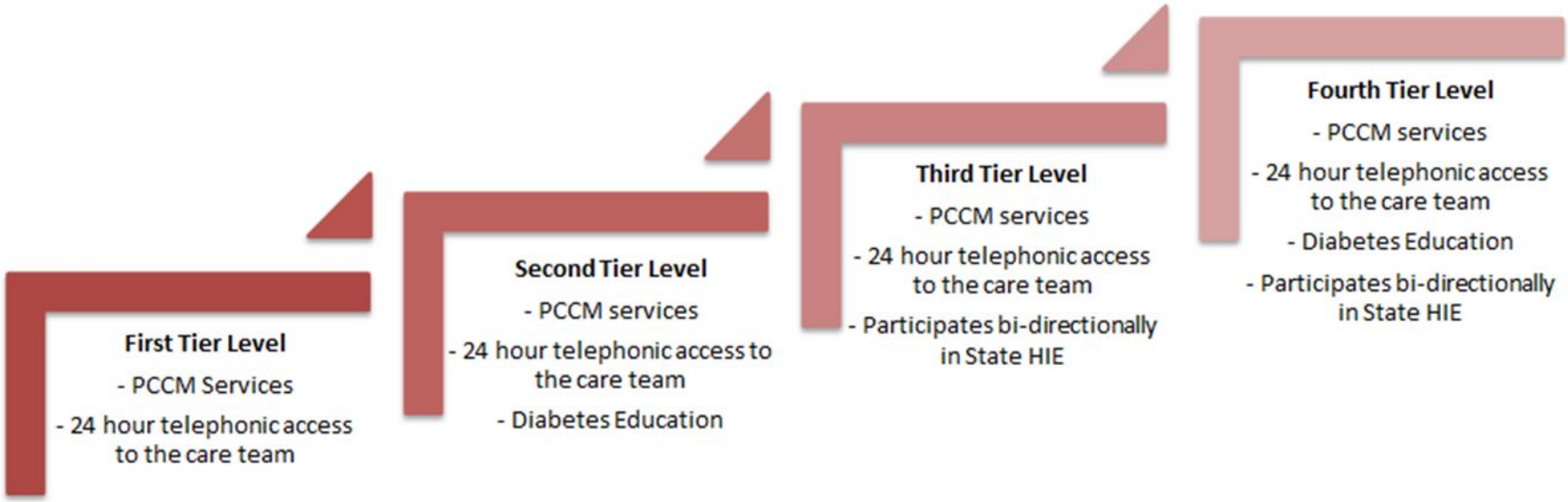
IHS/638 Provider Types that can choose to become an American Indian Medical Home Provider

Provider Type	Description
02	Hospital
05	Clinic
29	Community Rural Health Center
C2	Federally Qualified Health Center
C5	638 Federally Qualified Health Clinic (FQHC)
IC	Integrated Clinic

AIMH Reimbursement Rates

- Facilities who choose to become an AIMH will receive a Prospective Per Member Per Month (PMPM) rate for services provided by their medical home.
- Payments are dependent upon the AIMH tier level selected.
- Tier levels (4) include annual rate increases.

American Indian Medical Home Tiers



AIMH Reimbursement Rates CY2023

AIMH 4.6% Rate Increase Calculation 10- Year Forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Level 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
Level 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
Level 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
Level 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Chinle Comprehensive Healthcare	4	14,363
Fort Yuma Health Care	1	10
Parker Indian Health Center	1	994
Phoenix Indian Medical Center	2	5,578
San Carlos Apache Healthcare	4	5,591
Tuba City Regional Healthcare Corporation	4	2,569
Whiteriver Indian Hospital	2	6,618
Winslow Indian Health Care	4	4,116




The End of the Additional Reimbursements of the Pharmacy All Inclusive Rate (AIR) for the Administration of COVID-19 and Influenza Immunizations

End of Additional Reimbursement at the AIR For Covid-19 and Influenza Administrations

TimeLine:

- ***Prior to November 23, 2020*** all IHS/638 pharmacies were allowed one pharmacy AIR per day at the point of sale (POS) through OptumRX.
- ***Beginning November 23, 2020*** additional All Inclusive Rate (AIR) reimbursements were permitted for IHS/638 pharmacies for COVID-19 and Influenza immunizations.
- ***Effective May 11, 2023*** the end of the Public Health Emergency (PHE) period was declared and the additional pharmacy AIR allowances is no longer permitted.

End of Additional Reimbursement at the AIR For Covid-19 and Influenza Administrations

- As a reminder, AIRs for COVID-19 and influenza immunizations, submitted to the PBM on or after May 11, 2023, shall be reimbursed for zero dollars ($0.00) when it is not the first point-of-sale claim adjudicated by the pharmacy benefit manager, OptumRx, for the member on that date of service.
- The pharmacy AIR shall be reimbursed once daily per member per facility pharmacy through the point-of-sale system.

Additional Pharmacy AIR for COVID-19/Influenza Ending

Additional information may be found in the following manual.

IHSProviderBillingManualChapter10Pharmacy

FFSProviderBillingManualChapter12Pharmacy

Vaccine Memo:

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/MemoUnwindingFluandCovidAIRs.pdf




IHS/638 Billing
Stand Alone Visits, Clinic Visits, Lab Services and Orphan Visits

AHCCCS
Arizona Health Care Cost Containment System

Clinic Visits

- A clinic visit is inclusive of all services provided in conjunction with the visit and includes any laboratory service that may be performed on the same day, before, or after the clinic visit.
- The AIR that is paid for the clinic visit (encounter) includes the laboratory services done on the same day or any other day.

Stand Alone Visit

- The federal OMB all inclusive rate (AIR) encompasses all services performed and/or ordered during the clinic visit including labs, x-ray and imaging. The technical component identified with the use of the (TC) modifier cannot be billed separately.
- A “Stand Alone Visit” is a visit (encounter) that occurs in conjunction with a clinic visit, either before or after that clinic visit, but on a separate day.
- As a matter of policy AHCCCS does not reimburse Stand Alone Visits for lab services.

Lab Tests Associated with a Clinic Visit

There are many components to a patient visit, for example; a examination, a pharmacy order, and/or a laboratory test. A lab test that is ordered during a clinic visit but is done on another day is not considered an “Orphan Visit” and cannot be billed separately.

Lab Tests Performed by a Independent Lab

If an outside laboratory instead of the IHS/638 clinic performs a pathology/laboratory service, the AHCCCS registered independent lab must bill AHCCCS medicaid directly.

Services must be submitted on the CMS 1500 claim form and will be reimbursed at the fee-for-service rate.

Orphan Visit

An “Orphan Visit” is a *planned laboratory visit* based on the provider’s care plan, i.e. a new medication and a laboratory assessment is required after treatment initiation. Since this Orphan Visit is a planned laboratory visit, the patient is checked in, a visit is created and the labs are performed. Documentation must reflect this is an Orphan Visit and must be supported in the provider’s care plan.

Billing: The Orphan Visit can be billed separately as an outpatient claim, reimbursable at the AIR and is counted as one of the allowable visits per day.

Stand Alone Visits for Radiology Services

AHCCCS does reimburse for Stand Alone Visits for radiology and medical imaging professional services.

AHCCCS registered radiologists may bill for their interpretation services on a CMS 1500 claim form with HCPCS/CPT codes and Modifier -26.




Reminder: Attending Providers

Attending Provider Billing Information

Effective with date of discharge 01/01/2016 the attending provider's NPI must be included on the UB-04. The attending provider must be an active AHCCCS registered provider in good standing on the date of service.




Billing Reminders for Behavioral Health Outpatient (77) and Integrated Clinics (IC)

Reminders: Date Span Billing Requirements

Effective with dates of service 2/17/2023, Provider Types 77 (Behavioral Health Outpatient Clinic) and IC (Integrated Clinics) submitting claims to AHCCCS Division of Fee for Service (FFS)Management must list a single claim line for each date of service and must include:

- Each service line billed must be equal to one (1) day of service,
- CPT/ HCPCS code and,
- The total units for each line of service.

Important Note: AHCCCS DFSM will deny any claim line submitted by provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Reminders: Date Span Requirements

Example of a Correct Claim Submission:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	13	23	02	13	23	11		H0004	HQ		95 00	4		NPI	1234567890
2	02	14	23	02	14	23	11		H0004	HQ		95 00	4		NPI	1234567890
3	02	15	23	02	15	23	11		H0004	HQ		95 00	4		NPI	1234567890

SUPPLIER INFORMATION

Example of a Incorrect Claim Submission:

	24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	13	23	02	28	23	11		H0004	HQ		1500 00	480		NPI	1234567890
2															NPI	
3															NPI	

SUPPLIER INFORMATION




Participating Provider Reporting Requirements

Participating Provider Reporting Requirements

Effective for dates of service on and after January 1, 2023, the following provider types must report the actual professional practitioner (provider) participating in/performing services associated with clinic visits.

- Provider Types:
  - Integrated Care Clinic (PT IC),
  - Behavioral Health Outpatient Clinic (PT 77) and,
  - Clinic (PT 05)

Participating Provider Reporting Requirements (cont.)

- Providers must follow the requirements outlined in Exhibit 8-2 in the AHCCCS IHS/Tribal Provider Billing Manual for the participating provider reporting requirements and billing instructions for proper claims submissions.
- ***Effective July 1, 2023***, any claim filed without the participating provider information will be systematically denied.
- IHS/Tribal Provider Billing Manual, Exhibit 8-2 Participating Provider Information




Non-Emergency Medical Transport (NEMT) Reporting Pickup and Drop-off Information

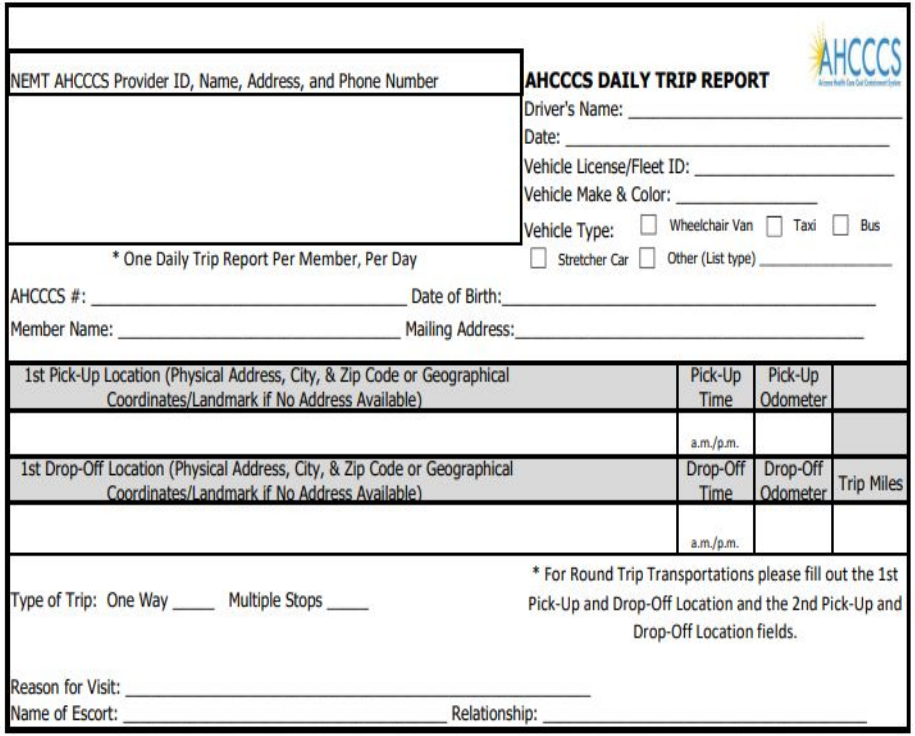
AHCCCS
Arizona Health Care Cost Containment System

Reporting Pickup/Drop-Off Information

- Reminder effective for dates of services 11/01/2022 and after, the pickup (PU) and drop-off (DO) information must be reported on each claim submission.
- This change applies to paper submissions on the *CMS 1500* claim form, electronic *EDI (837P)* transaction and the *AHCCCS Online Provider Portal.*

Reporting Pickup/Drop Off Information

- The pickup and drop-off information can be entered in the ***Additional Claim Information*** field (Box 19) and note spacing is limited.
- For NEMT claim submissions, providers must continue to include a copy of the AHCCCS Daily Trip Report with each claim.



NEMT AHCCCS Provider ID, Name, Address, and Phone Number

AHCCCS DAILY TRIP REPORT

Driver's Name: _____

Date: _____

Vehicle License/Fleet ID: _____

Vehicle Make & Color: _____

Vehicle Type: ☐ Wheelchair Van ☐ Taxi ☐ Bus ☐ Stretcher Car ☐ Other (List type) _____

* One Daily Trip Report Per Member, Per Day

AHCCCS #: _____ Date of Birth: _____

Member Name: _____ Mailing Address: _____

1st Pick-Up Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	Pick-Up Time	Pick-Up Odometer	
	a.m./p.m.		
1st Drop-Off Location (Physical Address, City, & Zip Code or Geographical Coordinates/Landmark if No Address Available)	**Drop-Off Time**	**Drop-Off Odometer**	**Trip Miles**
	a.m./p.m.		

Type of Trip: One Way ____ Multiple Stops ____

* For Round Trip Transportations please fill out the 1st Pick-Up and Drop-Off Location and the 2nd Pick-Up and Drop-Off Location fields.

Reason for Visit: _____

Name of Escort: _____ Relationship: _____

Reporting PU\DO Information (cont.)

- As spacing may be limited in the additional claim information field, we suggest to abbreviate an address to allow more characters, i.e., St, Rd, Ave, Ln, Blvd.
- If a house or street assignment is not available for the pickup, providers can enter the GPS coordinates for the pickup information.
- Do not enter the city and state. The Zip code is ***required*** and is used to identify the city and state
- Example:

NEMT PU/DO Address Updates (cont.)

- If the pickup and drop-off information is missing or incomplete this will result in an automatic denial of the claim.
- Below are the most common denial reason codes that may appear on the remittance advice if the pick-up and drop off information is missing and or incomplete on the claim form.

Denial Reason Code	Description
L214.3	Incomplete address and Zip Code
L214.4	No Address Listed

Reminder: NEMT Covered Transports

AHCCCS covers medically necessary non-emergency medical transportation (NEMT) to and from an AHCCCS covered medical or behavioral health service for most members.

Members must be transported to a AHCCCS registered provider.

Transports that do not meet the criteria set forth in the IHS billing manual cannot be billed to AHCCCS.

Reminder: NEMT Services Transports

- Transportation is limited to the cost of transporting the member to and from either of the following active AHCCCS registered provider locations capable of meeting the member's needs:
- The nearest appropriate IHS/Tribal 638 medical or behavioral health facility, or
- The nearest appropriate medical or behavioral health provider.
- Transport services are covered to transport a member to obtain Medicare Part D covered prescriptions.
- Effective for dates of services on or after 07/01/2022 AHCCCS FFS will no longer cover NEMT transports to local community-based support programs.




KidsCare (XXI) Billing Information

Title XXI KidsCare Claims Submissions

If the member is enrolled in an ACC Plan	Submit the claim to the ACC plan.
If the member is enrolled in AHCCCS FFS or AIHP	Submit the claim to AHCCCS DFSM.

Billing Reminders Title XXI KidsCare

AHCCCS covered services provided to Title XXI (KidsCare) members are not reimbursable at the All-Inclusive Rate (AIR).

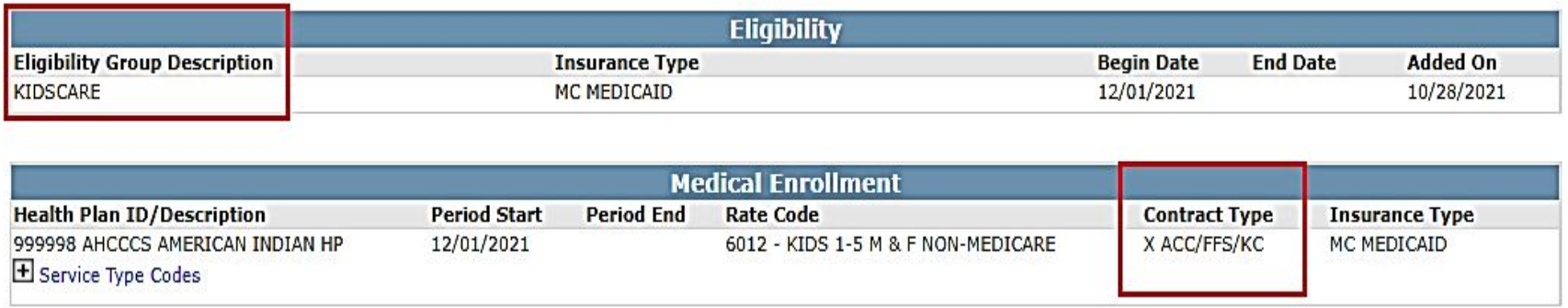
- Billing example: A claim is submitted for a member enrolled in the FFS KidsCare program and billed on the UB-04 claim form.

In this example the denial code is AD102. The description reads "IHS/638 KidsCare must bill on the CMS 1500, Dental (ADA) or Point of Sale for (pharmacy services)".

Verifying Title XXI KidsCare Enrollment

Providers can verify eligibility and enrollment for any member enrolled with AHCCCS Medicaid using the AHCCCS Online Provider Portal.

Select the member verification tab, under the field title **Eligibility Group Description** you will see KidsCare. Under the field title **Contract Type** you will see ACC/FFS/KC (KidsCare).



Eligibility

Eligibility Group Description	Insurance Type	Begin Date	End Date	Added On
KIDSCARE	MC MEDICAID	12/01/2021		10/28/2021

Medical Enrollment

Health Plan ID/Description	Period Start	Period End	Rate Code	Contract Type	Insurance Type
999998 AHCCCS AMERICAN INDIAN HP	12/01/2021		6012 - KIDS 1-5 M & F NON-MEDICARE	X ACC/FFS/KC	MC MEDICAID
⊞ Service Type Codes					




Billing Third Party Liability Claims

Third Party Liability (TPL) Secondary Claims

- Providers must follow AHCCCS FFS claim submission billing guidelines even when AHCCCS is the secondary payer.

- When submitting a secondary claim, providers must include the primary payer's *Explanation of Benefits (EOB)* which details how the claim was processed and or denied by the payer.

Third Party Liability (TPL) Secondary Claims

- **Filing a Reconsideration:**
  - Providers must follow the primary payer's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the primary payer's appeal decision for consideration of reimbursement of the claim.




Billing Medicare Secondary Claims

Medicare Parts A, B, C and D

Medicare Part A

Covers inpatient care in hospitals, skilled nursing facility, home health, hospice care and more.

Medicare Part B

Covers physician services, durable medical equipment X-rays, labs, etc.

Medicare Part C

Also referred to as a Medicare Advantage plan, which combines Medicare parts A, B, and may also include Medicare Part D drug coverage.

Medicare Part D

Provides prescription drug coverage.

Reminders: Billing Medicare Secondary Claims

- Medicare pays first for members enrolled in Medicare Parts *A ,B, C and D* coverage.
- Medicare secondary claims refers to any claim for which AHCCCS is the secondary payer after Medicare and any other third-party payers.
- The amount considered by AHCCCS Medicaid will be the copay, coinsurance or deductible as indicated on the MEOB.

Reminders: Billing Medicare Secondary Claims (cont.)

- AHCCCS will consider Medicare secondary claims even if the claim includes procedures that were not covered by Medicare.
- Medicare claims that were not automatically crossover to AHCCCS, a copy of the MEOB is required with each claim submission.
- All services billed to AHCCCS are subject to Medicaid policy and are subject to review.

How to Submit a Reconsideration Request for a Medicare Crossover Claim

- If Medicare adjusted a previously paid claim and there is no change in the coding details a replacement claim is not needed.
- Providers will only need to submit a copy of the original and adjusted MEOBs with the reconsideration request.
- This information can be submitted via Fax or the 275 Transaction Insight Portal.

Submitting Medicare Secondary Claims

- When submitting a secondary claim, please include the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* information identifying why Medicare denied the claim, this may be due to exhausted benefits, medical necessity or eligibility, or another reason that may apply.
- Reconsiderations:
  - Providers must follow Medicare's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the Medicare appeal decision for consideration of reimbursement of the claim.




AHCCCS FFS New Vendor Notification
Medicaid Travel Services Provider

AHCCCS
Arizona Health Care Cost Containment System

Medicaid Travel Services Provider

The Arizona Health Care Cost Containment System (AHCCCS), Division of Fee-for-Service Management has contracted with Medical Transportation Management (MTM) to coordinate services for medically necessary lodging and meal reimbursement for AHCCCS Fee-for-Service (FFS) members. MTM will assume responsibility of providing the coordination services as of February 1, 2023.

Lodging and meal services will be arranged by MTM, however, the AHCCCS Utilization Management (UM) department will continue to provide prior authorization oversight for these services. Manual 310-BB.




Attendant Care Provider Type 40 Providing (NEMT) Services

Attendant Care (PT 40) and NEMT Services

- As a reminder effective 06/01/2015, providers registering as a provider type 40 (Attendant Care Agency) will be required to be an AHCCCS registered provider for a period of twelve (12) months prior to being able to bill for non-emergency medical transportation (NEMT) services.
- Upon completion of the 12-month period attendance care provider types will be able to provider and bill NEMT services.
- NEMT services must be to and from an AHCCCS covered physical or behavioral health service rendered by a AHCCCS registered provider.
- The AHCCCS Daily Trip Report must be submitted with each claim.

Attendant Care (PT 40) and NEMT Services (Cont.)

However, the NEMT services should not exceed 30% of the overall services billed.

This guidance may be found in the IHS/Tribal Provider Billing Manual.

- IHS/Tribal Provider Billing Manual, Chapter 3, Provider Records and Registration
- IHS/Tribal Provider Billing Manual, Chapter 11, Transportation

Important Note: The NEMT benefit remains unchanged as outlined in the AHCCCS Medical Policy




Alternate Care Sites IHS/638 Tribally Operated Facilities

Alternate Care Sites IHS/638 Facilities

In alignment with the end of the COVID-19 PHE, the use of Alternative Care Sites (ACS) established by Indian Health Service (IHS) or Tribally owned/operated 638 facilities will end on dates of service starting May 11, 2023.

All services and reimbursements related to this flexibility will be discontinued in conjunction with the end of the PHE and the rollback of the CMS 1135 Blanket Waiver. This applies to all AHCCCS reimbursement of IHS and 638 facilities for services rendered at an ACS.

For additional information please refer to the Division of Fee-for-Service Management (DFSM) Alternate Care Site Memo.




COVID-19 Public Health Emergency (PHE) FAQs and Updates

COVID-19 Updates

6. *(updated 3/7/23)* Question: Does AHCCCS reimburse IHS and 638 providers for services rendered at an Alternate Care Site (ACS)?

Answer: Per the COVID-19 Emergency Declaration Blanket Waivers & Flexibilities for Health Care Providers document released by CMS, AHCCCS will reimburse for services provided at or through an ACS, with a retroactive effective date of March 1, 2020 through the end of the emergency declaration. Such services shall be reimbursable, so long as those services performed are administered to a Title XIX or Title XXI eligible AHCCCS member, and are medically necessary, cost-effective, federally and state reimbursable, provided by an AHCCCS-registered provider.

COVID-19 Updates

6. *(updated 3/7/23)* Question: Does AHCCCS reimburse IHS and 638 providers for services rendered at an Alternate Care Site (ACS)? (Cont.)

In alignment with the end of the COVID-19 PHE, the use of Alternative Care Sites (ACS) established by Indian Health Service (IHS) or Tribally owned/operated 638 facilities will end on dates of service starting May 11, 2023. All services and reimbursements related to this flexibility will be discontinued in conjunction with the end of the PHE and the rollback of the CMS 1135 Blanket Waiver. This applies to all AHCCCS reimbursement of IHS and 638 facilities for services rendered at an ACS. For additional information please refer to the Division of Fee-for-Service Management (DFSM) Alternate Care Site Memo.




IHS/638 Dental Limits Updates

Dental Limit Eliminated for AI/AN Receiving Services at IHS/638 Tribal Facilities

Effective 10/14/2022:

- The $1000 dental services limits for AI/AN members over 21 years of age, and AI/AN ALTCS members, receiving services for Medically necessary diagnostic, therapeutic, and preventative dental services at IHS/638 facilities are eliminated.
- This expenditure authority applies only when dental services are provided to American Indian/Alaskan Native (AI/AN) beneficiaries who receive services from participating IHS facilities and/or participating Tribal 638 facilities.

Dental Services Performed Outside IHS/638 Facilities

AHCCCS covered dental services performed outside of the IHS/638 Tribal facilities remain limited to the $1000 Emergency Dental Benefit for members 21 years of age and over, and additional $1000 for members enrolled in ALTCS.




DFSM Provider Education and Training Unit

DFSM Provider Education and Training

Our goal is to help providers understand billing policy and successful claim submission for the FFS program.

The provider training team offers eLearning and video training presentations on specific topics which are in a self-paced format that allows providers to access trainings.

We encourage the attendance of billing staff and agencies, practitioners and others.

DFSM Provider Education and Training

The provider training schedules are posted quarterly on the DFSM Provider Education Web page and registration is required to attend.

- DFSM Provider Training includes at any time and provide important information about how to use the AHCCCS Online Provider portal and the Transaction Insight Portal, recorded webinars and job aids for FFS providers.
- Courses can be attended remotely from any location via Zoom. To register for a session, click on the "Zoom Registration Link".
- For additional training videos, providers can visit the AHCCCS Medicaid YouTube Channel.

IHS 638 Provider Billing and Policy Resources

AHCCCS FFS Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual:

- https://www.azahcccs.gov/shared/MedicalPolicyManual/
- https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/MemoUnwindingFluandCovidAIRs.pdf

Questions?

Thank You.