





IHS/638 Tribal Providers Quarterly Billing Forum

Second Quarter 2024

Wednesday, June 26, 2024
2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

Topics

- Upcoming Events:
  - IHS Tribal ALTCS Consultations
  - IHS/638 Tribal Billing Forums
- Provider Moratorium Update
- June-National Safety Month
- AHCCCS Virtual Assistant (AVA)
- American Indian Medical Home (AIMH)
- Transaction Insight Portal Documentation Upload and Reminders
- Provider Work Number (PWK)
- Non-Emergency Medical Transportation (NEMT) Reminders and Denial Codes
- KidsCare Billing
- Hysterectomy and Sterilization Consent Forms
- Third Party Liability (TPL) Billing Reminders
- Medicare and Claims Processing
- Submitting a Non-Medicare Crossover Claim
- Tribal Self Insurance Plans
- Intensive Outpatient Program Billing Updates
- Appropriate Use of Respite Services
- Behavioral Health Documentation Requirements




Provider Moratorium Update

Provider Moratorium Update

In accordance with Section 42 CFR 455.470, Arizona Health Care Cost Containment System (AHCCCS), will implement for an additional 6 months a statewide moratorium on the enrollment of Behavioral Health Outpatient Clinic, Integrated Clinic, Non-Emergency Medical Transportation, Community Service Agencies, and Behavioral Health Residential Facility providers.

This moratorium extension will expire on December 9, 2024. This moratorium allows provider enrollment applications to be considered for an exemption on a case by case basis, under any of the following circumstances:

Provider Moratorium Update (cont.)

This moratorium extension will expire on December 9, 2024. This moratorium allows provider enrollment applications to be considered for an exemption on a case by case basis, under any of the following circumstances:

1. Medically Underserved Service Area and access to care with review and approval by State Medicaid Agency,
2. Service expansion in support of a State Medicaid Agency initiative,
3. At the request of an AHCCCS contracted managed care plan to ensure that access to care standards (i.e., time and distance) are not out of compliance, or
4. Additional exemptions as appropriate and as needs are identified




Upcoming Events

AHCCCS Tribal Consultations

AHCCCS Quarterly Tribal Consultation Events

Consultation Type	Date/Time	Time	Location	Zoom Registration
Quarterly Tribal Consultation Session	August 5, 2024 (Monday)	8:30am – 4:30pm	Hybrid (To be Determined)	Zoom Registration Link
Quarterly Tribal Consultation Session	November 14, 2024 (Thursday)	8:30am – 4:30pm	Hybrid (To be Determined)	Zoom Registration Link

Please check AHCCCS Tribal Consultation web page for meeting information.

IHS/638 Tribal Providers Quarterly Billing Forum 2024

Quarterly Billing Forums	Date/Time	Time	Zoom Registration
IHS/638 Tribal Providers Quarterly Billing Forum	September 25, 2024 (Wednesday)	2:00pm – 3:30pm	Third Quarter Zoom Registration
IHS/638 Tribal Providers Quarterly Billing Forum	December 18, 2024 (Wednesday)	2:00pm – 3:30pm	Fourth Quarter Zoom Registration

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




June is National Safety Month

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June is National Safety Month

June is National Safety Month. As the summertime weather start to reach higher than average temperatures, heat related illnesses can happen when the body is not able to properly cool itself. Remember to stay cool during the summer weather by staying hydrated, wearing weather-appropriate clothing, and scheduling outdoor activities during the morning or evening.



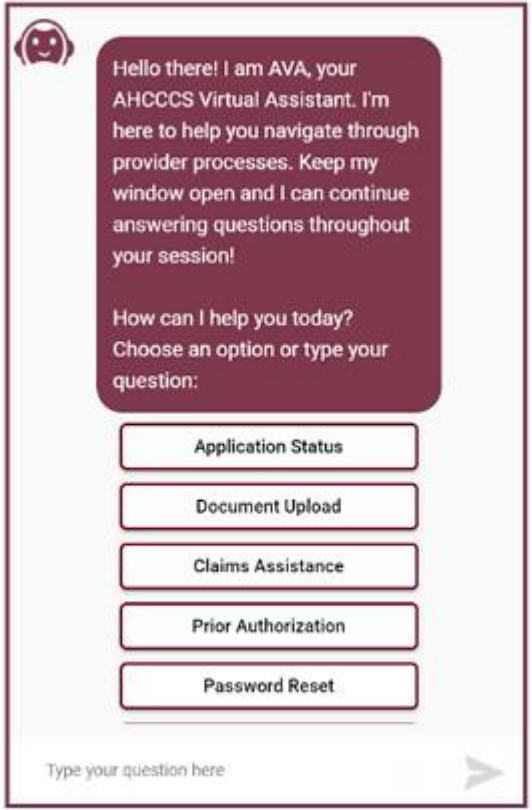

AHCCCS Virtual Assistant (AVA)

AHCCCS Virtual Assistant (AVA)

We have exciting news! AVA, our virtual chatbot, has been upgraded to make it easier to get answers to your most common provider questions, including provider enrollment, revalidation, claims, and prior authorizations.

If you have a complex question or simply want to chat with someone live, AVA can route you to a live chat specialist for help during business hours. Depending on your question, you may need to provide verification info like the provider NPI, the AHCCCS provider ID, or claim number to receive a personalized answer, so be sure to have that available.

You can find AVA at the bottom right-hand corner of the AHCCCS homepage, AHCCCS Online, and the APEP portal.






American Indian Medical Homes (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.

IHS/638 Qualifying Provider Types
American Indian Medical Home Provider

The following IHS/638 Tribal provider types may elect to become an AIMH.

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 and Provider Requirements

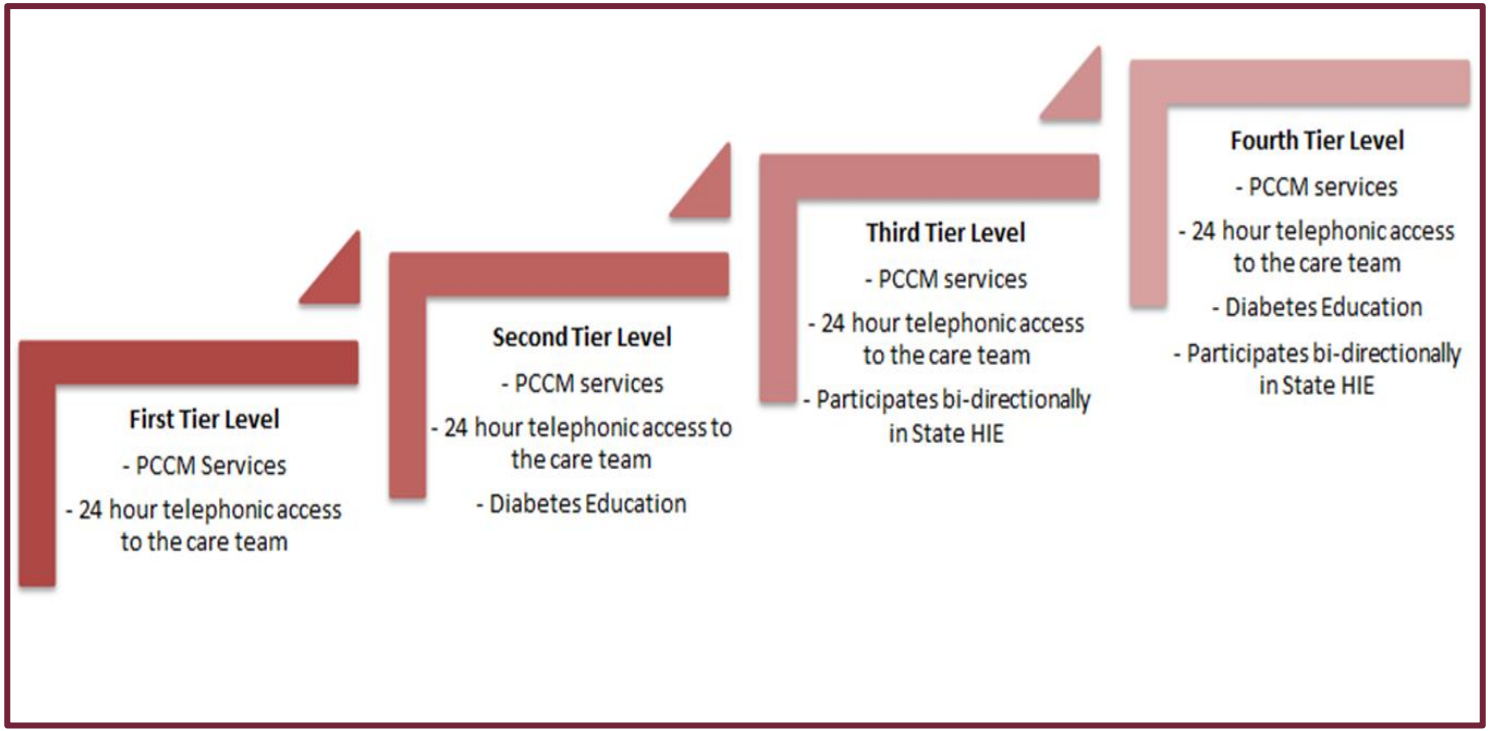
Facilities who choose to become an AIMH will receive a *Prospective Per Member Per Month (PMPM)* rate for services provided by their medical home.

- Payments are dependent upon the AIMH tier level selected.
- There are 4 Tier levels which includes annual rate increases.

AIMH Provider Requirements:

- Must be an IHS or Tribal 638 owned and operated facility,
- The provider must 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).

American Indian Medical Home Reimbursement Tiers



AIMH Reimbursement Rates CY 2024

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



Second Quarter AIMH Enrollments

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Chinle Comprehensive Healthcare	**4**	**13,201**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Fort Yuma Health Care	1	8

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Phoenix Indian Medical Center	**2**	**4,805**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Parker Indian Health Center	1	1,076

Current AIMHs and Members

American Indian Medical Home	Tier Level	Member Enrollment
San Carlos Apache Healthcare	**4**	**5,704**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Tuba City Regional Healthcare Corporation	**4**	**4,341**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Whiteriver Indian Hospital	**2**	**6,182**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Member Enrollment
Winslow Indian Health Care	**4**	**3,638**




Transaction Insight Portal (TIBCO)
Uploading Claim Attachments

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Uploading Claim Attachments using the Transaction Insight Portal

The Transaction Insight Portal is a tool that gives registered providers that are servicing members enrolled in the Fee-for-Service program including, American Indian Health Program (AIHP), ALTCS and Tribal Health Program (DD THP) access to attach required documentation to any type of claim form submission.

Need a User Account: How to Request a Transaction Insight Portal Account

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 Fee-for-Service claim.

Important:

- Each team member must have an individual TIBCO account.
- Requesting an account is easy - send your request to Servicedesk@azahcccs.gov
- Provider Identification Number,

  Important Note: Providers that are assigned a NPI number this is your primary ID number used for claim submissions and TIBCO.
- The service desk will forward confirmation of your TIBCO access code to the email address that you provide.
- Sharing of account information is **prohibited.**

275 Transaction Insight Portal Trading Partner Agreement

- AHCCCS FFS providers are not limited to using the AHCCCS TIBCO application. Did you know that your billing company or clearing house can request to become a 275 Transaction Insight Portal Trading Partner with AHCCCS. The AHCCCS Information Services Division (ISD) Service Desk is the first point of contact for all questions related to submission of electronic transactions and data
- The preferred method of contact is email. All inquiries/requests will result in a Customer Support Ticket Number assignment.
- Contact information: Email: servicedesk@azahcccs.gov
- If you are interested in signing up to become a 275 Trading Partner, please review the guide below:

www.azahcccs. gov/Resources/Downloads/EDIchanges/CCICompanionGuide.pdf




TIBCO Reminders

TIBCO Reminders

If you are using the Claim Reference Number (CRN) as your Payer Claim Control Number, you must use the **AHCCCS 12-digit CRN** (do not include the service line number i.e., 001, 002) as this is not part of the claim number used in TIBCO.

TIBCO Reminders (cont.)

It is the providers office's responsibility to keep track of the documents they upload. Providers can create a simple tracking tool such as shown in the example below:

Claim Submission Information			Transaction Insight (TI) Portal Information			
Claim Source (837 or Online/Web)	Claim Record Number (CRN#)	Claim PWK#	First Name and Last Name of staff who uploaded the trip reports	Date/Time Trip Reports were uploaded	10-digit NPI or 6-digit Provider ID	Payer Claim Control Number or Provider Attachment Control Number




Provider Work Number (PWK)

Provider Work Number (PWK)

1. The PWK Number is created during the initial submission of the claim and is populated on the Attachment tab.

2. The PWK number can also be created if the provider is using their own software, billing company or clearing house to submit the claims.

3. Did you know providers can submit a “trading partner agreement” request to set up the 275 Transaction Insight application using your software/app.

4. The PWK number (**A12345678032720**24) is unique to each claim submission including when a replacement claim is submitted.

5. If the same PWK number (**A12345678032720**24) is used for the replacement claim, the documents will link to the first claim. To link documents to the replacement claim, there must be a unique character at the end, for example (**A12345678032720**24**R1**). It is the provider's choice how to make the PWK number unique when submitting a replacement or correction claim.




Non-Emergency Medical Transportation (NEMT) Reminders

NEMT Reminders

The AHCCCS Daily Trip Report must be completed correctly and submitted with each NEMT claim.

Common errors include but are not limited to the following:

- Missing member and driver signatures
- Driver full name not entered,
- Driver information not provided to the program,
- Missing / invalid vehicle type,
- Under reporting of actual trip miles,
- Incorrect reporting of trip miles per member,
- Alterations to the AHCCCS Daily Trip Report,
- NEMT transports are to a service that is NOT covered under the program.

Exhibit 11-2, Non-emergency Medical Transport Daily Trip Report Instructions

Common NEMT Errors

Common errors made by NEMT Providers include the following:

- Lack of Disclosing Employee Information such as:
- Employee Name
- Employment Begin Date
- Employment End Date (if applicable)
- Employees Date of Birth
- Member Transported to a Service Not Covered by AHCCCS
- Incomplete or Incorrectly Filled Out Trip Report

Common NEMT Erros (cont.)

Missing Driver's Name:

- The Daily Trip Report may be missing the Driver's First and Last Name. This is not acceptable. The trip report MUST have the Driver's full First and Last Name listed.

No Facility Address Listed:

- Another common error is to have the facility name listed, instead of an address under the pick-up/drop-off section. However, the facility address is REQUIRED information.
- An address must be included in some format.
- The lack of a formal street address is not a cause for no address to be listed.
- In the event that no address can be found, coordinates of a nearby landmark, with the mileage from that landmark to the pick-up/drop-off location can be used.




Non-Emergency Medical Transportation (NEMT) Edit Denial Codes

AD101 and AD222

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NEMT Edit Denials

AD101-Incorrect Procedure Code for Service:

This edit is a manual claim review denial. NEMT claims the vehicle type identified on the AHCCCS Daily Trip report must match the HCPCS base code billed. The provider must review the claim and coding to determine if a correction claim is required for processing.

Exhibit 11-2 Daily Trip Report Instructions

NEMT Edit Denials

AD222-Incomplete trip report:

This edit is a manual claim review denial. The provider must review the AHCCCS daily trip report and complete any missing fields and resubmit the trip report.

Providers should not resubmit the claim if there are no changes in coding or charges. The trip report can be uploaded via Transaction Insight Portal (TIBCO) using the AHCCCS 12-digit claim number as the attachment/linking control number.

For instructions on how to complete the AHCCCS Daily Trip report, providers can refer to Exhibit 11-2, Non-emergency Medical Transport Daily Trip Report Instructions




KidsCare Title (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). IHS/638 pharmacies must submit all Fee-For-Service and KidsCare prescription claims electronically at the point-of-sale to the AHCCCS FFS PBM, OptumRx.

- 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 edit code AD102 will present. 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 heading **Eligibility Group Description** you will see KidsCare. Under the field heading **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					




Hysterectomy Consent and Acknowledgement Form

Hysterectomy Consent Form

All claims for hysterectomy services are subject to medical review and AHCCCS requires all claims related to hysterectomy and sterilization procedures to be submitted with Hysterectomy Consent and Acknowledgement form. This form may be found in the AMPM Chapter 800 Exhibit 820.

If this form is not available, the hospital consent form that contains the same information as the Exhibit 820-A can be submitted for consideration.

Hysterectomy Consent Form (cont.)

The consent form must include the following:

- State that the patient will be permanently incapable of having children.
- Signed and dated by the member, the physician who performs the hysterectomy, the person who obtains the member's consent and, if applicable, an interpreter.

For further information please refer to the sections on Hysterectomy Services and Family Planning Services in Chapter 8, Individual Practitioner Services, of the IHS/Tribal Provider Billing Manual.




Sterilization Consent Form

Sterilization Services

AHCCCS requires a completed AMPM Exhibit 420A Federal Sterilization Consent Form to be submitted with all claims for voluntary sterilization procedures.

The Federal consent form outlines the standard requirements for voluntary sterilization to include the following:

- The member must be 21 years of age at the time consent is signed.
- Mentally competent.
- Consent to be voluntary and obtained without duress.
- Thirty days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.

Sterilization (cont.)

- At least 72 hours must have passed since the member gave informed consent for the sterilization if the member is to be sterilized at the time of a premature delivery or emergency abdominal surgery.
- The informed consent must be given at least 30 days before the expected date of delivery in the case of premature delivery.
- The person securing the informed consent and the physician performing the sterilization procedure must sign and date the consent form.
- A copy of the signed Federal Consent Form must be submitted by each provider involved with the hospitalization and/or the sterilization procedure.

Sterilization (cont.)

The sterilization consent **may not** be obtained when an eligible member:

- Is in labor or childbirth,
- Is seeking to obtain or obtaining an abortion,
- Is under the influence of alcohol or other substances that affect that member's state of awareness.

Additional information related to these services and guidelines can be found in the IHS/638 Provider Billing Manual Chapter 8 Individual Practitioner Services




Billing Reminders:
Third Party Liability Claims

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Medicaid and Third-Party Liability

Medicaid enrolled members that have Third Party Liability (TPL) other than Medicare as their primary payer, AHCCCS Administration's reimbursement responsibility is limited to no more than the difference between the AHCCCS capped fee and the amount of the first- or third-party payer's payment.

- Fee-for-Service providers must meet the initial 6 month filing period for claim submissions.
- IHS/638 providers must meet the initial 12 month filing period for claim submissions.

Third Party Liability (TPL) Secondary Claims

Secondary Claim Denials by the Primary Payer

- Secondary claims must be received by FFS within the specified claim submission time frames.
- Claims that are denied by the primary payer, the provider must follow the primary payer's appeal or reconsideration process.
- A copy of the primary payer's appeal decision (EOB) is required for consideration of claim.

Third Party Liability (TPL) Secondary Claims

Secondary Claim Denials by the Primary Payer

- If the claim is reaching the timely filing period and has not been processed by the primary payer, providers may submit the claim to AHCCCS to meet the FFS timely filing timeframe, pending the finalization of the claim by the primary payer.
- The processing of the claim by the primary payer does not extend the timely filing period with AHCCCS FFS.

Medicare Billing and Claims Processing

Medicaid and Medicare Cost Sharing

Medicaid enrolled members who have Medicare as their primary payer, AHCCCS may only be responsible for the *copay, coinsurance and deductible* amounts listed on the Medicare Remittance Advice.

- It is important to submit the MEOB with the claim for processing.
- The MEOB and claim details must match.
- The MEOB reason codes must be listed on the explanation.
- Replacement claims must be submitted with the MEOB.

To review the complete billing information for Medicare and TPL claims please visit: IHS Tribal Provider Billing Manual Chapter 7 Medicare/TPL

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.

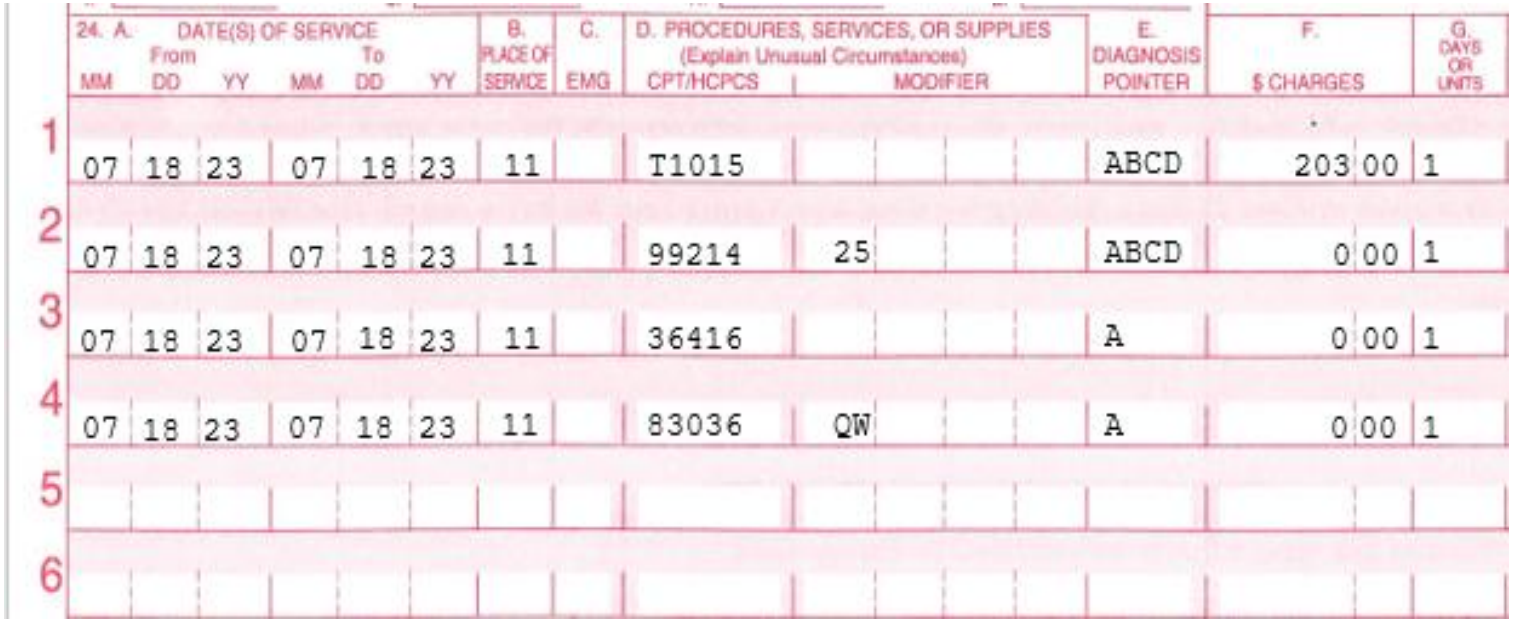
Reminders: Billing Medicare Secondary Claims (cont.)

- 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.

Example: Medicare Primary Claim Service Code T1015

In this example the provider submits a primary claim to Medicare Part B.

The claim was billed with the CPT codes T1015, 99214, 36416 and 83036.



	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
1	07	18	23	07	18	23	11		T1015		ABCD	203 00	1
2	07	18	23	07	18	23	11		99214	25	ABCD	0 00	1
3	07	18	23	07	18	23	11		36416		A	0 00	1
4	07	18	23	07	18	23	11		83036	QW	A	0 00	1
5													
6													

Example: Medicare Primary Claim Service Code T1015

In this example the provider submits a primary claim to Medicare Part B.

The claim was billed with the CPT codes T1015, 99214, 36416 and 83036.

- The Total billed amount $203.00,
- CO-45 Medicare contractual write off amount is $116.82 (this is the amount that exceeds Medicare's fee schedule for the CPT code(s),
- CO-253 $2.02 (Sequestration this is the reduction in federal payment and not included in the payment).
- Medicare total combined payment for each line of service is $98.78
- PR-2 Balance remaining or due is the **Medicare coinsurance amount $54.40**
- To verify the total amount approved by Medicare, add the Medicare paid amount, deductible and coinsurance amounts as shown on the MEOB.

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 MEOB and a copy of the adjusted MEOB with the reconsideration request.
- This information can be submitted with a cover letter indicating the details regarding the submission of the adjusted MEOB for reprocessing via the 275 Transaction Insight Portal (TIBCO).




Submitting a Non-Medicare Crossover Claim

Non-Medicare Crossover Claims

If the "**crossover**" **claim is not** automatically transmitted from **Medicare** and received by Medicaid, then the provider must **submit** a claim to Medicaid. The submission must include a copy of the Medicare EOB for processing.

- AHCCCS timely filing requirements will apply to secondary claims.

Submitting Medicare Secondary Claims

- When submitting a secondary claim, providers must 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.




Tribal Self-Insurance Plans

Tribal Self Insurance Plans

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted, per A.R.S. §36-2946.

Per R9-22-1002, AHCCCS is not the payer of last resort (AHCCCS will be the primary payer) when the following entities are the third-party:

- The payer is Indian Health Services contract health **(IHS/638 Tribal Plan)**; or
- Title IV-E; or
- Arizona Early Intervention Program (AZEIP); or
- Medical services provided through schools under the federal Individuals with Disabilities Education Act under 34 CFR Part 300; or
- Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. Seq.

Tribal Self Insurance Plans

Members with Tribal Self Insurance plans, providers must submit a letter/document from the TPL plan confirming the plan is a Tribal Self Insurance plan. The document must include the following information:

- The document must indicate that the type of insurance is a tribal self-funded plan.
- The document must be on a letterhead from the tribal insurance plan.
- The document must include the member's name and identification number.

Documentation can be submitted to the claim via the Transaction Insight Portal (TIBCO).

Note: Providers must include a separate letter for each claim submission. Upon receiving the appropriate documentation, the claim can be considered for processing.




Behavioral Health
Intensive Outpatient Treatment Billing Update

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Intensive Outpatient Treatment (IOP) S9480

Providers billing **S9480** for intensive outpatient psychiatric services must meet the minimum requirements as described below:

A. Treatment shall consist of a minimum of 9 hours of service per week, a minimum of 3 hours per day, conducted on at least 2 days and shall include, but is not limited to the following;

i. 1 session with the members treating Psychiatric Provider (Behavioral Health Medical Practitioner-BHMP) per week, and

ii. 1-3 individual counseling sessions with a BHP, no less than 50 minutes in duration, per week, and

iii. 2 group counseling sessions, no less than 50 minutes in duration, per week.

B. A BHMP shall be available on-site at least 80% of the time during IOP Program operation.

Intensive Outpatient Treatment (IOP) H0015

Providers billing **H0015** for intensive outpatient *alcohol and/or drug* services provide substance use disorder and co-occurring treatment, in alignment with ASAM Criteria, 3rd Edition, level 2.1, must meet the minimum requirements as described below:

A. Services may include individual and group counseling, medication management, family therapy, educational groups, occupational and recreational therapy, and peer support.

B. Services are provided in amounts, frequencies, and intensities appropriate to the objectives of the treatment plan.

C. Treatment shall consist of a minimum of 9 hours of services a week, conducted for at least 3 hours a day and at least 3 days a week.




Appropriate Use of Respite Services

AMPM 310-B Title XIX/XXI Behavioral Health Service Benefit And AMPM 1250-D Respite Care

Clarification of Billing Respite Services AMPM 310B and 1250-D

In accordance with AMPM 310-B Title XIX/XXI Behavioral Health Service Benefit:

Unskilled respite care (respite) is short term behavioral health services or general supervision that provides *an interval of rest or relief to a family member or other individual caring for the member receiving behavioral health services as authorized under the Section 1115 Waiver Demonstration* and delivered by providers who meet the requirements in A.A.C. R9-10-1025 and A.A.C. R9-10-1600.

Appropriate Use of Respite Services AMPM 310B and 1250-D (cont.)

In accordance with AMPM 1250-D Respite Care:

- Respite Care is provided as an interval of rest and/or relief to a family member or other individual caring for an ALTCS member.
- Respite Care may be provided by a respite provider coming to the member's home, or by admitting the member to a licensed institutional facility or an approved Alternative HCBS setting for the respite period.
- Respite care may only be delivered as *specified in the member's Person-Centered Service Plan and requires prior authorization by the case manager.*

Reminders:
Required Documentation for Outpatient Behavioral Health Claims

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BH Documentation Requirements

- The Arizona Health Care Cost Containment (AHCCCS) recommends that before you submit a claim or any medical records that have been requested, you ensure that the medical records for that specific service meet Medicaid's guidelines for signatures.
- Documentation must meet AHCCCS signature requirements. The AHCCCS clinical review team checks for signed and dated medical documentation that meets the signature requirements. If entries aren't correctly signed and dated, AHCCCS may deny the claim.
- Documentation must have enough information to show the date the service was performed and by what practitioner.
- Providers must make sure that all staff involved in the billing process including if you are using a billing service that they are trained to identify where signatures are necessary and understand the importance of obtaining them before the claim and documents are submitted for review.

Required Documentation for BH Outpatient Claims

As a reminder, the following documentation must be submitted with each outpatient behavioral health claim for all services billed on each date of service:

- Signed Consent to Treat form,
- Comprehensive Assessment,
- Treatment plan, and
- Medical record documentation.

This requirement is for but not limited to the following provider types:

- Integrated Clinic (IC),
- Behavioral Health Outpatient Clinic (77), and
- Clinic (05).

Reporting same day services on separate claim submissions can result in denial of services



Common Documentation Denial Errors

Common Denial Errors - Member Missing Information

- The submitted documentation does not identify the **member, date of birth and or AHCCCS ID** on every page of the documentation.
- Missing member signature – consent to treat form.
- The first page of the documentation must include the primary identifier which is the AHCCCS Medicaid member ID, first and last name and date of birth.
- Each subsequent page of the documentation must identify at a minimum two of the following elements, AHCCCS member ID, first and last name and date of birth.
- If this information is missing, corrective action is required by the provider to resolve the claim before the claim can be adjudicated.

Missing Provider Signature Denial

- The denial edit code AD282 Missing Provider Signature identifies the documentation submitted does not meet the necessary requirements for processing.
- It is the provider's responsibility to review each page of the documents that were uploaded to determine which document is in non-compliance.
- Providers must address these issues by reviewing and ensuring that all required documentation is properly signed by the authorized individual before claim submission.

Common Provider Signature Denials

- The provider's signature is not present on the required forms or documents that were submitted with the claim.
- The signature provided is illegible or does not match the signature on file.
- The documentation may have a signature, but it lacks the necessary credentials or titles.
- The provider must take corrective action by obtaining a signature that meets all necessary criteria and updating any relevant records.

Documentation Review for Behavioral Health Outpatient Claims

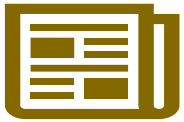
- The quickest and most efficient way to attach your documentation for review is to use the Transaction Insight Portal (TIBCO).
- For payment reviews, documentation is required and to help expedite the review process, we suggest that providers insert a “title sheet” identifying each document type that is uploaded followed by the documents.
- The documents should be attached as a single file upload.
- All combined services rendered on each day billed to FFS will require documentation to include physical services rendered and any services units billed.



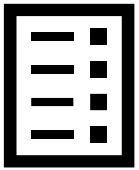

DFSM Provider Education and Training Unit

Stay Informed
AHCCCS Newsletters and Resources

Providers can **Sign Up Here** to receive email news alerts, which provides information directly *to your email inbox* regarding upcoming provider trainings, claims and billing updates and requirements, changes to the program, system changes, forums and other business news.



Providers can also access **DFSM Monthly Provider Claims Clues Newsletter** , which is a publication of the claims department. This is a monthly newsletter that provides FFS updates regarding billing, coding, system and programmatic changes.



Providers can view the **Medical Coding Resources** webpage which publishes news and updates related to AHCCCS claims and encounters processing, place of service, modifiers, new procedure codes, new diagnoses, and coding rules and more.

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.
- Let us know what you need.

Fee-For-Service Provider Training Requests

FFS Providers can submit training requests to servicedesk@azhcccs.gov

Your training request must include:

- Business email address,
- Full name and position title,
- AHCCCS Provider NPI or 6-digit provider ID number,
- Telephone number,
- Number of attendees,
- The specific type of training and include any questions you may have.

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".

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

Provider Services Contact Information

For basic claims and prior authorization questions providers can contact the Provider Services Call Center Monday through Friday, 7:30 a.m. to 5:00 p.m. Phone: **(602) 417-7670**

Our Provider Services representatives are skilled to provide help to many basic prior authorization and claims questions.

Providers should use the AHCCCS Online Provider Portal as the first step in checking the status of your claims and prior authorizations. Questions that cannot be answered via the portal please contact provider services for assistance.

Provider Services cannot assist providers with questions regarding Fee-for-Service (FFS) rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims. Providers should refer to the AHCCCS Website Plans/Providers for more information.

Service Desk

Providers that have questions or needs assistance with prior authorizations or claim submissions can submit a service ticket request via email at servicedesk@azahcccs.gov.

Submitting a service ticket will require specific details to include questions, or clarification regarding the issue you need assistance with.

When a service ticket is submitted the following will occur:

- The service desk will assign a ticket number to track your request.
- The service ticket confirmation number will be sent to the email address provided.
- The service desk will assign your inquiry to the appropriate area based on the service issue identified in the request.
- Once completed the service desk will provide you with an update.

Division of Business and Finance (DBF)

The Division of Business and Finance (DBF) can assist providers with questions about warrants, paper Explanation of Benefits (EOB) and Electronic Funds Transfer (EFT).

Providers can email (DBF) at ahcccswarrantinquiries@azahcccs.gov or call (602) 417-5500. Hours: 10:00 AM – 4:00 PM Arizona Time.

Electronic Transactions and 835/Electronic Remittance Advice (ERA)
Questions related to electronic transactions or to request an 835/ERA transaction setup email servicedesk@azahcccs.gov or contact (602) 417-4451.
Hours: 7:00 AM – 5:00 PM Arizona Time.

Thank You.