IHS 638 Tribal Providers Quarterly Billing Forum

Third Quarter 2022

Wednesday, August 24, 2022

Time: 2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

IHS/638 Quarterly Billing Forum Agenda

- Upcoming Tribal Consultations
- American Indian Medical Homes
- AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency
- Vaccine Reminders
- AHCCCS Complete Care / RHBAs
- Serious Mental Illness Integration
- Reminders Medicare and Third-Party Liability Billing
- FQHC Reminders

Upcoming AHCCCS Tribal Consultation Meetings

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Next AHCCCS Tribal Consultation:

November 03, 2022 at 1 p.m.

Please check AHCCCS Tribal Consultation Web page for meeting information.

2022-2023 Tribal Consultation Calendar

- **February 9, 2023: Regular Quarterly TC Session**
  - Hosted Virtually via Zoom only
  - Agenda Item Request Deadline: January 16, 2023

For all AHCCCS Tribal Consultation Dates and Meeting Materials, see the following link:
https://www.azahcccs.gov/AmericanIndians/TribalConsultation







American Indian Medical Homes (AIMH)

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What is an American Indian Medical Home

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.

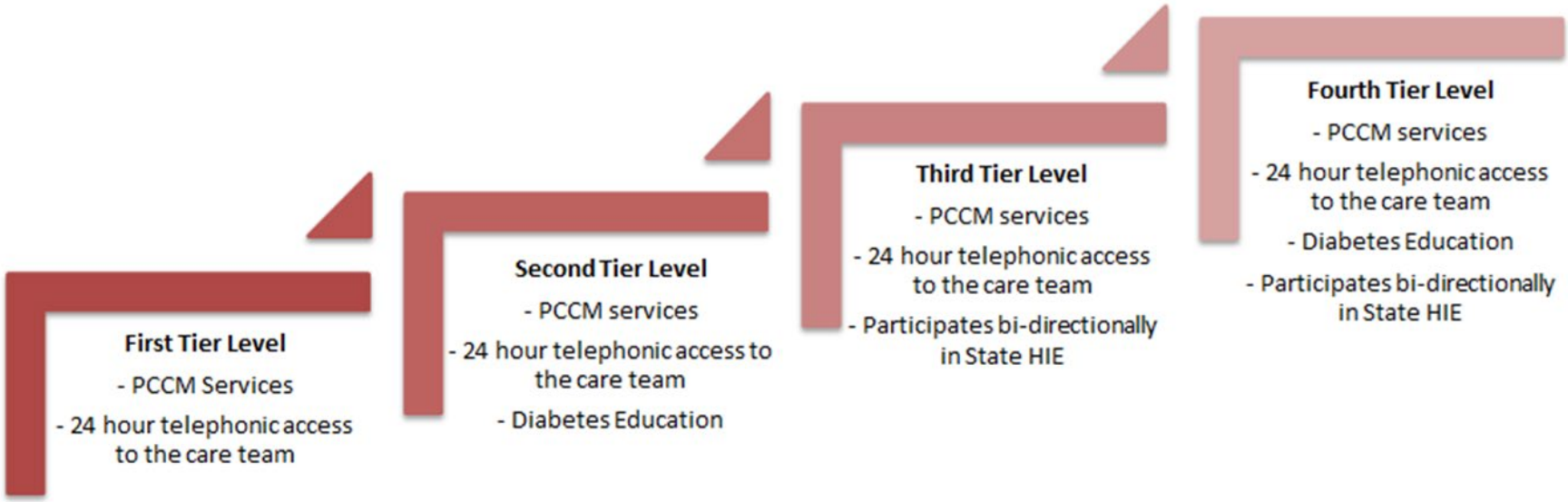
AIHM Provider Requirements

- 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
  - Participate bi-directionally in the State Health Information Exchange (HIE)

AIHM Medical Provider Types

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

American Indian Medical Home Tiers



AIMH Reimbursement Rates 2022

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	**13,931**
Fort Yuma Health Care	1	**11**
Parker Indian Health Center	1	**604**
Phoenix Indian Medical Center	2	**5,595**

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
San Carlos Apache Healthcare	4	**4,866**
Tuba City Regional Healthcare Corporation	4	**2,651**
Whiteriver Indian Hospital	2	**6,514**
Winslow Indian Health Care	4	**3,989**







AHCCCS Prior Authorization (PA) and Concurrent Review (CR) Standards during COVID-19 Emergency for Fee-for-Service Health Programs

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AHCCCS Prior Authorization (PA) And Concurrent Review (CR) Standards During COVID-19 Emergency

The updated **Fee for Service memo** outlines the updated AHCCCS Prior Authorization and Concurrent Review Standards for AHCCCS Division of Fee-for-Service Management (DFSM) in response to Governor Ducey's declaration of a public health emergency for COVID19 and is effective October 1, 2022.

AHCCCS Prior Authorization (PA) And Concurrent Review (CR) Standards During COVID-19 Emergency

- These changes impact members enrolled with a Fee-for-Service Program, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), Tribal Arizona Long Term Care Services (Tribal ALTCS), and Division of Developmental Disabilities Tribal Health Program (DDD THP).
- These standards are subject to change as the emergency conditions evolve. All services reimbursed must be medically necessary, cost-effective, federally and state reimbursable, and will be subject to post-payment review.

Behavioral Health Updates For Dates Of Service On And After October 1, 2022

- Behavioral Health Inpatient Residential Treatment Center (RTC)- concurrent review prior authorization will resume to a concurrent review frequency of every 30 days.
- Behavioral Health Residential Facilities (BHRF) provider type (B8) will continue at concurrent review intervals of up to 90 days.

Pharmacy Services Member Signature Requirements Effective 10/01/2022

Effective for dates of service on and after October 1, 2022, AHCCCS FFS will reinstate the requirement for the member signature at the pharmacy to confirm that counseling occurred and that the medication was dispensed to the member.

Prior Authorization Requirements
Facility Services

Prior authorization and concurrent review requirements will be reinstated for the following levels of care. DFSM will reinstate prior authorization and concurrent review requirements for the following levels of care effective for dates of service on and after October 1, 2022.

- Acute Inpatient hospitalization;
- Skilled Nursing Facilities (SNF)
- Assisted Living Facilities/Centers; and
- Inpatient Rehabilitation Facilities (e.g., Long Term Acute Care Hospitals).

Non-Emergent Medical Transportation Prior Authorization and Signature Requirements

Reminders:

A. NEMT providers transporting a member over 100 miles one way or round trip must obtain prior authorization.

B. Effective for dates of service on and after July 1, 2022 AHCCCS NEMT drivers are required to collect a passenger's written or electronic signature on the FFS AHCCCS Daily Trip Report.

Home Health Services and Durable Medical Equipment Face-to-Face Requirement Change

A. CFR § 440.70 requires that the initiation of home health services and medical equipment and supplies be subject to face-to-face encounter requirements for the FFS population.

B. Pursuant to section 1135(b)(5) of the Social Security Act, effective for dates of service on and after October 1, 2022, AHCCCS will reinstate CMS requirements for completion of face-to-face encounters prior to the initiation of orders for home health services and durable medical equipment.







General Billing Questions

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Covid-19 Vaccine Billing Information

(updated 7/11/22) **Question: Can my child receive a COVID-19 vaccine at a pharmacy?**

Answer: Children three years of age and older can receive a COVID-19 vaccine at a pharmacy. Children under three years of age can only receive a COVID-19 vaccine at a PCP's or pediatrician's office.

AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) Contractors

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AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) Contractors

- ACC-RBHA Contractors responsible for:
  - Integrated physical and behavioral health services for Title XIX/XXI eligible individuals with Serious Mental Illness (SMI)
  - Administration of Non-Title XIX/XXI funded services including, but not limited to:
    - Crisis services, grant funded services, and Court Ordered Evaluations (COE)
- ACC-RBHA Awards made 11/15/2021
- Transition occurring 10/1/2022

AHCCCS Complete Care-Regional Behavioral Health Agreement (ACC-RBHA) Contractors

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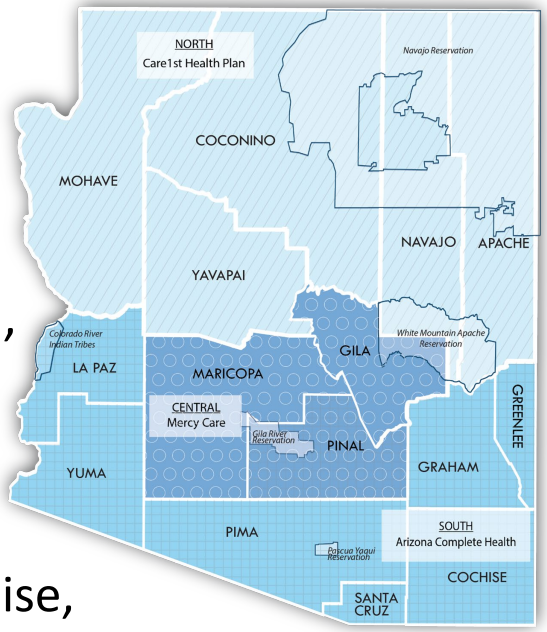
ACC-RBHA Geographical Service Areas (GSA)

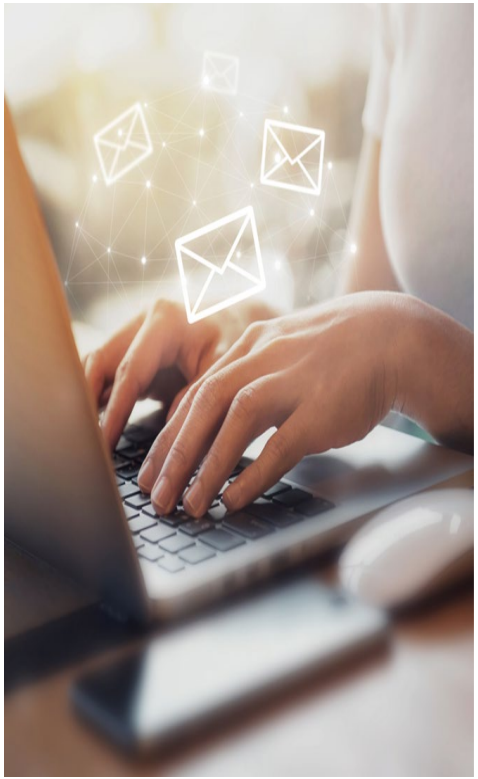
- Aligning GSAs to match ACC and EPD GSAs:
  - Gila moving from North to Central
  - Pinal moving from South to Central
- ACC-RBHAs and awarded GSAs
  - Care1st - North GSA: Mohave, Coconino, Yavapai, Navajo, Apache
  - Mercy Care - Central GSA: Maricopa, Gila, Pinal
  - Arizona Complete Health-Complete Care Plan - South GSA: La Paz, Yuma, Pima, Santa Cruz, Cochise, Graham, Greenlee



Transitions for Members

- Central GSA – ACC-RBHA will be Mercy Care effective 10/1/2022.
  - Members in Maricopa County will ***continue*** to receive services from Mercy Care.
  - Members in Gila County will ***transition*** from Health Choice to Mercy Care.
  - Members in Pinal County will ***transition*** from Arizona Complete Health-Complete Care Plan to Mercy Care.

Member Transitions (cont.)



- AHCCCS will send out enrollment notices to all members transitioning to a new health plan.
- Member notices will be sent out by AHCCCS at least 30 days prior to the 10/1/2022 transition date.
- AHCCCS will work with all involved health plans to transition important member information.




American Indian Health Program
Member Transition
Serious Mental Illness (SMI) Effective 10/01/2022

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Member Transitions

- Individuals with an SMI designation currently enrolled with the American Indian Health Program (AIHP) for physical health services and receiving behavioral health services from a Regional Behavioral Health Authority (RBHA) will have:
  - Behavioral Health services ***transition*** to AIHP effective 10/1/2022, and
  - Physical health services ***continue*** with AIHP.
- This transition will impact roughly 300 members.*

*Enrollment as of December 2021

Member Transitions (cont.)

- Individuals with an SMI designation currently enrolled with an AHCCCS Complete Care (ACC) plan for physical health services and receiving behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA) will have:
  - Physical health services ***transition*** to AIHP effective 10/1/2022, and
  - Behavioral health services ***continue*** with TRBHA.
- This transition will impact roughly 100 members.*

*Enrollment as of December 2021




Reminders:
Billing Medicare Secondary Claims

Reminders: Billing Medicare Secondary Claims

What is a secondary claim?

- Secondary claims refer to any claims for which Medicaid is the secondary payer, including third party insurance as well as Medicare crossover claims.
- If the claim was denied by Medicare due to billing issues, the provider should submit a corrected claim to Medicare.

Medicare Secondary Claims

- Medicare pays first for members enrolled in Medicare Parts *A,B,C or D* coverage.
- Medicaid pays after all first and third party payers.
- Medicare direct crossover claims are considered based on the information presented on the claim (copay, coinsurance, deductible).
- Replacement Claims:
  - Attachments required with the initial claim submission are required for replacement claim submissions.
  - Claim corrections can be done via the Online Portal.

Medicare Secondary Claims

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







Reminders:
Billing Third Party Liability Secondary Claims

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Submitting Third Party Liability (TPL) Secondary Claims

- When submitting a secondary claim, providers must include the primary payers *Explanation of Benefits* which details how the claim was processed and or denied by the payer.
- Appealing a Claim Denial:
  - Providers must follow the primary payers appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The primary insurer explanation of benefit is required.


FQHC/638 Billing Reminders

FQHC/RHC Billing Reminders

FQHC/RHC Multiple Visits on the Same Day

- The member must be seen by different practitioners with different specialties.
- The diagnoses billed on the second claim must be “unrelated”.
- Each encounter/visit must be billed on a separate claim form.
- Multiple encounters with the same health professional on the same day at a single location constitute a single visit.

FQHC/RHC Billing Reminders (cont.)

- FQHC/RHC providers can submit individual claims for multiple visits on the same day with “unrelated diagnosis” codes when the services are performed by different providers with different specialties.
- FQHC/RHC should bill the encounter code on the first line with the PPS rate and include all other informational lines and CPT codes to identify the services provided with $0.00 amount.
- The appropriate place of service codes must be billed.
- FQHC/RHC claims by be billed on the CMS 1500, 837P, ADA 2012, and 837D.

FQHC/RHC Billing Dental Services

FQHC/RHCs are allowed to bill for AHCCCS covered dental services. To receive reimbursement for an AHCCCS covered dental service, the FQHC/RHC must bill using HCPCS code T1015, and the appropriate CDT dental codes.

- Claim Form Type: ADA 2012 or 837D.
- Billing: Encounter/visit code T1015.
- Secondary lines: Bill the detail line items at $0.00
- Reimbursement Rate: Prospective Payment Schedule (PPS)

FQHC Billing Multiple Visits - Modifier 25

Multiple visits on the same day within the same discipline which are distinct based upon the FQHC/RHC visit definition above must be identified by billing the T1015 visit code for the same-day subsequent visit with a *modifier 25* to indicate a distinct and separate visit.


DFSM Provider Education and Training Unit

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DFSM Provider Education and Training

Our goal is to help providers understand billing policy and successful claim submission.

The provider training team offers eLearning and video training presentations on specified topics which is a self-paced format that allows providers to access trainings. We encourage the attendance of billing staff and agencies, practitioners and others to attend.

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.

DFSM Provider Education and Training Updates

Upcoming IHS/638 Tribal Provider Billing Forums

- November 9, 2022, 2:00 - 3:30pm.

Provider Training Requests and Questions email: **Providertrainingffs@azahcccs.gov**

Claims Customer Service Assistance

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Monday – Friday from 7:30am – 4:00pm (Phoenix Time).
- (602) 417-7670 – Select Option 4
- Use the AHCCCS Online Provider Portal to view claims.
- AHCCCS Online Provider Portal

FFS Prior Authorizations

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
  - https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/
- DFSM Prior Authorization Web Page:
  - https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231

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/

Questions?

Thank You.