CLAIMS CLUES

A Publication of the AHCCCS Claims Department
MAY 2013

CHANGES COMING FOR NON-EMERGENCY TRANSPORT CLAIMS

Many changes are coming for all non-emergency medical transport (NEMT) claims as the result of AHCCCS DFSM post-payment claim audits.
While the coverage criteria for non-emergency medical transports has been in place as presented in the AMPM Chapters 310-B and 820-W, the online billing manual will be updated by May 31, 2013, with the coverage criteria as well as the billing and documentation requirements.
When free transportation services are unavailable and an eligible person is unable to arrange or pay for transportation, AHCCCS covers medically necessary non-emergency medical transportation to and from an AHCCCS covered medical service for most recipients. Transportation is limited to the cost of transporting the recipient to the nearest AHCCCS registered provider capable of meeting the recipient's medical needs. Transportation must only be provided to transport the recipient to and from the required, AHCCCS covered medical service.
For AHCCCS American Indian recipients who reside either on-reservation or off-reservation and are enrolled with AIHP (Contract ID # 999998), transportation services are covered on a FFS basis under the following conditions:

1. Request for transport is prior authorized through AHCCCS/DFSM UC/UM when mileage is greater than 100 miles, whether one way or round trip
2. The recipient is not able to provide, secure or pay for their own transportation and free transport is not available; and
3. The transportation is provided to and from either of the following locations:
   a. the nearest appropriate IHS/Tribal 638 facility located either on-reservation or off-reservation or
   b. the nearest appropriate AHCCCS registered provider located off-reservation

PA for non-emergency medical transport provided to an AHCCCS FFS recipient through the use of a private vehicle must be requested by the recipient's medical service

provider. The PA for transport will not be issued unless the transport provider is an AHCCCS registered provider **prior** to seeking the PA.

Beginning with services incurred 7/1/2013 all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. This new standard Daily Trip Report will be included in the online manual updates.
A training session will be held for submitting the NEMT claims online with the required Daily Trip Report. All training notices will be sent to providers via List Serve.
Some of the most common audit errors are:

- PA or Case Plan miles are billed rather than actual loaded mileage *as supported* by the odometer readings
- Billing for 99 miles when odometer readings indicate >100 miles and no PA was done for trip
- Round trip is billed when trip record supports 1 way trip
- Wait time is billed inappropriately
- Trip records are incomplete or illegible
- Claims with date spans or "bulk" billing multiple dates of service are not supported by the trip records
- The purpose of the transport is not for "an AHCCCS covered medical service" to the nearest AHCCCS registered provider capable of meeting the recipient's medical needs

REMINDERS FROM UM/CM PRIOR AUTHORIZATION UNIT

The UM/CM Unit's Tribal Health Care Coordinator performs inpatient stay related member care coordination and disease management functions for the AIHP population. For general member related inquiries please contact Member Services at 602-417-7070.

Authorization Status - Please use the online system to check the status of your authorization requests. You can check authorization status by using the following link: https://azweb.statemedicaid.us/Home.asp

Member Referrals for Specialty Care - If your office is referring a member out of area for specialty services, please be sure to inquire to see if the member has personal transportation to and from their appointments. Though FFS members can receive services from any registered provider, **transport will only be covered to the nearest appropriate facility when AHCCCS is covering the cost of the transport.**

99601 and **99602** – Are codes indicated for the home infusion/administration of "specialty drugs" and should not be used to bill for enteral nutrition administration.

Please fax in MD authorization requests with supporting documentation for review prior to scheduled procedures. You can fax in the documentation using the FFS Prior Authorization Request Form.

Transportation Reminders:

Odometer readings must support your billed mileage. If the odometer readings indicate more or less mileage than what was billed reimbursed monies are subject to recoupment.

If the mileage is greater or less on one leg of a roundtrip transport than on another, you must submit documentation with your claim to explain the difference in mileage.

Please allow up to 72hrs turnaround time for processing of transportation authorization requests. Please use the online system to check authorization status. See the following link: https://azweb.statemedicaid.us/Home.asp

Effective for all billed dates of service **07/01/2013** and forward, the new **mandatory AHCCCS Trip Ticket** must accompany all transportation claims. Please register for the AHCCCS List Serv in order to receive updates and announcements regarding these changes. Use the following link to register for email notifications (ListServ) http://listserv.azahcccs.gov/cgi-bin/wa.exe?A0=FFS-TRANSPORTATION-L

Timeliness of Transport Authorization Requests - Authorization requests should be submitted on or before the date of the NEMT service. Authorization requests can be faxed, or entered using the AHCCCS website 24 hours a day, 7 days a week *including weekends and holidays*. Authorization requests received after the date of service, even if the date of service falls on a holiday or a week-end will be considered to be untimely.

ENHANCED RATES FOR PRIMARY CARE SERVICES

Section 1202 of the Affordable Care Act requires that Medicaid reimburse designated primary care providers who provide primary care services and vaccine administration services at rates that are not less than the Medicare fee schedule in effect for 2013 and 2014, or, if greater, at the payment rates that would result from applying the 2009 Medicare physician fee schedule conversion factor to the 2013 or 2014 Medicare payment rates. These reimbursement requirements apply to dates of service between January 1, 2013 and December 31, 2014. To receive the enhanced payment, CMS requires that physicians meeting one of the required criteria provide a "self-attestation" to AHCCCS verifying that they qualify for the enhanced payment through

either the requisite Board certification or the 60% CPT code requirement. This means that before AHCCCS or its Contractors can provide an enhanced payment, **the physician must submit an Attestation form.**

Physicians filing the required Attestation on or before April 30, 2013 will be paid the enhanced fee retroactively for dates of service from January 1, 2013 forward for all primary care eligible services. Physicians filing the required Attestation on or after May 1, 2013 will be paid the enhanced fee on a going forward basis from the time the successful Attestation is received.

The Primary Care Provider Attestation Form for AHCCCS registered providers is available on line. **Prior to the completion of the form, please review the information in the memo carefully. Links to the memo, the Attestation page, and general information are provided below:**

http://www.azahcccs.gov/commercial/ProviderRegistration/pcpattestation.aspx

http://www.azahcccs.gov/commercial/Downloads/rates/PCP_EnhancedPaymentsMemo.pdf

http://www.azahcccs.gov/commercial/ProviderBilling/rates/PCSrates.aspx