

October 2020

EMS Providers and Flu Shots

AHCCCS Reimbursement Option for EMS Agencies Administering Flu Vaccine

AHCCCS continues to develop and expand the eligible providers that may offer and bill Medicaid for administering the flu vaccine. As a result of ongoing conversations with the Arizona Department of Health Services (ADHS), AHCCCS is allowing qualified emergency medical service providers, defined as ADHS licensed/certified AHCCCS registered provider types 06, 97 and TR, the opportunity to bill AHCCCS for the flu vaccine and the administration of the flu vaccine within their scope of practice effective October 1, 2020.

Qualified emergency medical service providers will be given the ability to bill AHCCCS FFS for the codes specified in the following September 1, 2020 public notice for the flu vaccine and/or the flu vaccine administration. [The AHCCCS Claims System, PMMIS](#), will be updated to include these codes.

The flu vaccine and administration codes shall be billed separately as a unique service. This means it shall be billed on a separate claim form.

- The administration of the vaccine shall not be delivered as part of a transport or be billed with a transport code such as ALS/BLS.

The intent is that providers would deliver these as a separate service outside of transportation, such as at a flu vaccination drive or another stationary venue.

For qualified emergency medical service providers, reimbursement is being made at the AHCCCS FFS fee schedule.

Flu Vaccine Administration For Members 3-18 Years Of Age

Access to the flu vaccine has been expanded as of September 1st, 2020. This expansion allows Fee-For-Service (FFS) members ages 3 through 18 years of to obtain their flu shot at an IHS, 638, or other Optum network pharmacy.

For additional information, including information for IHS and 638 pharmacies and billing the All-Inclusive Rate (AIR), please refer to the [Flu Vaccine Administration For Members 3 Years Through 18 Years Of Age memo](#).

CONTACTS

- For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at ProviderTrainingFFS@azahcccs.gov.
- Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM [Provider Training Web Page on the AHCCCS website](#).
- The Fourth Quarter FFS Provider Training Schedule can be [found online](#).
- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5

ELECTRONIC PAYMENT

SIGN UP

Electronic Payment Sign Up
(Remittance Advice Sign Up/835)

[Contact:
ISDCustomerSupport@azahcccs.gov](mailto:ISDCustomerSupport@azahcccs.gov)

OR

call 602-417-4451

AHCCCS E.V.V.

ELECTRONIC VISIT VERIFICATION

This notice is intended for stakeholders interested in information on Electronic Visit Verification

In the coming weeks and months, AHCCCS will be posting to the EVV webpage FAQ documents on specific topics of interest based on questions and concerns that have been shared with us by stakeholders.

AHCCCS is pleased to announce the creation of two **new** FAQ documents to help stakeholders prepare to comply with EVV.

Live-In Caregiver This FAQ will explain why EVV is required for members with live-in caregivers and the flexibilities being offered to accommodate the flexible ways in which members receive services.

Required Use of DCWs SSN:

This FAQ will explain why the DCW's Social Security Number (SSN) is required and how the data is protected.

Providers who plan to use the Sandata EVV System:

AHCCCS is pleased to announce that an email was sent on October 7, 2020 to the provider agency's EVV primary point of contact (agency administrator) regarding the details of the training including how to register for the pre-requisite training and requirements for agency administrators. The agency's EVV primary point of contact was identified by the agency on the Differential Adjusted Payment attestation submitted earlier in the year or subsequently was confirmed by one of the health plans.

If you feel that you should have received this email for your agency but did not, please contact Sandata Customer Care at 844-289-4246 for assistance.

More information for training is provided on the AHCCCS EVV Webpage (www.azahcccs.gov/EVV) under the "Sandata EVV System Training" tab.

Providers who plan to use an alternate EVV System:

- **If you plan to use an alternate EVV system, please contact 844-289- 4246 or AZAltEVV@sandata.com as soon as possible** to initiate the process to send information to the Sandata aggregator in order to comply with EVV.
- Alternate EVV users will be required to complete some basic online training. This training is specific to viewing your data sent to the EVV aggregator. You should have

already received a link to this training from Sandata.

- If the Alternate EVV Vendor's system is not making timely progress to with testing for system compliance, the provider agency will be expected to complete all required training offered by Sandata in preparation to use the Sandata EVV system should the alternate system not be ready on January 1, 2021. AHCCCS and Sandata will be monitoring Alternate EVV vendor progress to conduct provider specific outreach to ensure providers are ready to comply with EVV on January 1, 2021.
- In the coming weeks, AHCCCS will be releasing updated technical specifications that both remove and add requirements. Many of the changes are in response to stakeholder feedback generated during the past few months. Therefore, AHCCCS is permitting Alternate EVV Vendors additional time to comply with the updated technical specifications. This means that Alternate EVV Vendors can complete phase one of testing without verification of the updated specifications and the vendors will be required to undergo a phase two of testing to verify the updated specifications are met prior to the January 1, 2021 mandatory use date.

If you have questions about using an alternate EVV system or are waiting for testing information, please contact support at 844-289-4246 or AZAltEVV@sandata.com.

Stay Informed

Please sign up for the AHCCCS Constant Contact email list to receive any and all EVV notices (like this one) from AHCCCS under the "Stay Informed" tab on the AHCCCS website.

AHCCCS appreciates the active engagement of the providers and continues to monitor and respond to emails while noting the topics of most interest to the stakeholder community. This correspondence along with other provider outreach and engagement activities continues to help us to prioritize communication topics as well as build our directory and timeline for the release of future FAQ installments.

Provider Location within the United States

Per the Provider Participation Agreement (PPA), “pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. 1396a(a)(80), AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institutions or entity located outside of the United States.”

Providers rendering services to an AHCCCS member must be located within the United States, or a territory of the United States, and also be an AHCCCS-registered provider, in order to be reimbursed.

COVID-19 Information

AHCCCS is responding to an outbreak of respiratory illness, called COVID-19, caused by a novel (new) coronavirus. Health officials urge good hand washing hygiene, covering coughs, and staying home if you are sick.

On March 11, Governor Doug Ducey issued a [Declaration of Emergency](#) and an [Executive Order](#) regarding the COVID-19 outbreak in Arizona, and subsequent [Executive Orders](#) with further administrative actions.

On March 17, 2020, AHCCCS [submitted a request](#) to the Centers for Medicare and Medicaid Services (CMS) to waive certain Medicaid and KidsCare requirements in order to ensure ongoing access to care over the course of the COVID-19 outbreak. As of March 23, AHCCCS has received federal approval to implement programmatic changes to help ensure access to health care for vulnerable Arizonans.

To address Medicaid-related questions from providers and contractors about COVID-19, AHCCCS has developed a list of Frequently Asked Questions Regarding Coronavirus Disease 2019 (COVID-19), updated regularly as more information be-

comes available.

The AHCCCS COVID-19 FAQs includes information on:

- Billing for services related to COVID-19 (such as CPT/ HCPCS and the CR Modifier usage);
- IHS and 638 specifics;
- FFS Programs;
- Alternate Care Sites (ACS);
- Flu Shots;
- Telehealth Services;
- Provider Enrollment;
- Pharmacies and Medications;
- Rates;
- General COVID-19 Questions;
- And much more!

[COVID-19 FAQs](#)

Learn how to protect yourself and stop the spread of COVID-19. Visit azdhs.gov/COVID19 and cdc.gov/COVID19.

COVID-19 Modifier Use

AHCCCS has designated the CR modifier to be used on all claims for services provided as a result of, or related to COVID-19.

It is imperative that providers begin utilizing this modifier immediately in all appropriate instances in order for AHCCCS to identify

the costs of services attributable to this emergency. All other guidance regarding use of modifiers continues to be applicable.

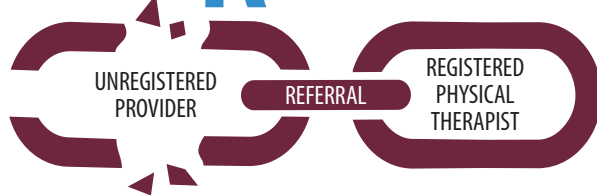
DON'T BE THE WEAK LINK IN THE CLAIM



Even if you don't submit Medicaid claims, providers who are not registered with AHCCCS, but who may be the **Referring, Ordering, Prescribing, or Attending (ROPA)** provider, **may keep members from getting needed health care.**

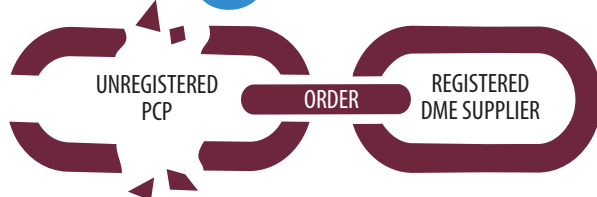
Enroll with AHCCCS to become a Referring, Ordering, Prescribing or Attending provider by **January 1, 2021.**

Referring



REFERRAL NOT ACCEPTED AND CLAIM FROM PHYSICAL THERAPIST NOT PAID OR MEMBER GOES WITHOUT NEEDED CARE

Ordering



ORDER NOT ACCEPTED AND CLAIM FROM DME SUPPLIER NOT PAID OR MEMBER GOES WITHOUT DME

Prescribing



PRESCRIPTION NOT COVERED AND CLAIM FROM PHARMACIST NOT PAID OR MEMBER GOES WITHOUT PRESCRIPTION

Attending



ATTENDING NOT APPROPRIATE AND CLAIM FROM HOSPITAL NOT PAID OR MEMBER GOES WITHOUT NEEDED CARE

IHS 638 Nursing Facility and Skilled Nursing Facility AIR Updates

Effective October 1, 2020, nursing facility and skilled nursing facility services furnished by facilities owned or operated by the Indian Health Services (IHS) or tribes under PL 93-638, provided to American Indians, **may be reimbursed at the outpatient All-Inclusive Rate (AIR)**.

- Note: For the purposes of this article, nursing facility services and skilled nursing facility services shall be referred to as “nursing facilities” and “nursing services.”

Per the Arizona Medicaid State Plan, nursing facilities owned or operated by IHS or tribes under PL 93-638 may now be reimbursed at the current outpatient AIR.

Billing Guidance

Nursing Facilities operated by IHS or tribes under PL 93-638 bill as follows:

- **Claim Form:** UB-04 Claim Form
- **Revenue Codes:** 0183, 0185, 0191, 0192, and 0193
- **Diagnosis Codes:** ICD-10
- **Reimbursement Rate:** Outpatient AIR

There is *no change* to how the UB-04 Claim Form is filled out, except for the reimbursement rate requested. This will be reflected in the following fields:

- Field 42: Rev Code
- Field 47: Total Charges

For additional instructions on “how to” fill out a UB-04 Claim Form, please visit [Chapter 5, Claim Forms, of the IHS/Tribal Provider Billing Manual](#).

Long Acting Reversible Contraceptives (LARC)

Long Acting Reversible Contraceptive (LARC) devices are permitted to be separately reimbursed outside of the APR-DRG payment when billed by the Hospital on a CMS 1500 claim form with the appropriate HCPCS procedure code and will be reimbursed at the appropriate AHCCCS fee schedule rate for that code. In addition to procedure code 58300 (insertion of Intrauterine Device (IUD)), AHCCCS has identified LARC procedure codes as follows:

J7297 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52mg

3 Year Duration

- J7298 Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 Mg

5 Year Duration

- J7300 Intrauterine Copper Contraceptive
- J7301 Levonorgestrel-Releasing Intrauterine Contraceptive System, 13.5 Mg

Many unintended pregnancies could be prevented through the use of Immediate Postpartum LARC (IPLARC). National organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Physicians (AAFP) recommend improving access to IPLARC. Providing access to LARC in the hospital after delivery is expected to increase utilization of such devices.

Currently no ICD-10 PCS code for the LARC device exists for inpatient hospital use thus AHCCCS will pay hospitals for the device in addition to a DRG payment. For additional information, please refer to the Fee-For-Service (FFS) Provider Billing Manual, Chapter 11 Addendum – APR-DRG on the AHCCCS Website.

Claim Tips Corner – Claim Submission Errors on CMS 1500 Claim Forms

To assist providers with accurate claim submission, AHCCCS FFS has identified common submission errors received on the CMS-1500 claim form.

Claims submissions that fail to meet AHCCCS requirements will be returned to the provider as “un-processable”.

Common Claim Submission Errors:

- Claim data not entered in the correct field or overlapped into another field.
- Stamps included on the claim.
- Diagnosis codes are not entered in order. For example, the claim is submitted with a single diagnosis code but placed in diagnosis code field “C” in error and should be field “A”.
- The billed charge amount entered in the cents field.
- Single unit entered in error as 001.
- Different font size and styles entered on the same claim form.
- Copy or reproductions of the CMS 1500 submitted.

- Liquid paper correction fluid (“White Out”) may not be used. Correction tape may not be used.
- Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system.

Recommended Suggestion for Claim Corrections Includes:

- Resubmitting claims electronically as a new claim;
- Using the preferred font style and size: Lucinda Console size 10;
- Signing-up for an AHCCCS Online Provider Portal web account to begin electronic claim submissions and corrections;
- Reviewing the DFSM Provider Training Web Page on the AHCCCS website, to review the variety of available claims training; and
- Contacting Provider Training for Online Claim submission training (via the AHCCCS Online Provider Portal) at Provid-ertrainingFFS@azahcccs.gov.

Documentation Requirements and the Transaction Insight Portal (TI)

The Division of Fee-for-Service management (DFSM) may require providers to submit documentation for certain services.

The [Transaction Insight Portal](#) is the preferred method for submitting medical records, the AHCCCS Daily Trip Report (for Non-Emergency Medical Transports), and any other supporting documentation required for the processing of a claim.

AHCCCS will be holding continued trainings on use of the [Transaction Insight Portal](#) throughout the 4th quarter of 2020. These trainings are also available on the [DFSM Provider Training Web Page](#) 24/7 under “Trainings by Subject” (select AHCCCS Online Provider Portal) and the “Provider Training Video Library” headings.

AHCCCS will also be offering a new training to providers on Documentation for Claims Submission and Concurrent Review requirements in the 4th quarter of 2020.

Documentation for Claims Submission and Concurrent Review

This training covers the responsibility of providers to submit required documentation with claims, and to respond to AHCCCS requests for documentation for concurrent review.

NOTE: This training does not cover ‘how to use’ the Transaction Insight Portal.

Trainings require advanced registration. Please visit the [DFSM Provider Training Web Page](#) and look under Training Schedules for registration links. A copy of the provider training schedule for the 4th quarter of 2020 is also in [last month's newsletter](#).

Behavioral Health Matrix Reminder

As a reminder for our Behavioral Health Providers, the Medical Coding Resources web page on the AHCCCS website has the new and improved Behavioral Health Services matrix (Formerly B2 Matrix) available at: <https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>

Please note this is a GUIDE only and all policy, correct coding and documentation guidelines must be met.

Instructions on how to use the Matrix:

1. The gold colored tabs have drop down options for you to search the specific pages.
2. The blue colored tabs contain all the complete information with no drop down capability.

3. Read tab 1 for the policy links and other pertinent information.
4. The revisions tab will reflect all the updates made with the date. This “Matrix” will be updated monthly if needed. Always check the revision date on top of this page for the most current changes.

The links below will take you to the correct page for the information listed. Just a reminder, Behavioral Health Services Matrix questions, changes and updates must be submitted via the Reference Table Review and Update (RTRU) Form listed on the page.

[Matrix with instructions](#)

[Update form with instructions](#)

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

The below memo can be found on the [AHCCCS website](#).

Released: March 25th, 2020

Last Update: June 8th, 2020

This 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 COVID-19 and is effective April 1, 2020, through the duration of the 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), and Tribal Arizona Long Term Care Services (Tribal ALTCS).

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.

I. Behavioral Health Services

Initial prior authorization is still required for non-emergency Behavioral Health Inpatient, Residential Treatment

Center (RTC) and Behavioral Health Residential Facility (BHRF) levels of care.

DFSM plans to extend concurrent reviews from 30 to 90 days for Residential Treatment Center (RTC) levels of care.

Clinical Staffings, Child and Family Teams (CFTs), Adult Recovery Teams (ARTs), and coordination of care between facilities and outpatient providers should continue to inform appropriate levels of care and continued stay. Telehealth and telephonic modalities are strongly encouraged for these staffings and coordination.

II. Dental Services

Dental prior authorization approvals, which are within 60 days of expiration, will be extended for 6 months.

III. Pharmacy Services

A. Refill-too-soon edits and 90 day fills

OptumRx Clinical Affairs is allowing members to refill their maintenance medications early to ensure they have an uninterrupted supply of medication during the COVID-19 emergent time as outlined below.

1. The refill-too-soon edit on all non-controlled medications has been removed.
 - a) Members may continue to fill prescriptions for up to a 30-day supply or they may fill a 90-day supply of

continued

AHCCCS PA and CR Standards Continued

maintenance medications, both of which may be done early. Members must have refills remaining on file at their pharmacy.

- b) Specialty medications, which are filled for a 30-day supply and delivered to the member's home, may be filled early for the same day's supply as previously filled.

To override for a specialty medication, IHS & 638 Pharmacies must submit the following in the NCPDP fields:

- A value of, the number, 1 in the Prior Auth Type Code Field (461-EU); and
- A value of, the numbers, 88885 in the Prior Auth Number field (462-EV).

The entry of values into both of these NCPDP fields will allow prescription claims from IHS/638 Pharmacies to override the 30 Day Supply Limit to a 60-day supply for AIR Specialty when the member has a history of the product in their claim history. The maximum days supply that may be adjudicated is for a 60-day supply.

- c) DFSM's pharmacy benefit manager (PBM), OptumRx, will continue to ensure that quantity limits and duplicate therapy edits will not cause a rejection when the prescription is refilled early.
- d) For IHS/638 Pharmacies, members may continue to obtain their chronic medications for up to a 90-day supply, for reimbursement at the AIR .

2. Controlled Substances may be refilled early when the pharmacy staff has checked with the prescribing clinician and the clinician has agreed to the early refill. The pharmacy staff or the prescribing clinician shall contact the OptumRx help desk for an immediate override.

- The opioid current maximum fill is 30-days and an additional fill would be for a maximum of 30 days.

3. Removal of prior authorization for specific therapeutic classes:

- a) Prior authorization requirements have been removed for the following Therapeutic Classes:
 - Beta2 Agonist Inhalers, Inhalant Solutions and Oral Agents
 - Inhaled Short and Long Acting Anticholinergic Inhalers

- Long-acting Beta2 Agonist-Corticosteroid Combination Inhalers
- Long-acting Beta2 Agonist-Anticholinergic Combination Inhalers
- Corticosteroid Inhalers and Inhalant Solutions
- Corticosteroid Oral Agents
- Nebulizers (must be available through pharmacies)
- Cough and Cold products
 - o Antihistamines
 - o Nasal Decongestants
 - o Combination products of antihistamines and nasal decongestants
 - o Cough suppression products including guaifenesin and combination products
 - o Guaifenesin oral tablets and combination products
 - o Analgesics/Anti-febrile products (aspirin, ibuprofen, acetaminophen, acetaminophen suppositories, etc.)
- Mast Cell Stabilizers
- Methylxanthines (aminophylline and theophylline)

For Dual Eligible Drug Plans – OTC products that are included in the drug classes above will also be added to the Dual Eligible Drug List.

B. Prior Authorization Extensions

For members enrolled in the American Indian Health Program (AIHP), Tribal ALTCS, or a TRBHA, approved prior authorizations for all medications, which are set to expire on or before May 1, 2020, will be extended for an additional 90 days. The pharmacy may have to contact the provider for an approval to request a fill of an expired prescription, but a prior authorization will not have to be submitted during the 90 day prior authorization extension.

Prior authorizations for medications with significant abuse potential (i.e. opioids) or those that are general dosed for finite durations or intermittently (i.e. hepatitis agents) will not be extended. Those PAs will follow the normal process for renewals.

C. Addressing Drug Shortages

1. The AHCCCS Drug List has preferred medications that the AHCCCS Medical Policy Manual (AMPM) 310-V specifies should be utilized prior to a non-preferred agent. In the event of a shortage, a non-preferred medication must be approved.

AHCCCS PA and CR Standards Continued

For example, ProAir is the preferred albuterol inhaler. Using ProAir as an example, if there is a shortage of ProAir, OptumRx, subject to AHCCCS' approval, will allow all other branded and generic albuterol products to be reimbursed through the pharmacy claims system without prior authorization.

- As of 3/26/20 ProAir and Tamiflu are both in short supply, and OptumRx will allow for reimbursement of all federally and state reimbursable generic and brand products.
2. Please check the FDA web links daily for shortage updates:
 - a) accessdata.fda.gov/scripts/drugshortages/default.cfm
 - b) www.fda.gov/news-events/press-announcements/coronavirus-covid-19-supply-chain-update
 3. To ensure access to care, DFSM and OptumRx shall not require a prior authorization for compounded drugs for children under the age of ten years old.

D. Signature Requirements

42 CFR 456.705 and the Arizona State Board of Pharmacy requires that members receive counseling when prescriptions are dispensed. While counseling is still required, the Arizona State Board of Pharmacy has waived the member's signature requirement, and will instead allow the pharmacist to enter confirmation that counseling occurred. This will allow members to not have to sign a document and to keep appropriate distance from the counter.

IV. Physical Health Services

A. COVID-19 Testing and Treatment Services

DFSM will not require prior authorization or concurrent review for services related to testing, diagnosis, and/or treatment of COVID-19.

B. Facility Services

1. DFSM will remove prior authorization requirements for the following levels of care:
 - Acute Inpatient hospitalization;
 - Assisted Living Facilities/Centers;
 - Skilled Nursing Facilities (SNFs); and
 - Inpatient Rehabilitation Facilities (e.g. Long Term Acute Care Hospitals).
2. FFS Providers shall coordinate care management activities to ensure FFS members have safe and effective transitions between levels of care.

3. Prior Authorization approvals for elective inpatient services, which are within 60 days of expiration may be extended for 6 months, as needed.

C. Outpatient Services

1. DFSM may extend outpatient service prior authorization approvals, which are within 60 days of expiration, for 6 months, as needed.
2. For services related to the COVID-19 emergency, other than testing, diagnosis and treatment, the document submission period for Prior Authorization will be extended to 90 days. Covid-19 testing, diagnosis and/or treatment are exempt from Prior Authorization. Please see IV A.

V. Non-Emergency Medical Transportation (NEMT) Services

1. Prior authorization requirements have been temporarily waived for NEMT services over 100 miles.
2. AHCCCS has waived the requirement for NEMT drivers to collect a passenger's signature, whether on paper or electronically at this time.

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

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. Pursuant to section 1135(b)(5) of the Social Security Act, CMS has temporarily approved an extension of the timeline required for completion of the face-to-face requirement.

Effective 6/8/20, through the duration of the emergency, the face-to-face encounter does not need to be completed before the start of services, and may occur at the earliest time feasible for a provider, provided that the face to face encounter occurs within 12 months from the start of service.

This is a temporary extension of the timeline for completion of the face to face requirement, and all services are subject to post-payment review.

VII. COVID-19 Frequently Asked Questions (FAQs)

We encourage everyone to please continue to check the AHCCCS COVID-19 FAQs. The [FAQs are updated daily](#),

Behavioral Health Transportation Responses

1. The air transportation is for AHCCCS patients who are having a behavioral health crisis, and while IHS may be calling this situation as an emergency, the air ambulance provider reports that it is a non-emergency behavioral health service (i.e. suicidal ideation).

- Per policy 310-BB “Emergency Transportation may be initiated by an emergency response system call “9-1-1”, fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by an AHCCCS member automatically dispatches emergency Ambulance and Emergency Medical Technician (EMT) or Paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond, however, upon arrival on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:
 - a. Emergent,
 - b. Non-emergent, but medically necessary, or
 - c. Not medically necessary.”
- Non-emergency medically necessary transportation is covered consistent with A.A.C. R9-22-211 when furnished by non-emergency transportation providers to transport the member to and from a covered physical or behavioral health service. Such transportation services may also be provided by Emergency Transportation providers after an assessment by the Emergency Transportation team or Paramedic team determines that the member’s condition requires medically necessary transportation.

See AM/PM Policy 310-BB for additional transportation policy information.

2: I would like to know whether it is okay for IHS to call any air ambulance provider for AHCCCS patients needing urgent BHS.

- FFS members can receive services from any AHCCCS registered provider. For the purpose of behavioral health service coverage, FFS plan members are members who are enrolled with AIHP, TRBHA, or Tribal ALTCS for BH services.
- Air transportation for BH – Clinical documentation must indicate why ground transport is not sufficient to meet the needs of the member, what care the member requires during transport to support the type and/or mode of transportation ordered, what type of care or treatment the member is being transferred for, and when applicable, why

it is medically necessary for the member to travel beyond what would reasonably be considered to be the nearest appropriate facility to receive care (Ex: Bypassing Phoenix and instead travelling from White River to Tucson to access behavioral health services).

- Per AM/PM Policy 310-BB Medically Necessary Non-Emergency Transportation Furnished by Ambulance Providers. Medically necessary non-emergency transportation furnished by Ambulance providers is appropriate if:
 - o Documentation that other methods of transportation are contraindicated,
 - o The member’s medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an Ambulance,
 - o For hospital patients only: i. Round-trip air or ground transportation services may be covered if an inpatient hospitalized member travels to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy). Such transportation may be covered if services are not available in the hospital in which the member is inpatient,
 - o Transportation services to the nearest medical facility that can render appropriate services are also covered, when the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the member’s condition is determined to be non-emergent but one which requires medically necessary transportation.
- Cost containment must be supported through cost effective utilization of available resources.

3. Is there a protocol that IHS should follow with respect to helping the AHCCCS patient access behavioral health services?

Per Chapter 12 of the IHS/Tribal Provider Billing Manual the following applies:

Behavioral health services should be coordinated with the plan the member is enrolled with for behavioral health services. FFS members will either be enrolled with an integrated plan or with a behavioral health entity as shown below:

- Integrated health plans include:
 - o ACC health plans,
 - o AIHP, and
 - o AIHP/TRBHA.

Behavioral Health Transportation Responses Continued

- For members enrolled with different entities for their physical and behavioral health services, the Behavioral Health Entity is the entity which provides behavioral health services. Behavioral Health Entities can be one of the following:

- o Regional Behavioral Health Authority (RBHA);
- o Tribal Regional Behavioral Health Authority (TRBHA)

4. Is coordination with the local RBHA or TRBHA required? Who are the RBHA contacts?

- If the member is enrolled with a Tribal Regional Behavioral Health Authority (TRBHA) for BH services, BH care should be coordinated with the TRBHA. TRBHA members can access behavioral health services using any AHCCCS registered provider.
- If the member is enrolled with the American Indian Health Program (AIHP) for BH services, BH care should be coordinated with the case manager at the IHS/638 facility in the member's service area. Fee For Service Case Management can be contacted to assist if barriers are identified. Members enrolled with AIHP for behavioral health services can access behavioral health services using any AHCCCS registered provider.
- If the member is enrolled with a Regional Behavioral Health Authority (RBHA) for BH services, BH care should be coordinated with the RBHA. RBHA members are limited to the RBHA network when accessing BH services through non-IHS/638, BH providers.
- If the member is enrolled with an American Indian Medical Home (AIMH), BH care should be coordinated between the member's AIMH, and the member's plan of enrollment for BH services.
- AHCCCS Fee For Service Case Managers can assist with identification of AHCCCS registered behavioral health providers for all FFS members.

See #3. The Health Plan Contact List can be found on the [AHCCCS website](#).

- 5. **Unfortunately, one common scenario for urgent or emergent need for service, consists of the IHS doctors determining transportation by air is needed, as opposed to ground. However, the provider called for the patient pick up continues to have issues billing AHCCCS for these services and insists that IHS pay for the service. Denial reasons as shared by the provider include, no prior authorization, med-**

ical necessity, billing for a non-emergent service, and timely filing.

Transport services may be pended or denied related the following:

- Use of inappropriate modes (Ex: Air when ground ambulance will meet the needs of the member) and/or types (Ex: ALS is requested when BLS will meet the needs of the member) of transport that are not medically necessary and/or are not cost effective will not be reimbursed when services that are medically necessary, appropriate, safe, and cost effective are available.
- As outlined in AMPM policy 310-BB transportation services are covered to the nearest appropriate provider that can meet the member's needs.
- Per policy 310-BB "Emergency Transportation is covered in emergent situations in which specially staffed and equipped Ambulance transportation is required to safely manage the member's medical condition. Basic Life Support, Advanced Life Support, and Air Ambulance services are covered, depending upon the member's medical needs. Prior authorization shall not be required for reimbursement of Emergency Transportation."
- Per AM/PM Policy 310-BB Medically Necessary Non-Emergency Transportation Furnished by Ambulance Providers. Medically necessary non-emergency transportation furnished by Ambulance providers is appropriate if:
 - o Documentation that other methods of transportation are contraindicated,
 - o The member's medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an Ambulance,
 - o For hospital patients only: i. Round-trip air or ground transportation services may be covered if an inpatient hospitalized member travels to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy). Such transportation may be covered if services are not available in the hospital in which the member is inpatient,
 - o Transportation services to the nearest medical facility that can render appropriate services are also covered, when the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the member's condition is determined to be non-emergent but one which requires medically necessary transportation.

Behavioral Health Transportation Responses Continued

6. How do we select or determine which transportation companies are authorized to transport members with urgent BHS needs?

- If the member is enrolled with FFS for behavioral health services (TRBHA, or AIHP) they can access behavioral health services using any AHCCCS registered provider.
- The online Provider Search tool can also be used to identify providers in AZ for FFS members.
- The online Tribal Business License list is available for use identifying FFS providers that are approved for transport on tribal lands.
- AHCCCS Fee For Service Case Managers can assist with identification of AHCCCS registered behavioral health providers for FFS members.
- If the member is enrolled with a Regional Behavioral Health Authority (RBHA) for BH services, BH care should be coordinated with the RBHA. RBHA members are limited to the RBHA's provider network when accessing BH services through non-I H S/638, BH providers.

7. Is there a link to help us learn how to use the BHS in northern Arizona?

- AMPM policy 310-B covers AHCCCS behavioral health services.
- AMPM policy 310-BB covers NEMT covered services.
- See #6 for FFS behavioral health services coordination information.
- Email using the FFS Training link to request training.

8. Also, may you let me know who is the responsible payer when the AHCCCS American Indian member is enrolled with the American Indian Health Program (AIHP)?

Per chapter 12 of the IHS/Tribal Provider Billing Manual:

- Claims for AIHP and TRBHA members should be sent to AHCCCS DFSM.

Resource Links:

[AMPM Policy 310-BB NEMT Services](#)

[AMPM Policy 310-B Behavioral Health Services](#)

[Chapter 11 IHS Billing Manual \(General Billing Criteria for IHS/638 providers\)](#)

[Chapter 12 IHS Billing Manual](#)

[Chapter 14 FFS Provider Billing Manual \(General Billing Criteria for non-IHS/638 providers\)](#)

[Provider Search Tool](#)

[Provider Tribal Business License List](#)

[Provider Training Inbox](#)