AHCCCS Prior Authorization and Concurrent Review Standards during the COVID-19 Emergency for Fee-for-Service Programs

The memo on AHCCCS Prior Authorization (PA) and Concurrent Review Standards during the COVID-19 Emergency for Fee-for-Service Programs has been updated as of August 18th, 2021. Please review the PA standards.

APEP Updates – Service Addresses May Now Be Updated Directly in APEP

The APEP system now allows service addresses to be updated directly in APEP. This means uploading the list of service addresses is no longer required. The service address(es) are updated in Step 2: Locations and require a minimum of one service address to complete the step.

Providers that submitted a list of service address(es) along with the application that has not been approved, the application will be placed back into an "In Process" status to allow the user to update the service address(es) and resubmit.

Providers in an approved status requiring a service address, If the user has domain permissions to access the file, submit a modification request in APEP and add the service address(es) in Step 2: Locations.

If the user doesn't have domain permissions, email APEPTrainingQuestions@azahcccs.gov to open a service ticket, include the APEP username of the person requesting domain permissions and the provider NPI and name.

APEP FAQs

If you're seeking quick answers to common questions regarding APEP or enrolling as an AHCCCS provider. Please visit the current list of common questions regarding the provider enrollment process. The list of FAQs can be found at: https://azahcccs.gov/PlansProviders/NewProviders/registration/APEP/faq.html
For all other enrollment questions, please contact Provider Assistance (602) 417-7670

option 5 or email APEPTrainingQuestions@azahcccs.gov

ANNOUNCEMENTS
IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, if you select Non-Person Entity (2) when submitting documentation:

- **DO NOT enter information into the Provider First Name field. If you do this as a Non-Person Entity, then your attachments will not link to the claim.**

This will cause your claim to be denied for missing documentation.

Please read the article in this edition of Claims Clues for more detailed information and images showing the issue we have been seeing.

TRAINING AND CONTACTS
The DFSM Provider Training Team's Third Quarter Training Schedule is posted on the DFSM Provider Training web page.

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.

- 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)

ISDCustomerSupport@azahcccs.gov

OR call 602-417-4451

COVID FAQ
FAQs on the AHCCCS website.

********IHS AND 638 TRIBAL FACILITY / PHARMACY*********
AUTHORIZATION FORM FOR SUBMISSION TO OPTUMRX
Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY	
Contacted:	
Prescriber:	
Pharmacy:	
Patient:	

OPTUMRX Prior Authorization Department
P.O. Box 5252
Lisle, Il 60532-5252
Fax: 866-463-4838

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY	
Approved:	
Denied:	
Returned:	
PA #	

Instructions:
This Medication Request Form is only for use by prescribing clinicians for AHCCCS FFS members and must be signed by the prescribing clinician. In addition to member identifying data, the prescribing clinician must provide the medication requested, the dosage and the clinical justification/rationale for the request. If the request is for a drug not listed on the AHCCCS Drug List, the documentation must demonstrate why the member cannot use the medication(s) listed on the drug list. The Medication Request Form is also used to request overrides for step therapy, quantity limits and other edits. If you have any questions regarding this process, please contact Optum Rx's Customer Service at (855) 577-6310. **Please complete this form and fax to Optum Rx at (866) 463-4838.**

Pharmacy Instructions for After Hours Emergencies, Hospital Discharges & Care Transitions
The participating network pharmacy staffs are to contact the Optum Rx's Customer Service Unit at (855) 577-6310 to request medication overrides for after-hours emergencies, hospital discharges or patients transitioning from the hospital to a lower level of care; this also includes antibiotic infusion requests.

☐ **CHECK HERE IF THE PATIENT IS A DIRECT TRANSFER FROM A HOSPITAL TO A LONG-TERM CARE FACILITY.**

Medication Request Information (please complete each section of this form prior to submission): *Denotes Required Fields

PATIENT INFORMATION	PRESCRIBING CLINICIAN INFORMATION	
*Name:	*Name:	
*ID#:	*Specialty:	
*Date of Birth:	ID# / DEA#:	
*Health Plan:	*Phone: ( ) -	*Fax: ( ) -
*Diagnosis (ICD-9 Code, if known):		

REQUESTED DRUG INFORMATION		PHARMACY INFORMATION	
*Requested Drug:		Name:	
Dose:	Strength:	Phone: ( ) -	Fax: ( ) -
Quantity: (per month)	Dosage Form: (Oral, Injection, etc.)	Length of Treatment: (Please be specific.)	
Clinical Justification for the Requested Medication:			
Other Medications Tried and/or Failed (Please be specific, give detail.):			
Additional Information / Other Pertinent History:			
*Prescriber Signature Required:		Date:	

Revised 07/01/2021

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Attention All Transaction Insight (TI/TIBCO) Portal / Web Upload Attachment Users

This is an **important notice** for providers who log onto the Transaction Insight Portal (also known as TIBCO or the TI Portal) to upload attachments, such as medical records and the Daily Trip Report

If you select **Non-Person Entity (2)** and then enter in information into the **Provider First Name** field, this will cause an error and your attachments will not link to the claim.

This will cause your claim to be denied for missing documentation.

AHCCCS has been seeing multiple errors amongst providers who are submitting documentation as a Non-Person Entity (2). Do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.

INCORRECT
Provider Entity Type Qualifier: Person (1) Non-Person Entity (2)
Provider Last or Organization Name: Organization Name
Provider First Name: Organization Name (If you put something here, the documentation may not attach and the claim could deny.)
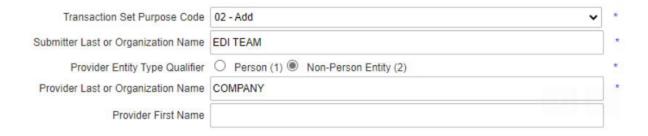
CORRECT (Provider First Name must be blank/empty)
Provider Entity Type Qualifier Person: (1) **Non-Person Entity (2)**
Provider Last or Organization Name: Organization Name
Provider First Name:

The Provider First Name field **must** be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the portal.

Please also review Page 8 (Submitter Last or Organization Name) in the guide:

Transaction Insight Web Upload Attachment Guide

If you encounter problems logging on to the TI Portal, please contact EDI Customer Support at servicedesk@azahcccs.gov
Please click on the link below to download the latest training on the new web upload attachment layout.

- New TI Portal User Guide

Any additional questions regarding training on the TI portal, please contact:

- ProviderTrainingFFS@azahcccs.gov

ROPA

Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

The [Patient Protection and Affordable Care Act (ACA)](#) and the [21st Century Cures Act (Cures)](#) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA", and

has set a deadline of June 1, 2021 by which providers must register in order to be reimbursed.

Until these acts passed, referring, ordering, prescribing, and attending providers were required to obtain a National Provider Identifier (NPIs), but were not required to be registered as an AHCCCS provider.

Learn more at [azahcccs.gov/PlansProviders/NewProviders/ROPA.html](#).One-on-One training requests, designed for a specific provider based on request.

Fee for Service Authorization Reminders

Authorization Reminders

General

- Providers and facilities have separate authorization requirements that may differ. Each FFS provider is responsible for verifying authorization requirements and obtaining authorization for the services they intend to bill when authorization is required.

- Each provider must ensure they are requesting authorization under the NPI or AHCCCS # of the provider who is rendering the service when requesting authorization. PA staff cannot authorize services under a group NPI.

- Providers should submit documentation that is sufficient to establish medical necessity for the services requested at the time of their initial submission. Routine authorization processing times can be up to 10 days. When resubmission of missing information is required this causes delays and extends the time needed to complete the authorization process.

Skilled Nursing Facilities

- Authorizations for Fee for Service (FFS) member admissions to skilled nursing facilities covers room & board, and services that are included in the skilled nursing facility stay as specified in R9-22-216 and R9-28-204. Prescription medications and medical equipment that is not basic in nature can be billed separately to AHCCCS under the member's benefit for those items.

Web Portal Use Reminders

- Multiple clinical documents for the same request should be uploaded as a single file.

- Member eligibility must be verified before entering a request into the Web Portal.

- All hospital admission notifications and/or authorization requests for hospital admissions *must* be accompanied by the facility's face sheet, and the history and physical documentation for the admission.

- Hospital authorizations pended for a discharge date should be updated online by the facility. When updating the discharge date for an admission facility providers must attach the discharge summary using the web portal attachment feature.

- The status of all prior authorization requests must be viewed using the Web Portal. Prior authorization staff will no longer provide authorization status or issue authorizations to callers over the phone.

- *Urgent/Expedited requests should be submitted online with supporting documentation, **AND** a call must be made to the FFS Prior Authorization line to notify PA staff that a request requiring expedited review has been submitted.

Fee for Service Authorization Reminders Continued

* NOTE: Submission of requests on short notice does not constitute an urgent request. An urgent/expedited request can take up to three days to review. Requests submitted as urgent that are determined upon review to be routine in nature will be processed in accordance with standard review timeframes.

- The authorization area does not authorize anesthesia codes, E/M visits, or rehab therapies. Please do not submit requests for these services.

*Exceptions:

- Providers that do not have access to the FFS web portal can fax time sensitive requests after they have requested access to the online system from AHCCCS' ISD area. Faxed authorization requests must include confirmation that online access is pending.

- If submission of a Prior Authorization request or documentation is not possible due to internet outage or other unforeseen events, then faxed requests will be temporarily accepted during the timeframe the web portal is unavailable. The Prior Authorization Request Form must be utilized with all faxed documents.

Physical Health vs. Behavioral Health Authorization Requests

- Hospitals submitting authorization requests for inpatient admissions involving the provision of both physical and behavioral health services during the same admission must bill a single claim for the entire admission using either a behavioral health principle diagnosis OR a physical health principle diagnosis. The authorization type entered online must be submitted with diagnosis and billing codes that correspond with the admission type that will be billed on the claim as the claim billed must match the services authorized.

  Medical inpatient hospital admissions are reimbursed using diagnosis related grouping (DRG) methodology and behavioral health inpatient hospital admissions are authorized using revenue codes for per diem reimbursement methodology.

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See below for a brief description of the code types used to enter authorization requests for inpatient hospital admissions online.

Hospital Admission Types	Authorization Event Type	Corresponding Activity Type	Corresponding Activity (Billing) Codes
Physical Health/Medical Physical health principle diagnosis on claim.	IP (Medical Inpatient)	D (DRG)	DRG
Behavioral Health Behavioral health principle diagnosis on claim.	BI (BH Inpatient)	R (Revenue Code)	0114, 0116, 0124, 0126, 0134, 0136, 0154, 0156

NOTE: All acute hospitals (provider type 02 or 71) located in Arizona must enter Activity information on their authorization requests for inpatient admissions.

Training

- Providers requiring assistance with the online authorization entry process are encouraged to review training resource materials on the website.

- For general questions about the PA process please contact the Prior Authorization line at 602-417-4400 or 800-433-0425 (In-state-outside the Phoenix area). PA staff will direct providers requiring in-depth instruction related to authorization entry to the FFS Training area.

Quality Management (QM) Housekeeping Tips

The AHCCCS/DFSM Quality Management (QM) investigates QOC Concerns, IADs, and Health and Safety Conditions for members enrolled in FFS Programs in accordance with 42 U.S.C. §1396a(a)(30)(A).

Quality Management is an important component of a member's care, and here are some tips for providers:

- Make sure to verify a Member's eligibility for Behavioral Health and Physical Health assignment when providing services to a new member.

- Please coordinate care with the member's health plan. This includes TRBHAs, who are to be considered as the member's Behavioral Health plan.

- Keep your provider contact information updated with AHCCCS Provider Enrollment. The Division of Fee-for-Service Quality Management frequently utilizes your PMMIS contact information to help with mentioning clinical documentation from your facility.

- Please include all applicable clinical documentation when reporting any incidents, accidents and deaths in the QM Portal.

The AHCCCS Medical Policy Manual chapter on 'Quality of Care

Fee-for-Service provider requirements' can be found on our website:

Per AMPM 830: "The Tribal ALTCS and TRBHA programs shall participate in the investigation of QOC Concerns, IAD reports and Health and Safety Conditions related to their enrolled members, in accordance with applicable IGAs and in coordination with AHCCCS.

Reports of QOC Concerns and service issues may be raised at AHCCCS internally or externally by members/Health Care Decision Makers and designated representatives, providers, and stakeholders, from anywhere in the community.

The AHCCCS Provider Participation Agreement (PPA) provides the authority for AHCCCS/DFSM to ensure that FFS providers comply with all applicable state and federal rules and regulations, including alignment with state licensure requirements, as well as AHCCCS rules and policies relating to the audit of provider records and the inspection of the provider's facilities. FFS providers are responsible for adhering to the requirements specified in all applicable AHCCCS policies, including this Policy. For specific requirements applicable to Tribal ALTCS and the TRBHAs, refer to the respective IGA."

Non Emergency Medical Transportation (NEMT) Daily Trip Report Instructions

AHCCCS requires the use of the AHCCCS standard Daily Trip Report, which is Exhibit 14-1 in the Fee-For-Service Provider Billing Manual.

- Please note that different versions of the Daily Trip Report may **not** be used or submitted. The attachment in Exhibit 14-1 is the **only version** that may be submitted.

- Providers are **not** permitted to create their own versions of the AHCCCS Daily Trip Report for submission. **Only the AHCCCS approved Daily Trip Report can be used.**

- It is available as a PDF and Excel file (to allow providers to expand the additional information area if needed).

The upper left area of the form is where the provider will write the NEMT provider's name, provider ID, address, and phone number.

The driver must print clearly. Illegible Daily Trip Reports can result in audit error and recoupment.

The AHCCCS Daily Trip Report must be completed in pen. It may be filled out in either blue or black pen. If an error is made, draw a single line through the error and print the correct information.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, as long as all federal and state requirements are taken to protect member information. If this is done it may be submitted in one of two ways:

1. Printing it out and mailing it in, or
2. Electronic submission through the provider portal as a PDF file.
   - AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.

Non Emergency Medical Transportation (NEMT) Daily Trip Report Instructions Continued

o AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was included at provider request.

o AHCCCS **will accept** PDF files of the AHCCCS Daily Trip Report.

NOTE: If the AHCCCS Daily Trip Report is submitted as a PDF file through the 275 Provider Portal, it is necessary that the PDF file allow AHCCCS to extract the document, otherwise AHCCCS will not be able to view the submitted PDF file.

If a member's transport has more than one "stop" or destination, then each trip must be fully documented on the Daily Trip Report.

For example:

- A member is picked up at home and transported to the doctor's office. (1st trip)

   The doctor gives the member a prescription for medication.

   The member is transported from the doctor's office to a pharmacy that is at a different location than the doctor's office. (2nd trip)

   The member picks up their prescription.

   The member is then returned home. (3rd trip)

In the above example, the Daily Trip Report would have 3 trips documented as indicated. Only one trip report should be filled out per member, per day. If there are more than three stops for one member, in one day, please use multiple pages. If more than one vehicle is used and/or if more than one driver transports the member on the same day, please use multiple pages (one for each vehicle) and document that more than one vehicle and/or driver was used in the additional information section. If multiple pages are used, the page number must be indicated at the bottom right of the Daily Trip Report. All pages become the complete Daily Trip Report for **the** transport services for that member, on that service date.

How to Fill Out the Trip Report

Upper Left Hand Corner

- Provider Information:
   o Provider Name
   o Provider ID
   o Provider Address
   o Provider Phone Number

o **NOTE:** Using a stamp is acceptable.

Upper Right Hand Corner

- **Driver's Name:** Printed first and last name and signature of the driver who provided the service.

- **Date:** Indicate the date of service (mm/dd/yy) or (mm/dd/ccyy).

- **Vehicle Identification:**
   o List the state the vehicle is licensed in.
   o License Plate Number/Fleet Number
   o Make and Color of Vehicle
   o **NOTE:** If the driver uses more than one vehicle for the same date of service, they must use a new Daily Trip Report for each separate vehicle and they must indicate (at the bottom right) the page number. All pages become the complete Daily Trip Report for the transport services for that member, on that service date.

- **Vehicle Type:** Check the box next to the type of vehicle used (car, van, wheelchair van, stretcher van, etc.)
   o **NOTE:** Check 'Other' and write in the vehicle type if the description does not match the available options.

Upper Middle Section

- Member Information:
   o Member's AHCCCS ID
   o Member's Name
   o Member's Date of Birth (mm/dd/ccyy)
   o Member's Mailing Address.

Main Section for Transportation Information

There will be 3 trip sections per Daily Trip Report page. The 1st Pick-Up and Drop-Off area, the 2nd Pick-Up and Drop-Off area, and the 3rd Pick-Up and Drop-Off area. This is to accommodate multiple trips on the same day. If more than 3 stops occur on the same day please use additional Daily Trip Reports as pages and indicate that they are the 4th, 5th, etc. stops.

- **Pick-Up Address:** Complete address (including street address, city, state and zip code) of pick-up destination.
   o If no formal street address is available coordinates can be used. An address must be included in some

Non Emergency Medical Transportation (NEMT) Daily
Trip Report Instructions Continued

format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the pick-up location can be used.

- **Pick-Up time:** Clock time including the a.m./p.m. indicator (example: 7:12 AM). Please circle the appropriate time of day (a.m./p.m.) provided.

- **Pick-Up Odometer:** Document the actual odometer reading at the pick-up location.

- **Drop-Off address:** Complete address (including street address, city, state and zip code) of drop-off address.
  - o If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the drop-off location can be used.

- **Drop-Off time:** Clock time including the a.m./p.m. indicator (example: 7:12 PM). Please circle the appropriate time of day (a.m./p.m.) provided.

- **Drop-Off Odometer:** Document the actual odometer reading at the drop-off location.

- **Trip miles:** Subtract the pick-up odometer reading from the drop-off odometer reading, and that will equal the total number of trip miles. (Drop-Off Odometer Reading – Pick-Up Odometer Reading = Total Trip Miles)

- **Type of Trip:** Round Trip, One Way, or Multiple Stops (Check the appropriate one.)

- **Reason for Visit**: Only include as much information as the member is willing to share.
  - o **NOTE:** When transportation services are initially arranged, the transportation provider must obtain sufficient information to determine whether the transportation is occurring to an AHCCCS covered service. This should be done prior to the transportation taking place.

- **Diagnosis (if known):** Only include as much information as the member is willing to share.

- **Name of Escort:** If member is traveling with an escort, include their first and last name.

- **Relationship:** Indicate the escort's relationship to the member.

Lower Section

- **Member Signature:** Member must sign, if able. If member is unable to sign, please check the appropriate box and identify the person* signing for the member *or* include the member's fingerprint.
  - o If a tablet or other electronic device is being used, a method for the member or authorized representative of the member to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name). A fingerprint may also be used if they are unable to sign.
  - o Typing the member's name in cannot serve as a substitute for an actual signature or fingerprint.

- **Driver's Signature:** The driver must sign each page.
  - o If a tablet or other electronic device is being used, a method for the driver to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name).
  - o Typing the driver's name in cannot serve as a substitute for an actual signature or fingerprint.

- **Date:** The driver must date each page.

- **Page of :** Indicate each page number and the total number of pages used to document all transports for the member, for the same date of service.

- **Did multiple members get transported in the same vehicle on this trip?** Choose yes if multiple AHCCCS members are being transported in the same vehicle.
  - o Were the pick-up and drop-off locations different for the members? Choose yes if even one member in the vehicle had a different pick-up or drop-off location, as this can affect the odometer readings.

- **Additional Information:** Any additional information that the provider thinks is needed for the processing of the claim can be entered here.

Non Emergency Medical Transportation (NEMT) Daily Trip Report Instructions Continued

Clarification of member's "signature" requirement

- If a member is physically unable to sign (or fingerprint) the non-emergency medical transport Daily Trip Report then a parent or guardian, caretaker, escort, or family member can sign for the member and indicate their relationship to the member. If the member is transporting alone, then the trip report may be signed by the provider at the medical service appointment.

When someone else signs the trip report for the member, the trip report should show the member's name and a notation such as "by J Smith, daughter" to identify the person signing for the member.

Under no circumstances is the transport driver to sign for a member.

- Even if the transport driver is a physical or behavioral health care provider for the member, they still cannot sign for the member. If the member cannot sign for themselves then a parent, guardian, caretaker, escort, or other family member would have to sign for them. The driver cannot sign, even if the driver overlaps one of the categories that normally could.