AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

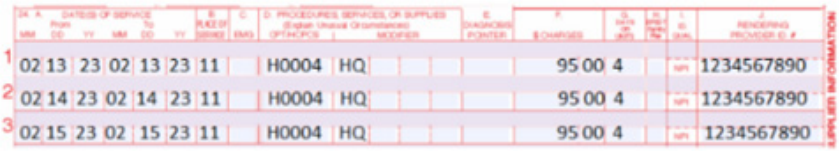
March 2023

Claim Date Span Billing Requirement

Effective with dates of service beginning February 17, 2023 and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to AHCCCS Division of Fee for Service Management must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service.

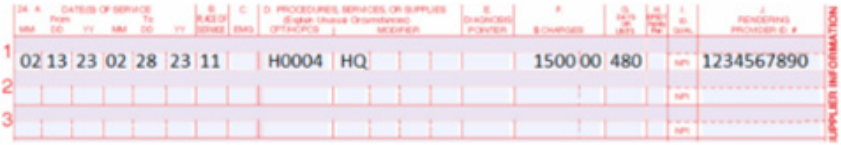
AHCCCS DFSM will deny any claim line submitted by a provider type 77 or IC when the billed claim line date span is greater than one (1) day of service.

Example of a Correct Claim Submission:



1	02	13	23	02	13	23	11		H0004	HQ			95	00	4	1234567890
2	02	14	23	02	14	23	11		H0004	HQ			95	00	4	1234567890
3	02	15	23	02	15	23	11		H0004	HQ			95	00	4	1234567890

Example of an Incorrect Claim Submission:



1	02	13	23	02	28	23	11		H0004	HQ			1500	00	480	1234567890
2																
3																

Claim Denials Information

This guide is available for providers to review the most common claim denial codes and steps to take to help resolve the edit. The information presented on the website is to provide general guidance only.

AHCCCS FFS New Vendor Notification Medicaid Travel Services Provider

The Arizona Health Care Cost Containment System (AHCCCS), Division of Fee-for-Service Management has contracted with Medical Transportation Management (MTM) to coordinate services for medically necessary lodging and meal reimbursement for AHCCCS Fee-for-Service (FFS) members. MTM will assume
responsibility of providing the coordination services as of February 1, 2023.

Lodging and meal services will be arranged by MTM, however, the AHCCCS Utilization Management (UM) department will continue to provide prior authorization oversight for these services. Manual 310-BB.

ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address of servicedesk@azahcccs.gov

TRAINING AND CONTACTS

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website at: https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

The DFSM Provider Training Team's First 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

- 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

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

Provider Registration – Fax Applications (602) 256-1474

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

ELECTRONIC PAYMENT SIGN UP

(Remittance Advice Sign Up/835) Contact: ISDCustomerSupport@azahcccs.gov
–OR- call (602) 417-4451

COVID FAQ

FAQs COVID Fact Sheet.

Please note that these materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional

APEP Reminder –Service Addresses Can Be Updated Directly in APEP

If the user has APEP 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 does not 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.

Claim Denial Resolution Guide

Prior Authorization Reminders

Providers entering authorization requests online must complete the **CASE**, **EVENT**, and **ACTIVITY** levels for each authorization request entered. Remember to routinely check the status of the PA request. Providers should use the online PA Attachment tool to upload supporting documents when needed.

Providers can refer to the Prior Authorization Procedure Code List to verify if the service requires a prior authorization. Updated Prior Authorization forms are posted here: Prior Authorization Forms

We recommend that providers verify eligibility and benefits prior to rendering services for all members. Payment, regardless of authorization, is contingent on the member's eligibility at the time service is rendered. **Remember, prior authorization is not a guarantee of payment. Unauthorized services will not be reimbursed.**

For training on how to enter authorizations using the Web Portal please submit your training request to: ProviderTrainingFFS@azahcccs.gov

Reminder: Common PA Submission Errors

Incorrect Event Type: Selecting the incorrect Event Type based on the type of service and the provider type.

PA Activity Type: Fail to complete the PA request entry. Providers entering authorization requests online must enter CASE, EVENT, and ACTIVITY levels for each authorization request entered.

Missing / Not Submitting Documentation: When it is known that supporting documentation is required for a PA determination, documentation should be submitted at the time of the initial authorization request. This may include but not limited to documentation required from the medical doctor, face-to-face or the prescription order.

Durable Medical Equipment: Submitting PA requests for DME rental equipment that overlap a month span, for example incorrect entry 10/01/2022 - 01/30/2023 on a single PA event.

Adult Orthotics: Missing letter of medical necessity/least costly statement for adult orthotics.

FFS Rate Changes: Submitting PA request that overlap different rate periods. AHCCCS Fee-For-Service (FFS) rates are effective for dates of service beginning October 1 – September 30.

By-Report Procedure: Not submitting the charge price for the equipment or procedure when it is not listed on the AHCCCS FFS rates.

How to Submit a Prior Authorization Training

AHCCCS FFS New Vendor Notification Medicaid Travel Services Provider

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Attendant Care Provider Type 40 Non-Emergency Medical Transportation Services

Effective 06/01/2015, providers registering as a provider type 40 (Attendant Care Agency) will be required to be an AHCCCS registered provider for a period of twelve (12) months prior to being able to bill for non-emergency medical transportation (NEMT) services. Upon completion of the 12-month period this provider type will be able to bill for NEMT services.

However, the NEMT services should not exceed 30% of the overall services billed.

This guidance may be found in the FFS Provider Billing Manual, Chapter 3 Provider Records and Registration and Chapter 14 Transportation.

FFSChapter3ProviderRecordsandRegistration
FFSChapter14Transportation
Important Note: The NEMT benefit remains unchanged as outlined in the AHCCCS Medical Policy

Payment Error Rate Measurement (PERM) Audit

The Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) program recorded the Provider Education webinar conducted in April 2022. The recorded webinar is intended to educate the provider and supplier community about the PERM program and explain the responsibilities to those who are participating in the Medicaid program and/or Children's Health Insurance Program (CHIP).

The PERM program is designed to measure and report improper payments in the Medicaid and CHIP programs. Improper payment rates are based on reviews of Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the Reporting Year (RY) under review. The improper payment rate is not a "fraud rate" but a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. These improper payments may be overpayments or underpayments and do not necessarily represent expenses that should not have occurred.
The objectives of this recorded webinar is for those participating in the Medicaid and CHIP programs to better understand:

- The PERM program.
- The PERM medical review process.
- PERM medical record and documentation requests.
- Methods for record submission.
- Provider best practices.
- PERM resources for providers.

CMS uses a 17-state rotational approach to review the states' Medicaid program and CHIP so that the PERM program measures each state once every three years. Listening to this recorded webinar is an opportunity for the provider and supplier community to better understand their responsibilities during a PERM cycle. For additional information, please go to the CMS

PERM website:

What is Payment Error Rate Measurement (PERM) Audit

What is Payment Error Rate Measurement (PERM) AUDIT?

The PERM Audit is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Improvement Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 IPERIA). The improper payment rates are based on reviews of the Fee-for-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the year under review.

Provider Billing Reminders:

It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement. For each claim submitted, you must be sure to include the correct member's name and AHCCCS ID number, date(s) of service, revenue, procedure codes, units, and charge amounts (etc.). Claims should adhere to standard coding practices to also include modifiers if applicable. Providers should utilize the respective state and federal billing & coding resources to ensure claims meet the appropriate billing guidelines. Training Resources

Responding to PERM Documentation Requests:

Providers must submit the requested information by the due date noted on the request. Please note that it will be the responsibility of the provider identified on the claim to ensure that all supporting medical records, from the provider who rendered an AHCCCS covered service for which the claim payment under review was requested, is submitted in a timely manner. PERM webpage