ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Coordination of Benefits
Frequently Asked Questions

Q1: What happens if a member has other insurance coverage in addition to Medicaid?

A1: AHCCCS is the payor of last resort for payment of covered services unless specifically prohibited by state or federal law. Contractors are required to perform Coordination of Benefit (COB) activities. There are two methods used for COB, Cost Avoidance and Post-Payment Recovery.

Q2: What is Pay and Chase?

A2: Pay and Chase is one method of Post-Payment Recovery. The Contractor is required to pay the applicable full amount of the claim and then seek reimbursement from any Third Party. Pay and Chase applies to the following:

- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program, or
- Services covered by TPL that are derived from an absent parent whose obligation to pay support is being enforced by the Arizona Department of Economic Security (DES), Division of Child Support Services (DCSS).
- When the claim is filed, the Contractor is not able to establish the probable existence of a liable third party.

Q3: Is there a specific list of EPSDT services for which the Pay and Chase rules apply?

A3: The Pay and Chase logic is based on the primary diagnosis billed on the claim, regardless of the associated procedure code(s). Services are identified as EPSDT services based upon information found on the RF724 screen in PMMIS.

Some Examples of Preventive Pediatric Services

- Physical Health

  All types of health conditions — medical, dental, developmental, acute, and chronic — must be treated, including pre-existing conditions or those detected outside of a comprehensive well-child "screening" visit. Some common treatment and intervention services include: specialty referrals (initial consultation and subsequent visits related to the issue), eyeglasses, hearing aids, durable medical equipment such as wheelchairs and prosthetic devices, occupational, physical and speech therapies, prescribed medical formula foods, assistive communication devices, therapeutic behavioral services, and substance abuse treatment.

- Behavioral Health:

  Children's mental health services including behavioral/social/emotional screening tests during well-child visits, diagnosis, treatment, and referrals to comprehensive systems of care, and all evidence-based mental health services for children are included in this coverage. Examples of services would include comprehensive or focused ABA, residential placement and treatment, behavioral health referrals, and other therapeutic interventions for other pediatric psychiatric conditions as necessary.

Q4: Does the Pay and Chase requirement to pay services as the primary payer apply to all age ranges?

A4: No. The requirements apply to EPSDT aged members under the age of 21.

Q5: Does the TPL flag associated with procedure codes found on the RF113 screen in PMMIS come into play in determining the Contractor's COB activities?

A5: This TPL flag identifies if a procedure is commonly covered by Third Party payors. If a procedure is flagged on RF113 as TPL yes and the member has a primary payor, the Contractor should require the provider to bill the primary insurer first. This is the case UNLESS the primary diagnosis on the claim is found on the RF724 screen, in which case the Contractor must treat the claim as a Pay and Chase situation.

Q6: What happens if a prior authorization request is received by the Contractor for a member who may potentially have a potential third party payer?

A6: COB issues must not be used to delay authorization decisions. COB considerations are to be treated separately from the Contractor's independent responsibility to timely issue an authorization determination as specified in state and federal provisions. This means that the Contractor must timely and independently review any authorization request that is received and make a prompt determination of coverage based on Title XIX requirements so that members timely receive medically necessary services. The Contractor is not permitted to rely on the coverage determination of the other payor for purposes of the Title XIX coverage determination and must perform an independent determination. Services determined to be medically necessary are not to be delayed due to COB payment concerns.