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Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PROVIDER NOTIFICATION

DATE: October 27, 2010

TO: AHCCCS Providers

FROM: Marc Leib, M.D.
Chief Medical Officer

SUBJECT: Copayment Requirements Effective 10/1/2010 ***Revision 4*** *

As a result of changes in Federal and State laws and regulations, including provisions of the Deficit Reduction Act of 2005, AHCCCS will expand member copayment requirements effective October 1, 2010. The expanded copayment requirements, which are described in AHCCCS Final Rule A.A.C. R9-22-711, include mandatory copayments for certain populations, higher optional (nominal) copayment amounts for certain populations, and clarification of the services and populations which are exempt from both mandatory and optional copayments. The expanded copayment requirements will result in a modest cost savings to the State. This memorandum provides general information regarding copayment requirements that will become effective October 1, 2010. Providers will be able to identify a member's particular copayment requirements by checking the AHCCCS eligibility verification systems other than IVR (Refer to the "Copayment Tracking" section below.) A sample table with copayment information for AHCCCS members accompanies this memo.

Certain populations and certain services are always exempt from copayments.
Copayments are never charged to the following persons:

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program
- People who are acute care members and who are residing in nursing homes, or residential facilities such as an Assisted Living Home and only when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year
- People who are enrolled in the Arizona Long Term Care System
- People who receive hospice care
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs

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* Revision 4 clarifies that copays do not apply to acute AHCCCS members who reside in nursing facilities or residential facilities for up to 90 days in a contract year;
* Revision 3 discusses the October 25, 2010 federal Ninth Circuit Court of Appeals Order which allows the imposition of mandatory copays for the AHCCCS Expansion Population. This revision also clarifies that the IVR does not include the copay level.

Also, copayments are never charged for the following services:

- Hospitalizations
- Emergency services
- Family Planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women
- Services paid on a fee-for-service basis

Be aware that copayment requirements specified in this memo for the MED and AHCCCS Care ("Childless Adults") populations may change as a result of litigation. On October 25, 2010 the federal Ninth Circuit Court of Appeals issued an Order which allows AHCCCS to resume imposition of mandatory copayments for members in MED and AHCCCS Care. The injunction by the federal district court that was in place for the month of October 2010 ended. Beginning November 1, 2010, members in MED and AHCCCS Care will be subject to mandatory copays as described below. Future copayment requirements for MED and AHCCCS Care members may continue to change due to the lawsuit, and we will keep you informed of new developments. The AHCCCS website will be updated to reflect any upcoming changes.

Mandatory Copayments:

AHCCCS members who will have mandatory copayments for certain services:

- Transitional Medical Assistance (TMA) members, effective October 1, 2010. In the table, the TMA population is designated as Member Copay Level of 50.
- Childless Adults (also known as AHCCCS Care), effective November 1, 2010. In the table, the Childless Adult population is designated as member Copay Level of 40
- MED (Medical Expense Deduction) members, effective November 1, 2010. In the table, the MED population is designated as Member Copay Level of 40.

("Childless Adults" and MED members are also referred to collectively as the "AHCCCS Expansion Population" or the "TWG (Title XIX Waiver Group) Population.")

Mandatory copayments **permit** providers to **deny** services to members who do not pay the copayment. However, certain services (such as emergency services) are exempt from mandatory copayments, and specific members (such as individuals under the age of 19) are also exempt from copayments in the table. Exempt members are designated by a Member Copay Level of 00 in the table. The copayment amounts for Childless Adults and MED members are higher than those applicable to the TMA population. In addition, TMA members are not responsible for making additional copayments in a quarter when the total aggregate amount of copayments that have been made exceeds 5% of the family's income. (The 5% limit does not apply to Childless Adults and MED members; therefore, these individuals *are required* to pay each copayment irrespective of the total aggregate amount of copayments that these members have paid.) Please be aware that payments to providers have been reduced by the amount of a member's copayment obligation *regardless of whether or not the provider successfully collects the mandatory copayment.*

Optional (Nominal) Copayments:

Optional (also known as nominal) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. In the table, members with nominal copayments are designated as Member Copay level of 20 or 21. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment. The optional copayment amounts have been updated to reflect slightly higher amounts beginning October 1, 2010. If a member indicates that s/he is unable to pay the copayment, the provider is prohibited from denying the service.

Copayment Tracking

The AHCCCS Administration will track each member's specific copayment levels by service type, and this information will also identify those TMA members who have reached the 5% copayment limit. AHCCCS will further specify whether the member is subject to a mandatory or a nominal copayment and when copayments cannot be charged, i.e. the service or member is exempt from copayments. This information will be communicated by the specific Member Copay Level applicable to the various populations. Refer to the accompanying table which identifies each population (TMA, Childless Adults, MED, and Nominal) by Member Copay Level, e.g. 50 for TMA's. Therefore, there will be no need to identify a member's particular eligibility category. Members who are exempt from copays (due to population type) are also identified by Member Copay Level, e.g. 00. The Member Copay Level will be communicated to providers through the various verification systems: EVS, the web, and HIPAA transactions 270 and 271. Copay information will **not** be available through IVR. Because most AHCCCS members will not know their eligibility category, anticipate that members may ask you about their eligibility category or their copayment requirements when they receive services.

Please note, there is a hierarchy of services used in determining the amount of the copay. With the exception of prescription drugs (where a copay is charged for each drug received), only **one** copay may be assessed for services received during a visit. A "visit" is considered to be all services received in one day from a single provider, or components of the same service received in one day from multiple providers, e.g. a surgery in an ASC where both the ASC and the surgeon provide the same service.

For additional information regarding the copayment requirements, please visit the AHCCCS website at: www.azahcccs.gov/commercial/ProviderBilling/copayments.aspx

Member CoPayments Matrix

Member Co-Pay Level	Description	Mandatory, Optional or Exempt	CoPay Service(s)	CoPay Amount	Services Identified as:	No Show Fee Eligible *(Refer to specified criteria/required plan for application of this member fee).*
00	Exempt from CoPays *(note - all members will have a copay level; if copay level is not equal to one of the categories below the member will default to 00)*	Exempt - No CoPays for any services	None	None	None	No
20	Nominal - Traditional; Excluding 1931 parents with residence counties Maricopa and Pima	Optional - Services cannot be denied for failure to pay a CoPay	Pharmacy	$2.30	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning.	No
			Office Visits	$3.40	**For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Outpatient Professional Therapies	$2.30	**If no copay for a "visit" imposed above; For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	

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25	Nominal - Traditional; 1931 parents with residence counties other than Maricopa and Pima	Optional - Services cannot be denied for failure to pay a CoPay	Pharmacy	$2.30	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning.	Yes
	Elig Keys 231 nd 232		Office Visits	$3.40	**For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Outpatient Professional Therapies	$2.30	**If no copay for a "visit" imposed above; For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
21	Nominal - HIFA Parents	Optional - Services cannot be denied for failure to pay a CoPay	Pharmacy	$2.30	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning.	No

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Member Co-Pay Level	Description	Mandatory, Optional or Exempt	CoPay Service(s)	CoPay Amount	Services Identified as:	No Show Fee Eligible (Refer to specified criteria/required plan for application of this member fee).
			Office Visits	$3.40	**For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Outpatient Professional Therapies	$2.30	**If no copay for a "visit" imposed above; For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
40	TWG (MED; Non-MED; AHCCCS Care); Residence county Maricopa and Pima	Mandatory - Services may be denied for failure to pay a CoPay	Generic Pharmacy	$4.00	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning and w/ **Generic Drug** Indicator of "Y" or a **Generic Available Indicator of "N"**.	No
			Brand Pharmacy	$10.00	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning and w/ **Generic Drug** Indicator of "N" or a **Generic Available Indicator of "Y"**.	

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Member Co-Pay Level	Description	Mandatory, Optional or Exempt	CoPay Service(s)	CoPay Amount	Services Identified as:	No Show Fee Eligible *(Refer to specified criteria/required plan for application of this member fee).*
			Office Visits	$5.00	**For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Non-Emergency Use of the ER	$30.00	Facility Form type (OP); ER Revenue Code 0450, 0451 or 0459 Billed with an Admit Type of 2 or 3 OR a HCPCS/CPT Code of 99281; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Non-Emergency Transportation - Taxi	$2.00	**Per "trip";** Professional Form type (1500); HCPCS/CPT Codes = A0100; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
45	TWG (MED; Non-MED; AHCCCS Care); Residence counties other than Maricopa and Pima	Mandatory - Services may be denied for failure to pay a CoPay	Generic Pharmacy	$4.00	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning and w/ **Generic Drug** Indicator of "Y" or a **Generic Available Indicator of "N"**.	Yes
			Brand Pharmacy	$10.00	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning and w/ **Generic Drug** Indicator of "N" or a **Generic Available Indicator of "Y"**.	

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			Office Visits	$5.00	**For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Non-Emergency Use of the ER	$30.00	Facility Form type (OP); ER Revenue Code 0450, 0451 or 0459 Billed with an Admit Type of 2 or 3 OR a HCPCS/CPT Code of 99281; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
50	TMA (Transitional Medical Assistance)	Mandatory - Services may be denied for failure to pay a CoPay	Pharmacy	$2.30	Pharmacy Form type; **For each** NDC Code not indicated as Family Planning.	No
			Office Visits	$4.00	**For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	

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			Outpatient Professional Therapies	$3.00	**If no copay for a "visit" imposed above; For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
			Surgeries (In Office; Outpatient non-emergent; ASC's)	$3.00	**If no copay for a "visit" imposed above; For a "visit";** Professional Form type (1500); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
					OR	
					Facility Form type (OP); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416); w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
					OR	

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Member Co-Pay Level	Description	Mandatory, Optional or Exempt	CoPay Service(s)	CoPay Amount	Services Identified as:	No Show Fee Eligible (Refer to specified criteria/required plan for application of this member fee).
					Provider Type ASC (43); Professional Form type (1500); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416); w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.	
	Visit - a visit equals all services received in one day from a single provider, or components of the same service received in one day from multiple providers (i.e. a surgery in an ASC where both the ASC and surgeon provide the same service).	**Trip -** defined as each occurrence of a base rate.				