





IHS/638 Tribal Providers Overview

Billing At The All Inclusive Rate (AIR)

DFSM Provider Training

October 2022

AHCCCS

Arizona Health Care Cost Containment System

Topics

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IHS/Tribal 638 All Inclusive Rate (AIR)

- The Indian Health Service (IHS) rate is an all-inclusive rate reimbursed to IHS and 638 tribal providers by AHCCCS for Medicaid covered services. Billing is per encounter.
- An encounter for an IHS/638 Tribal facility means a face-to-face visit between a member and any AHCCCS registered provider for a AHCCCS covered service.
- Qualified providers are those who are registered and eligible to bill AHCCCS Medicaid for reimbursement of an covered service.

Billing the All Inclusive Rate

- All-inclusive rates are billed by an encounter which covers all allowable services provided during a single visit/ encounter. Encounters are billed on the UB-04 claim form and reimbursed at the AIR rate.
- Providers must bill all services related to the encounter visit rendered on the same day by the same provider are submitted on a single UB-04 form.

Billing at the Fee-for-Service Rate

- Fee-for-service rates, refers to a set rate of reimbursement based on the CPT/HCPCS code billed and the servicing provider type.
- Services must be an AHCCCS covered physical or behavioral health service.
- Claims billed at the FFS rate must be billed on the CMS 1500 claim form and include CPT/HCPCS, modifier, units of service, etc.




All Inclusive Rate Billable Services

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Clinic Visits

- A clinic visit includes all services provided in conjunction with the visit and includes any laboratory service that may be performed on the same day, before, or after the clinic visit.
- The AIR that is paid for the clinic visit (encounter) also includes the laboratory services done on the same day or any other day.

The following IHS/ 638 Tribal services are covered and reimbursed at the IHS encounter rate when medically necessary

Outpatient Clinic (0510)	**Telemedicine (the practitioner or recipient must be located at the IHS/Tribal 638 clinic)**
Outpatient Dental Clinic (0512)	**Vision Encounter**
Emergency Room Department (0516) *(not admitted as inpatient)*	**Well-Child/ EPSDT Visit**
Pharmacy Encounter – Billed Point of Sale (POS) OptumRx	**Inpatient Hospital (0100- 0101)**




Peer Support Services

Peer Support Services

Peer support services do not meet the definition of "clinic services" required for reimbursement of the AIR (for example case management services do not meet the definition).

- Billing: CMS 1500 HCPCS: H0038

Resources:

- AMPM 963 – Peer And Recovery Support Service Provision Requirements
- https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/963.pdf




Covid-19 Billing and Testing Services

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COVID-19 Billing for Testing Services

- Professional FFS claims for COVID-19 testing may be submitted for payment by entities who have received a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver to conduct COVID-19 testing. Providers must report their CLIA information to provider enrollment before submitting claims for testing.
- Laboratory procedure codes denoted as CLIA waived (QW) may be submitted on a professional claim for reimbursement with a QW modifier.
- For COVID-19 tests that are not CLIA waived, full CLIA certification is required to submit claims for payment.
- COVID-19 lab testing codes are covered in the outpatient hospital setting.

Billing Information Covid-19 Testing

- AHCCCS registered providers that perform COVID-19 testing must meet the requirements and have the appropriate credentials to perform testing.
- Effective 10/1/2020, to align with Medicare, AHCCCS will allow HCPCS code G2023, G2024, and C9803 when billing for specimen collection, which includes drive-through testing.

IHS and 638 Pharmacies Billing The Covid-19 Vaccine

- IHS and 638 Pharmacies may bill the current outpatient All Inclusive Rate (AIR) in effect on the date of service for the COVID-19 Vaccine administration fee(s) when administered by a pharmacist or interns and technicians under the supervision of a licensed pharmacist.
- The licensed pharmacist must have completed immunization training which also includes the use and administration of emergency medications.

- https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2021/IHS638COVID19VaccineAdminBillingGuidelines.pdf

IHS and 638 Pharmacies Billing The Covid-19 Vaccine (cont)

- AHCCCS is also temporarily allowing IHS/638 pharmacies to be reimbursed an additional pharmacy AIR for COVID-19 administration fee(s) in addition to the limitation of one pharmacy AIR per day per member per facility.
- AHCCCS will also continue to reimburse a second AIR for the Flu vaccine.
- The limitation of 5 AIRs per day per member will remain the same.

IHS and 638 Pharmacies Billing The Covid-19 Vaccine (cont)

- The IHS and 638 Pharmacies shall submit COVID-19 vaccine administration claims to the AHCCCS FFS Pharmacy Benefit Manager (PBM) point-of-sale system through OptumRx at the AIR.


IHS/Tribal 638 Medical Claim Billing The Covid 19 Vaccination

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IHS/638 Medical Claim Billing for the COVID-19 Vaccination

- IHS and 638 Facilities administering the COVID-19 vaccine as a clinic service may bill the current outpatient AIR for the date of service for the administration of the vaccine. Services can be billed using the UB-04 for Title XIX AHCCCS members.
- The claim must include the NPI(s) of the ordering and rendering provider and the providers must be AHCCCS registered providers on the date of service.

IHS/638 Billing Guidance Covid-19 Vaccine Administration for FFS KidsCare

- For FFS KidsCare members, the facilities are to bill AHCCCS for the administration fee(s) using the CMS 1500 Form or the 837P electronic format.
- The facility may bill the AIR for the initial and second administration of the injections.




Billing Covid -19 Emergency Related Modifiers Catastrophe/Disaster "CR", and Disaster Related "DR"

COVID-19 Emergency Related - "CR" Modifier - Catastrophe/Disaster.

- The CR modifier must be used on all applicable claims for services provided as a result of, or related to, the national emergency declaration of March 13, 2020, related to the COVID-19 Public Health Emergency (PHE).

- The CR modifier must be used on all billing for both outpatient institutional and non-institutional forms:
  - i. ASC X12 837P and 837I (Outpatient)
  - ii. CMS – 1500
  - iii. NUBC UB-04 (Outpatient)

COVID-19 Emergency Related - “DR” Condition Code - Disaster Related

- a. The DR condition code must be used on all applicable claims for services provided as a result of, or related to, the national emergency declaration of March 13, 2020, related to the COVID-19 Public Health Emergency (PHE).
- b. The DR condition code must be used on all *inpatient* claims:
  - i. ASC X12 8371 (Inpatient)
  - ii. NUBC UB-04 (Inpatient)
- c. The DR condition code is applicable to inpatient stays for which a member has received a COVID-19 diagnosis.




Telemedicine Services

Telemedicine Services and the All-Inclusive Rate

IHS/Tribal 638 facilities are eligible to serve as an originating site for telemedicine services and may also provide distant site telemedicine services.

- **Originating Site**: Is the physical location of the Medicaid recipient at the time the service is provided.
- **Distant Site:** Is the physical location of the practitioner providing the service via telemedicine







Billing Orphan Visits at The AIR

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Orphan Visits and the AIR

- An Orphan Visit (OV) is a planned laboratory visit based on the provider's care plan. In this example, the PCP orders a new medication for the member on 9/1/2022 and a laboratory assessment is required after initiation of the new medication.
- The PCP orders the member to return on 9/5/22 for lab tests. In this example, the orphan visit is a planned lab visit, the patient presents on 9/5/22, checks in and the visit is created, and the lab tests are performed.

Orphan Visits and the AIR

- The orphan visit can be billed separately as an outpatient claim, reimbursable at the AIR and will be applied to the daily AIR encounter visit limit.
- Note: Documentation must show this is an “Orphan Visit” and must be supported in the provider’s care plan.

What is Not Considered As An Orphan Visit

- A lab test that is ordered during a clinic visit but is done on another day is not considered an “Orphan Visit” and cannot be billed separately.
- For example, during a billable outpatient clinic visit a lab test is ordered for that day’s assessment. For whatever reason, the lab work is not done the same day as the clinic visit. Documentation should reflect one single visit for the clinic and ordered lab work and therefore one billable All-Inclusive Rate (AIR) encounter will be billed.

Stand Alone Visits
Radiology Services Not Billable At The AIR

- AHCCCS does reimburse for Stand Alone Visits for radiology and medical imaging professional services.
- AHCCCS registered radiologists may bill for their interpretation of the services.
- Radiology services will be reimbursed at the Capped FFS rate and must be billed on the CMS 1500 form with the CPT code(s).
- Modifier "26" is used to indicate that only the professional component, the interpretation of results and a narrative report was provided.




Observation Services

Billing Observation Services for Title XIX Members

- Observation stays must be provided in a designated “observation area” of the hospital unless such an area does not exist.
- **Reimbursement:** AHCCCS will reimburse the observation services at the outpatient AIR rate.
- **Revenue Code**: Outpatient clinic code.
- **Attending Provider:** the attending provider NPI is required on the UB-04. The attending provider must be an active AHCCCS registered provider on the date of service.
- **Note:** if the member is admitted from observation to an inpatient status all charges are included on the inpatient claim and billed under the appropriate inpatient revenue codes (0100 – 0101).




Title XXI KidsCare Members Enrolled in FFS/AIHP

Billing Outpatient Services For Title XXI KidsCare Members Enrolled in FFS/AIHP

Providers must verify the member's eligibility/enrollment prior to providing services to ensure the appropriate guidelines for the member's plan are followed.

- KidsCare members that are enrolled as Fee-for-Service (FFS) or AHIP will submit the claim to AHCCCS.
- IHS/Tribal 638 hospital outpatient surgery claims for Title XXI (KidsCare) members are billed on the 1500 claim form (837P for electronic claims).

Medical Enrollment

Health Plan ID/Description	Period Start	Period End	Rate Code	Contract Type	Insurance Type
999998 AHCCCS AMERICAN INDIAN HP	10/01/2018		6013 - KIDS 6-13 M & F NON-MEDICARE	X ACC/FFS/KC	MC MEDICAID

Service Type Codes

Ambulatory Surgery Center
KidsCare Members Enrolled in FFS/AIHP

- The Ambulatory Surgery Center (ASC), Surgeon and Anesthesiologist services must be billed on the CMS 1500 claim form with the appropriate CPT/HCPCS codes and modifiers *(if applicable) and reimbursed at the FFS rate.*
- Claims are reimbursed at the AHCCCS Ambulatory Surgery Center (ASC) fee schedule amount for the AHCCCS covered surgery. ASC services are not reimbursable under the AIR.




Billing Outpatient Services for Title XXI KidsCare Members Enrolled in AHCCCS Complete Care Plan (ACC/MCO)

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Billing Outpatient Services for Title XXI KidsCare Members Enrolled in ACC

Providers should verify the member's eligibility/enrollment prior to providing services to ensure the appropriate guidelines for the specific plan are followed.

- KidsCare(XXI) members that are enrolled in an AHCCCS Complete Care (ACC) plan, must submit the claim to the member's ACC enrolled plan.




Billing Multiple AIRs

Billing Multiple Encounters

- The All-inclusive rate (AIR) is paid for up to five encounters/visits per recipient per day.
- Encounters/visits are limited to the AHCCCS-registered facilities that provide covered services to Medicaid members in an IHS or Tribal 638 facility.
- Each encounter/visit must be a separate and distinctive service and rendered by an AHCCCS registered provider.
- The encounters/visits will be differentiated based on the *patient account numbers* that are assigned by the facility/clinic for each encounter/visit.

Billing Multiple AIRs Provided on the Same Day

- Example: The member has a dental and a cardiology visit on 9/5/2022. The member is prescribed three medications, one RX for the dental visit and two RXs for the cardiologist visit. All visits occur at the same IHS 638 facility and all three prescriptions are filled on the same day at the same pharmacy.
- In this scenario there are three eligible AIRs that may be billed for reimbursement.
  - One AIR for the dental visit,
  - One AIR for the cardiologist visit, and
  - One AIR for all three prescriptions - POS (OptumRx).




Billing Pharmacy Services at the All Inclusive Rate

Pharmacy Billing

- AHCCCS covers vaccines and emergency medication for adults without a prescription order when administered by a pharmacist or an intern at the pharmacy, who is currently licensed and certified by the Arizona State Board of Pharmacy consistent with the limitations of this Policy and state law A.R.S §32-1974.

Billing for Pharmacy Services

- **Billing example:** A member presents to the pharmacy and has two prescriptions filled, and receives a vaccine administered by the pharmacist.
- The facility cannot bill AHCCCS an AIR for any of these services.
- In this example, the pharmacy may bill one AIR for the two prescriptions and the cost and administration of the vaccine. The claim should be submitted to the PBM (OptumRx) for consideration.

Medications Provided on an Inpatient/Outpatient Basis

- Medications administered during an outpatient clinic visit are included as part of the encounter/visit and cannot be billed as a separate service at the AIR.
- Medications provided to members during an inpatient stay are included in the inpatient All Inclusive Rate and cannot be billed as a separate service at the AIR.




Pharmacy Services
Title XIX/Title XXI

Pharmacy Services Title XIX Members

- Effective 4/1/2019, IHS/638 pharmacies must submit all Fee-For-Service XIX prescription claims electronically at the point-of-sale to the AHCCCS FFS PBM, OptumRx.
- All prescription claims for the AIR and Specialty Medication Plans shall be submitted at the pharmacy's Actual Acquisition Cost (AAC).
- Reimbursement shall be in accordance with the contract between the PBM and the IHS/638 Pharmacy.

Pharmacy Services Title XXI KidsCare Members

- Pharmacy claims for Title XXI (KidsCare) members must be submitted to OptumRx.
- Pharmacy claims for KidsCare members are not eligible for reimbursement at the All Inclusive Rate.

OptumRx Information

- The OptumRx Help Desk is available 24/7/365 days per year.
- For questions or assistance contact the OptumRx Customer Service Help Desk at (855) 577-6310.
- The OptumRx Prior Authorization Department's hours of operation are:
  - Monday through Friday: 7:00 AM – 6:00 PM Central Time
  - Saturday: 8:00 AM – 4:30 PM Central Time.
- For assistance with online claim submissions, contact the OptumRx Customer Service Help Desk at 855-577-6310.
- IHS Pharmacy Billing Manual Chapter 10







Vaccines and Emergency Medications Administered by Pharmacists to Members 19 Years of Age and Older

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Vaccine Administrations by Pharmacist/Intern

IHS and 638 Pharmacies may bill the outpatient AIR when the vaccine is administered by a pharmacist or intern for XIX members only.

The administration and the cost of the vaccine is covered under the AIR.

The claim must be submitted to OptumRx (PMB) with the appropriate National Drug Code (NDC).

The facility cannot submit a claim to AHCCCS for the administration of the vaccine in addition to the pharmacy billing the PBM for the cost of the vaccine/medication.




Non-Registrable Provider Types

Non-Registrable Provider Types

- Non-Registrable provider type is an individual who does not meet the qualifications to register as an AHCCCS **provider** type.
- Registered Nurse (RN) and Licensed Practical Nurses (LPN) are not a registrable provider type and services cannot be billed on an individual basis to AHCCCS.
- If a RN or LPN performs a service during a covered clinic visit with an eligible AHCCCS registered provider, then the services provided by the RN/LPN are included under the clinic AIR.

Diagnostic Services Performed During an Inpatient Stay

- Inpatient laboratory services are included in the inpatient AIR and cannot be billed separately.
- Inpatient radiology, the technical component services are included in the inpatient AIR.
- The professional interpretation/reading of the radiology services by the AHCCCS registered radiologist must be billed separately on the CMS 1500 form. The NPI for the radiologist who performed the interpretation must be included on the claims as the servicing provider.
- The CPT code and modifier must be included.

Technical and Professional Components

- X-ray/imaging has two parts or components:
- When a covered radiology service is completed in a facility using the facilities x-ray equipment, this is considered the *technical component* or TC and is included in the clinic AIR.
- The radiologist or physician interpretation of the x-ray/image results is the *professional component*.
- The interpretation services can be billed on the CMS 1500 claim form with the radiologist NPI number and modifier “26” when the professional and technical split is appropriate.




IHS/638 Tribal Facility Emergency Room Services

Billing Services Provided in the Emergency Room

- Effective 01/01/2016, the IHS/Tribal facility has the option to breakout Emergency Department (ED) services and bill with the revenue code 0516 in place of the clinic code 0510.
- The ED attending provider must be an AHCCCS registered provider and the attending NPI must be entered on the UB-04 claim form.
- There will be no edits placed to deny for incorrect place of service for revenue code 0516.

Billing Emergency Room Services (cont.)

Billing Reminders:

- **Bill Type:** Use bill type 131 for Hospital outpatient, admit through discharge.
- **Bill Type**: Use bill type 711 for Clinic, rural health, admit through discharge.
- **Charges:** Enter the outpatient all-inclusive rate (AIR) rate in the Total Charges field.




Billing The Inpatient All Inclusive Rate

Billing Scenarios at the Inpatient AIR

- For *same day admit/discharge* must be billed as inpatient stay. AHCCCS will reimburse the IHS/638 facility at the outpatient All Inclusive Rate (AIR).
- Inpatient services for Title XIX (Medicaid) and Title XXI (KidsCare) members are billed to FFS with two revenue codes only:
  - Revenue Codes: 0100 – 0101.
  - Dates of Services include the full date range.
- The registered attending physician's NPI must be included on the claim and must be an active AHCCCS registered provider on the date of service.

Observation to Inpatient Status (cont.)

- If a member is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, then services for the emergency room, observation, or other outpatient charges must be included and billed on the inpatient facility claim.

General Billing Reminders
Same Day Admit/Discharge/Transfer/Expires

- Providers must bill the appropriate inpatient revenue code.
- Same day admit/discharge: the IHS/638 facility will be reimbursed at the outpatient All Inclusive Rate (AIR).
  - Exception: If the AHCCCS system qualifies the claim as Maternity or Nursery tier, reimbursement will be at the inpatient All Inclusive Rate (AIR).
- Same day admit/transfer: if the transferring hospital is an IHS/638 facility the reimbursement will be at the outpatient All Inclusive Rate (AIR).
- Same day admit/patient expires: the IHS/638 facility will be reimbursed at the Inpatient All Inclusive Rate (AIR).

Billing Inpatient Professional Services

Professional services rendered by an AHCCCS registered provider during an inpatient stay must be billed separately on the CMS 1500 (professional) claim form.

- Service /Attending/Ordering providers must be an AHCCCS registered provider on the date of service.
- The servicing providers NPI numbers must be registered with FFS.







Billing Secondary Claims

Medicare and Third Party Liability

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Third Party Liability and Medicare Timely Filing Timeframes

By federal law, Medicaid is always the “Payer of last resort”. If the member has Medicare or a third-party insurance, providers must bill the primary first, obtain a copy of the EOB from the primary payer and then bill Medicaid. Timely filing timeframes will still apply to the initial claim submission.

Third Party Liability and Medicare Timely Filing Timeframes

Timely Filing Information

- The initial claim must be received by AHCCCS no later than 6 months from the date of service even when the member has a primary payer.
- For members that have *Retro-Eligibility* the claim must be received by AHCCCS no later than 6 months from the date retro eligibility is posted,
- Hospital Inpatient claim – the claim must be received by AHCCCS within 6 months of the date of discharge of the patient.
- Claims initially received beyond the 6-month time frame, except claims involving retro-eligibility, will be denied.

Third Party Liability and Medicare

- Medicaid is not responsible for any amount for which the beneficiary is not responsible to pay.
- Important Note: Providers must report payment or denial details from third party carriers on claims submitted to AHCCCS for payment and include a copy of the primary payer's explanation of benefits with every claim submission.

Third Party Liability (TPL)

- Third Party Liability coverage including private accident insurance, HMO coverage and other health care coverage held by or on behalf of an IHS member, is primary to AHCCCS Medicaid except when the TPL is a tribal self-insured insurance plan.
- The Medicaid TPL reporting system cannot distinguish a tribal self-funded insurance from a third-party insurance.
- Providers should include as much information as needed to assist with the adjudication of the claim and this information can be submitted using the 275 Transaction Insight Portal.

Tribal Self Insurance

If the member has a tribal self-insured insurance plan, follow these steps:

- Electronically attach (Transaction Insight Portal) a document with the claim indicating that the type of insurance is a tribal self-funded plan. The document must be from the tribal insurance plan and include the member's name and identification number.

- Include a separate letter for each claim submission

Note: Upon receiving the appropriate documentation, the claim can be considered for processing.




Billing Medicare Secondary Claims

Medicare Secondary Claims

- Medicare is primary to AHCCCS FFS. Services covered by Medicare must be provided by a Medicare-enrolled provider and billed to Medicare first for consideration. Providers should bill any remaining balance after Medicare to the TPL payer of record.

- If the total amount received from Medicare and the TPL payer is less than the AHCCCS FFS rate, submit a claim to AHCCCS with a copy of all primary payers explanation of benefits (MEOB/EOB) for processing.

- If Medicare pays a claim and the claim does not automatically cross over to FFS from Medicare, bill FFS in the same way the claim was billed to Medicare and include a copy of the EOB for processing.
- Exception: Dialysis claims must be billed on a monthly basis to AHCCCS.

Medicare Secondary Claims

If Medicare denies a claim, and the service is a AHCCCS covered service and the provider is an AHCCCS registered provider, submit the claim to AHCCCS FFS for consideration. Providers must adhere to AHCCCS FFS claim and billing guidelines.

Adjusted Medicare claims are not automatically crossed over to AHCCCS at this time. The provider must submit a replacement claim to AHCCCS with a copy of the original Medicare RA/EOMB and the adjustment RA/EOMB with all of the reason codes displayed.

Denied Medicare claims are not automatically crossed over to AHCCCS. Read the Medicare RA/EOMB carefully to determine if the claim crossed over to AHCCCS or if the provider must submit the claim and the Medicare RA/EOMB to AHCCCS. Read the Medicare reason codes carefully to determine if the Medicare appeal process must be followed before AHCCCS can determine reimbursement.

Medicare Secondary Claims

If AHCCCS FFS approves the claim, a payment of the sum of the coinsurance and deductible may be made. If the Medicare payment on a claim is equal to or greater than the FFS maximum allowable amount, AHCCCS will not pay anything on the claim.

https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap09Medicare.pdf


Questions
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Answers
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Division of Fee-for-Service Management (DFSM) Provider Education and Training Unit

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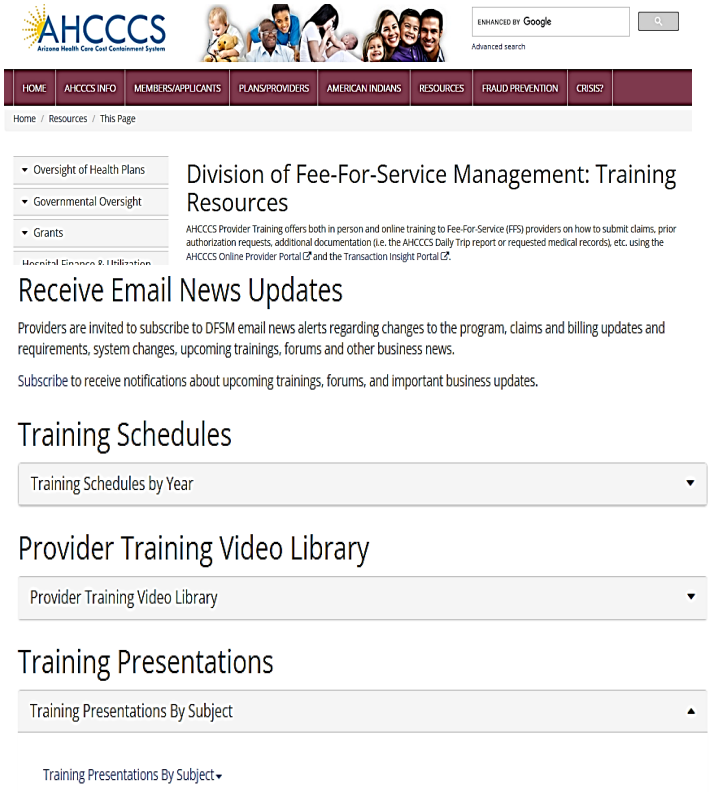
Provider Education And Training

- The DFSM Provider Training team offers training webinars and videos on many topics including how to submit and status claims and prior authorization requests, using the AHCCCS Online Provider Portal for the FFS programs including AIHP, TRBHAs and Tribal ALTCS.
- The training team also provides training on the Transaction Insight Portal application that is used to submit supporting claims documentation i.e., the AHCCCS Daily Trip report, explanations of benefits, Medical records and more.
- We also offer updates to program changes, system updates, and changes to the AHCCCS policy, guides and manuals.

Provider Education And Training Schedule

- The quarterly provider training schedules are posted to the provider training webpage. Registration is required to attend the scheduled trainings.
- To register, click the link below, select Training Schedule by Year, select the current quarter, and then select the training of your choice and complete the required information fields and submit.
- In addition to the training webinars the Provider Education team is available to assist providers with additional one-one training needs.

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html



Education And Training Questions

Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov

Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov

ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

Note: The Provider Training and the Coding teams cannot instruct providers on how to code or bill for a particular service. Providers should direct coding questions to your professional coder or biller.

- Email the provider training team at: providertrainingffs@azahcccs.gov

Thank You.