STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Arizona

Frequency of the diagnosis and trauma code edits ~~800-999 (excluding 994.6)~~ per 42 CFR 433.138(e).

Diagnosis and trauma code edits are conducted monthly. AHCCCS contracts with a TPL Contractor to perform the required diagnosis and trauma code edits matches and recovery.

The TPL Contractor is provided, via the secure FTP server, a monthly extract of fee-for-service (FFS) paid claims that include the claim specific diagnosis codes. The TPL Contractor conducts diagnosis and trauma code edits for codes ~~800 through 999, with the exception of code 994.6~~ identified in AHCCCS's published Trauma Code Set, for all fee-for-service claims, and removes all beneficiaries with any previous trauma code if the date of service is within six months of the previously reported date of service. The Contractor then returns a file of matched members not previously identified in a trauma code data match. Each member identified in the data match is sent a questionnaire, and they are asked to respond within ten days.

4.22(b)(2)
Methods used for meeting the follow-up requirements contained in 42 CFR 433.138(g)(l)(i), SWICA, SSA Wage and Earnings Files, and IV-A Agency.

AHCCCS and the DES Division of Benefits and Medical Eligibility (DBME) workers identify potential TPL based on information obtained from the SWICA and SSA Wage and Earnings files. Eligibility workers also obtain other insurance information if it is reported by the applicant through the CMS-approved application. The DES Division of Child Support Enforcement verifies coverage through the absent parent's employer via the National Medical Support Part B Medical Support Notice to Plan Administrator. The TPL information is inputted into the Arizona Technical Eligibility Computer System (AZTECS), ACE, or HEAplus eligibility systems. AZTECS is the DES eligibility system for various public assistance programs; AHCCCS Customer Eligibility (ACE) is the eligibility system used by AHCCCS for ALTCS enrollment; Health-e-Arizona Plus (HEAplus) is the state's new eligibility system designed to comply with the Affordable Care Act. Medical eligibility is currently being transitioned to HEAplus. Eventually, the state plans to use HEAplus to determine eligibility for all of the state's public assistance programs. This information is transmitted daily to the AHCCCS Prepaid Medical Management Information System (PMMIS). Once entered into the PMMIS, the information is sent to the AHCCCS TPL Contractor for verification. The Contractor verifies the health insurance information through its data matching processes with insurance carriers throughout the country. Once verified, the information is communicated to the AHCCCS Managed Care Contractors via the enrollment roster which provides the insurance carrier information.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Arizona

4.22(b)(4):

Method used for following up on paid claims contained in 42 CFR 433.138(g)(4)(i)(ii)(iii), diagnosis and trauma code edits.

AHCCCS' contracts with a TPL Contractor to perform the required diagnosis and trauma code edits for AHCCCS. The TPL Contractor conducts diagnosis and trauma code edits for codes ~~800 through 999, with the exception of code 994.6~~ identified in AHCCCS's published Trauma Code Set, for all fee-for-service claims. ~~The Centers for Medicare & Medicaid Services (CMS) developed a list of codes shown to be unproductive and offered a blanket waiver to all states. AHCCCS adopted the recommendation and edited all of the ICD-9 codes listed. The following lists of codes are currently being removed from the Trauma Code Edit Report: 900 919.5, 921.3, 930, 931 939.9, 942.22, 944.20, 945, 946.2, E950 E958.8, 958.3, 960 979.9, 980 980.9, 981, 986, 989.5, 990 995.89, 996 998.9 and 999.8 and are not included on the reports sent to the Contractor.~~

AHCCCS provides the TPL Contractor, via the AHCCCS secure FfP server, a monthly extract of the AHCCCS paid claims which include the claim specific diagnosis codes. The TPL Contractor matches an extract of those claims, that contain specific trauma codes, with the database of AHCCCS Members, and returns a file of matched members not previously identified in a trauma code data match. Each Member identified in the current data match is sent a questionnaire, and are asked to respond within 10 days. If the questionnaire is returned indicating an incorrect address, a letter is sent to the eligibility office where the member was determined eligible requesting the address be verified with the office records and that any difference be referred to the TPL Contractor for correction of their information. The TPL Contractor will then mail a new questionnaire using the corrected address information.

The TPL Contractor will review the response to the questionnaire and determine if a casualty case should be opened. A casualty case is opened if the returned questionnaire includes TPL or attorney information. Arizona does not specify a dollar threshold or minimum period of accumulation of claims. If a case is opened a medical lien is filed against the member for possible third party recovery within 60 days of a notification of injury and the TPL Contractor actively pursues recovery from the liable source. All recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

If after 30 days the completed questionnaire is not returned by the member, a letter is sent asking the member to contact the TPL Contractor. If a response to the letter is not received within 30 days, the TPL Contractor will attempt to contact the member by telephone, if a telephone number is available. If the member cannot be contacted by telephone, another letter is sent to the member stating that AHCCCS is requesting that the member contact the TPL Contractor.

4.22(d)(3):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Arizona

Method used for determining billing accumulation as specified in 42 CFR 433.139(f)(3).

Specific member claims must generally total $250.00, or more, in order for a case to be considered for potential recovery. Claims expenses are accumulated beginning with the date of injury to, whichever occurs first, the last date of treatment or the case is settled.

4.22(d)(4)

The State attests that ~~all~~ the Third Party Liability requirements outlined in 1902(a)(25)(E) and 1902(a)(25)(F)(i) of the Social Security Act are met. These requirements are:

- The state applies cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services;
- The state makes payments without regard to potential TPL for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days

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