





IHS/638 Tribal Providers Quarterly Billing Forum

Third Quarter 2023

Wednesday, August 30, 2023

Time: 2:00 – 3:30pm

AHCCCS
Arizona Health Care Cost Containment System

IHS/638 Provider Quarterly Agenda

- Upcoming Events: IHS Tribal Consultation
- American Indian Medical Home (AIMH)
- August National Immunization Month
- Transaction Insight Portal Tips
- Provider Revalidation
- Participating Provider Reporting Requirements
- KidsCare Billing Information
- Billing Third Party Liability Claims
- Telehealth Coding Update
  NEMT Diagnosis Code Reminders
- Billing H2016 and H0038
- Medicare and Secondary Claims
- Fee-for-Service Provider Moratorium
- Behavioral Health Documentation Requirements




Upcoming Events

AHCCCS Tribal Consultation
IHS/638 Tribal Provider Fourth Quarter Billing Forum

Next AHCCCS Quarterly Tribal Consultation Event

Thursday, November 9, 2023

1:00 p.m. - 5:00 p.m.

Registration Tribal Consultation Event

Please check AHCCCS Tribal Consultation web page for meeting information.

Next IHS/638 Tribal Providers Quarterly Billing Forum

Wednesday, November 15, 2023

Time: 2:00 p.m. - 3:30 p.m. (Phoenix)

Zoom information will be emailed via Constant Contacts at least 5 days prior to the IHS/638 Quarterly Billing Forum.

To sign up to receive information directly via Constant Contacts regarding IHS/638 forums click on **Subscribe to DFSM News**




American Indian Medical Homes (AIMH)

What is an American Indian Medical Home

The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP).

The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

American Indian Medical Homes help address health disparities that exist between American Indians and other populations in Arizona by offering services and supports which improve access to critically needed care.

Learn more about DFSM's efforts on the AIMH web page.

American Indian Medical Homes
Provider Requirements

- Must be an IHS or Tribal 638 owned and operated facility,
- Enter into an AIMH Intergovernmental Agreement (IGA),
- Primary Care Medical Home (PCMH) accreditation,
- Provide 24-hour telephonic access to the care team,
- Dependent on selected Tier Level,
  - Provide diabetes education, or
  - Participate bi-directionally in the State Health Information Exchange (HIE).

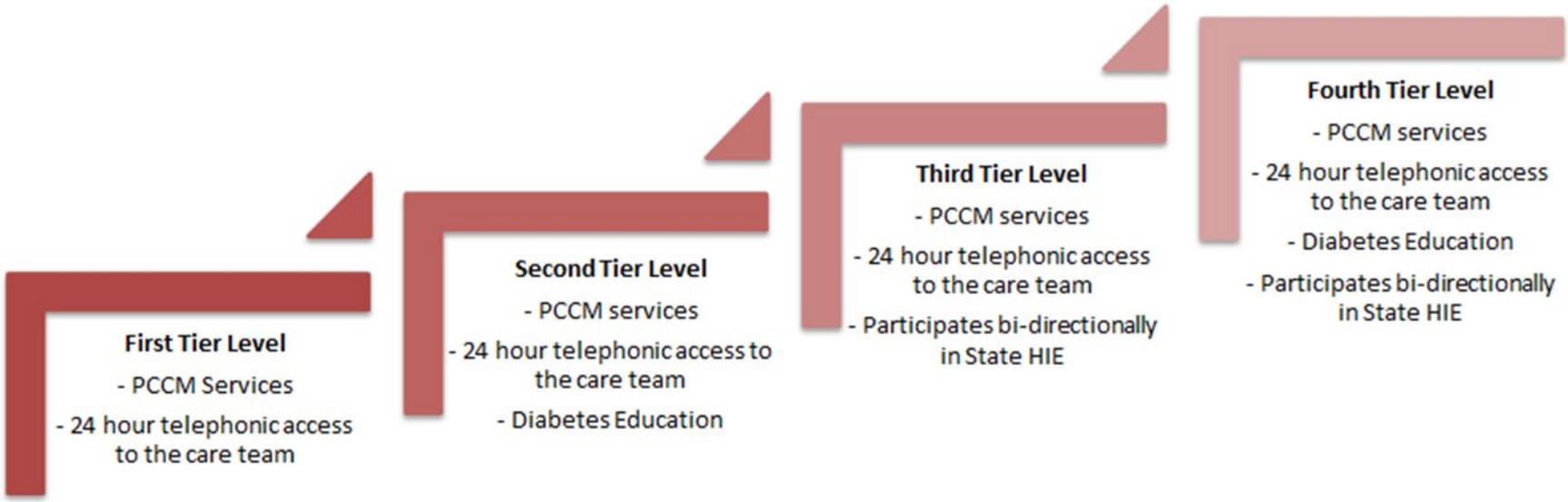
AIMH Reimbursement Rates

- Facilities who choose to become an AIMH will receive a *Prospective Per Member Per Month (PMPM)* rate for services provided by their medical home.
- Payments are dependent upon the AIMH tier level selected.
- Tier levels (1,2,3 and 4) include annual rate increases.

IHS/638 Qualifying Provider Types
American Indian Medical Home Provider

Provider Type	Description
02	Hospital
05	Clinic
29	Community Rural Health Center
C2	Federally Qualified Health Center
C5	638 Federally Qualified Health Clinic (FQHC)
IC	Integrated Clinic

American Indian Medical Home Tiers



AIMH Reimbursement Rates CY 2023

AIMH 4.6% Rate Increase Calculation 10- Year Forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Level 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
Level 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
Level 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
Level 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Chinle Comprehensive Healthcare	4	13,594

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Fort Yuma Health Care	1	9

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Parker Indian Health Center	1	953

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Phoenix Indian Medical Center	2	4,976

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
San Carlos Apache Healthcare	4	5,515

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Tuba City Regional Healthcare Corporation	4	2,337

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Whiteriver Indian Hospital	2	6,250

Current AIMHs and Members

American Indian Medical Homes	Tier Level	Members
Winslow Indian Health Care	4	3,900




August is
National Immunization Awareness Month

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August is National Immunization Awareness Month

The National Immunization Awareness Month (NIAM) is an annual observance held in August to highlight the importance of routine vaccination for people of all ages.

IHS/638 Pharmacy Billing

Medications and vaccines dispensed or administered at the IHS/638 Tribal pharmacy, claims must be submitted thru POS to OptumRx for Title XIX and XXI members.

The AIR shall be reimbursed once daily per member per facility pharmacy through the point-of-sale system. Please see the and the Fee-For-Service Provider Billing Manual Chapter 12- Pharmacy Services

This includes the cost and the administration of the vaccine, when administered by a ***pharmacist or intern.***

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/MemoUnwindingFluandCovidAIRs.pdf

Pharmacist and Pharmacy Technician Licensing Information

Pharmacist

Per Article 2. Chapter 23. Pharmacist Licensure R4-23-201 states: before practicing as a pharmacist in Arizona, a person shall possess a valid pharmacist license issued by the Board of Pharmacy.

Pharmacy Technician:

Per Article 11. Pharmacy Technicians R4-23-1104 states:

A. License required. A person shall not work as a pharmacy technician or pharmacy technician trainee in Arizona, unless the person possesses a pharmacy technician or pharmacy technician trainee license issued by the Board of Pharmacy.

View: https://apps.azsos.gov/public_services/Title_04/4-23.pdf

Billing Vaccines at the All Inclusive Rate

When billing for a vaccine or medication administered by pharmacists or interns, the facility may not submit a claim to AHCCCS for the administration of the vaccine in addition to the pharmacy billing OptumRX for the cost of the vaccine/medication.

For example, a member goes to a pharmacy and has two prescriptions filled, and receives a vaccine administered by the pharmacist. The facility shall not bill for any of these services. The pharmacy may bill one AIR for the two prescriptions and the cost and administration of the vaccine.

Vaccine Administration by a Pharmacist/Intern

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

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

The claim must be submitted to OptumRx (PBM) 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.

OptumRx Contact 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




Transaction Insight Portal (TIBCO)
Uploading Claim Attachments

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Uploading Claim Attachments using the Transaction Insight Portal

The Transaction Insight Portal is a tool that gives registered providers that are servicing members enrolled in the Fee-for-Service program including, American Indian Health Program (AIHP), ALTCS and Tribal Health Program (DD THP) access to attach required documentation to any type of claim form submission.

Need a User Account: How to Request a Transaction Insight Portal Account

Regardless of how the claim was initially submitted, Paper, EDI or on the AHCCCS Online portal, the Transaction Insight Portal is the most effective way to attach required documentation to a Fee-for-Service claim.

Important:

- Each team member must have a individual TIBCO account.
- Requesting an account is easy - send your request to Servicedesk@azahcccs.gov
- Provider Identification Number,

  Important Note: Providers that are assigned a NPI number this is your primary ID number used for claim submissions and TIBCO.
- The service desk will forward confirmation of your TIBCO access code to the email address that you provide.
- Sharing of account information is **prohibited.**

Uploading Claim Attachments using the Transaction Insight Portal

Attaching documentation is an easy process. TIBCO provides (2) Set Purpose Codes that can be used based on if the claim was submitted via the AHCCCS Online portal or EDI.

Quick Guide - Behavioral Health Providers - How to Attach Documentation Using the Transaction Insight Portal (TIBCO)




AHCCCS Fee-for-Service Provider Revalidation

Completing the Revalidation Application Process

Completing the Revalidation Application process is fast and easy!

- To begin your revalidation application, login to your Existing Provider account:
  To access APEP Direct
- Below are step-by-step instructions designed to teach providers how to complete a revalidation using a 14-digit Application ID APEP.
- For additional questions regarding how to troubleshoot through APEP to complete the revalidation application, contact APEPTrainingQuestions@azahcccs.gov or Provider Assistance 602-417-7670, include the provider's name, NPI and a brief description of the issue.




Participating Provider Reporting Requirements

Participating Provider Reporting Requirements

Effective for dates of service on and after January 1, 2023, the following provider types must report the actual professional practitioner (provider) participating in/performing services associated with clinic visits.

- Provider Types (PT):
  - Integrated Care Clinic (IC),
  - Behavioral Health Outpatient Clinic (77) and,
  - Clinic (05)

Participating Provider Reporting Requirements (cont.)

- Providers must follow the requirements outlined in Exhibit 8-2 in the AHCCCS IHS/Tribal Provider Billing Manual for the participating provider reporting requirements and billing instructions for proper claims submissions.
- ***Effective July 1, 2023***, any claim filed without the participating provider information will be systematically denied.
- IHS/Tribal Provider Billing Manual, Exhibit 8-2 Participating Provider Information

Participating Provider Claim Denial Edits

Claims that do not include the required participating provider information will deny and the submitter must correct the data fields and submit a replacement claim. The replacement claim must include all required documentation.

Claim Edit Denials

H482.1 NPI Missing or invalid; field is missing.

H482.7 NPI Missing or invalid; not valid for provider.

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/QuickGuideHowtoCompletetheParticipatingProviderReportingInformati

Participating Provider Reporting Errors

Example 1. XX123B456789JonesTom

NPI numbers consist of 9 numbers only. When reporting the NPI number of the participating provider, Alpha characters should not be entered.

Example 2. XX9999999999JonesTom

Non-registrable provider types identified by (10) consecutive 9's, the XX qualifier code is not used to report services for a non-registrable provider.

Example 3. **XX12345678900JonesTom**

AHCCCS registered provider type with NPI, the XX qualifier could is entered with the 10 -digit NPI number.




KidsCare Title (XXI) Billing Information

Title XXI KidsCare Claims Submissions

If the member is enrolled in an ACC Plan	Submit the claim to the ACC plan.
If the member is enrolled in AHCCCS FFS or AIHP	Submit the claim to AHCCCS DFSM.

Billing Reminders Title XXI KidsCare

AHCCCS covered services provided to Title XXI (KidsCare) members are not reimbursable at the All-Inclusive Rate (AIR). IHS/638 pharmacies must submit all Fee-For-Service and KidsCare prescription claims electronically at the point-of-sale to the AHCCCS FFS PBM, OptumRx.

- Billing example: A claim is submitted for a member enrolled in the FFS KidsCare program and billed on the UB-04 claim form.

In this example the denial edit code AD102 will present. The description reads "IHS/638 KidsCare must bill on the CMS 1500, Dental (ADA) or Point of Sale for (pharmacy services)".

Verifying Title XXI KidsCare Enrollment

Providers can verify eligibility and enrollment for any member enrolled with AHCCCS Medicaid using the AHCCCS Online Provider Portal.

Select the member verification tab, under the field heading **Eligibility Group Description** you will see KidsCare. Under the field heading **Contract Type** you will see ACC/FFS/KC (KidsCare).

Eligibility

Eligibility Group Description	Insurance Type	Begin Date	End Date	Added On
KIDSCARE	MC MEDICAID	12/01/2021		10/28/2021

Medical Enrollment

Health Plan ID/Description	Period Start	Period End	Rate Code	Contract Type	Insurance Type
999998 AHCCCS AMERICAN INDIAN HP	12/01/2021		6012 - KIDS 1-5 M & F NON-MEDICARE	X ACC/FFS/KC	MC MEDICAID
⊞ Service Type Codes					



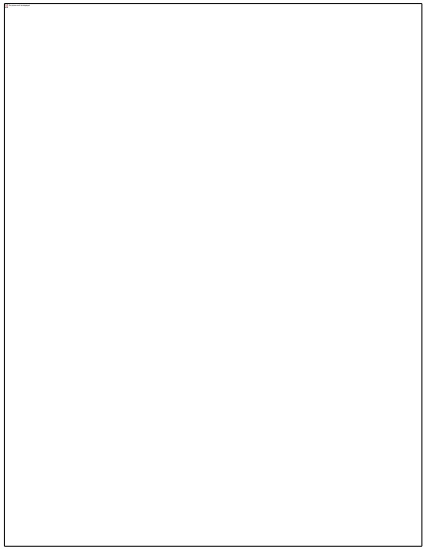

Billing Reminders:
Third Party Liability Claims

Medicaid and Third Party Liability

Medicaid enrolled members that have Third Party Liability (TPL) other than Medicare as their primary payer, AHCCCS Administration's reimbursement responsibility is limited to no more than the difference between AHCCCS capped fee and the amount of the first- or third-party liability.

Third Party Liability (TPL) Secondary Claims

- All Explanations of Benefits (EOB) payment or denials from the member's primary payer must be submitted with the claim to AHCCCS.
- A secondary claim cannot be processed with the details regarding how the primary payer processed and or denied the claim.
- Providers must follow AHCCCS Fee-for-Service claim submission billing guidelines even when AHCCCS is the secondary payer.



Third Party Liability (TPL) Secondary Claims

- **Filing a Reconsideration:**
  - Providers must follow the primary payer's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the primary payer's appeal decision for consideration of reimbursement of the FFS claim.
  - If the claim is reaching the timely filing period and has not been processed by the primary payer, providers may submit the claim to meet the FFS timely filing timeframe, pending the finalization of the claim by the primary payer.
  - The processing of the claim by the primary payer does not extend the timely filing period with AHCCCS FFS.

Telehealth Modifier Updates

Retired: Telehealth Modifier FQ

During the federally declared Public Health Emergency (PHE) AHCCCS received approval effective May 12, 2023, to use modifier FQ (audio only).

- The FQ modifier was used for a telehealth service furnished using real-time audio-only communication technology will no longer be valid for any ***Evaluation and Management*** codes.

This change/update is effective for dates of services July 1, 2023, and after. This information has been updated on the Telehealth Code Set (revised 06/16/2023)

Reminder: Non-Emergency Medical Transport Diagnosis Codes

Reminder: Non-Emergency Medical Transport Diagnosis Codes

If the diagnosis code is unknown at the time of the claim submission, NEMT providers (PT28) are allowed to use one of the following "general" diagnosis codes listed below based on the reason for the NEMT transport service:

- NEMT *physical health* transports, ICD-10 diagnosis code R68.89 can be billed.
- NEMT *behavioral health* transports, ICD-10 diagnosis code F99 can be billed.
- The Event Type (BT) must be selected for a behavioral health NEMT prior authorization request.

Behavioral Health Services Billing and Coding Updates H2016 and H0038

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Same Day Billing Denial Updates

Procedures codes Comprehensive Community Support Services, per diem (H2016) and Self-Help/ Peer Services per 15 minutes(H0038) when billed on the same date of service will automatically deny with the denial reason code L237.4 “Service Not Allowed On The Same Day”.

Medicare Billing and Claims Processing

Medicare Parts A, B, C and D

Medicare Part A

Covers inpatient care in hospitals, skilled nursing facility, home health, hospice care and more.

Medicare Part B

Covers physician services, durable medical equipment X-rays, labs, etc.

Medicare Part C

Also referred to as a Medicare Advantage plan, which combines Medicare parts A, B, and may also include Medicare Part D drug coverage.

Medicare Part D

Provides prescription drug coverage.

Medicaid and Medicare

Medicaid enrolled members who have Medicare as their primary payer, AHCCCS may only be responsible for the *copay, coinsurance and deductible* amounts listed on the Medicare Remittance Advice.

To review the billing information for Medicare and TPL claims please visit:

IHS Tribal Provider Billing Manual Chapter 7 Medicare/TPL

Reminders: Billing Medicare Secondary Claims (cont.)

- AHCCCS will consider Medicare secondary claims even if the claim includes procedures that were not covered by Medicare.
- Medicare claims that were not automatically crossover to AHCCCS, a copy of the MEOB is required with each claim submission.
- All services billed to AHCCCS are subject to Medicaid policy and are subject to review.

Reminders: Billing Medicare Secondary Claims

- Medicare pays first for members enrolled in Medicare Parts *A ,B, C and D* coverage.
- Medicare secondary claims refers to any claim for which AHCCCS is the secondary payer after Medicare and any other third-party payers.
- The amount considered by AHCCCS Medicaid will be the copay, coinsurance or deductible as indicated on the MEOB.

Example: Medicare Primary Claim Service Code T1015

In this example the provider submits a primary claim to Medicare Part B.

The claim was billed with the CPT codes T1015, 99214, 36416 and 83036.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1	07	18	23	07	18	23	11		T1015		ABCD	203 00	1
2	07	18	23	07	18	23	11		99214	25	ABCD	0 00	1
3	07	18	23	07	18	23	11		36416		A	0 00	1
4	07	18	23	07	18	23	11		83036	QW	A	0 00	1
5													
6													

How to Submit a Reconsideration Request for a Medicare Crossover Claim

- If Medicare adjusted a previously paid claim and there is no change in the coding details a replacement claim is not needed.
- Providers will only need to submit a copy of the original MEOB and a copy of the adjusted MEOB with the reconsideration request.
- This information can be submitted with a cover letter indicating the details regarding the submission of the adjusted MEOB for reprocessing via the 275 Transaction Insight Portal (TIBCO).

Example: Medicare Primary Claim Service Code T1015

In this example the provider submits a primary claim to Medicare Part B.

The claim was billed with the CPT codes T1015, 99214, 36416 and 83036.

- The Total billed amount $272.02,
- CO-45 Medicare contractual write off amount is $116.82 (this is the amount that exceeds Medicare's fee schedule for the CPT code(s),
- CO-253 $2.02 (Sequestration this is the reduction in federal payment and not included in the payment).
- Medicare total combined payment for each line of service is $98.78
- PR-2 Balance remaining or due is the **Medicare coinsurance amount $54.40**
- To verify the total amount approved by Medicare, add the Medicare paid amount, deductible and coinsurance amounts as shown on the MEOB.




Submitting a Non-Medicare Crossover Claim

Non-Medicare Crossover Claims

If the “**crossover**” **claim is not** automatically crossed from **Medicare** and received by Medicaid, then the provider must **submit** a claim to Medicaid and include a copy of the Medicare EOB for processing.

Timely filing requirements will apply.

Submitting Medicare Secondary Claims

- When submitting a secondary claim, please include the *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)* information identifying why Medicare denied the claim, this may be due to exhausted benefits, medical necessity or eligibility, or another reason that may apply.
- **Reconsiderations:**
  - Providers must follow Medicare's appeal or reconsideration process before submitting a claim to FFS for consideration.
  - The provider must submit the Medicare appeal decision for consideration of reimbursement of the claim.




Fee-for-Service Provider Moratorium

Provider Moratorium

At the Director's (or designee) discretion, this moratorium exempts provide enrollment applications under any of the following circumstances:

1. Medically Underserved Service Area and access to care with review and approval by State Medicaid Agency,
2. Service expansion in support of a State Medicaid Agency initiative,
3. At the request of an AHCCCS contracted managed care plan to ensure that access to care standards (i.e., time and distance) are not out of compliance, or,
4. Additional exemptions as appropriate and as needs are identified. This moratoria was approved by the Centers for Medicare and Medicaid Services (CMS).

Provider Moratorium

In accordance with Section 42 CFR 455.470, Carmen Heredia, Director of the Arizona Health Care Cost Containment System (AHCCCS), has implemented for 6 months effective June 9, 2023, through December 9, 2023, a statewide moratorium on the enrollment of the following provider types:

- Behavioral Health Outpatient Clinic (05),
- Integrated Clinic (IC),
- Non-Emergency Medical Transportation Provider (28),
- Community Service Agencies (A3), and
- Behavioral Health Residential Facility (B8).

This moratoria was approved by the Centers for Medicare and Medicaid Services (CMS).

Required Documentation for Outpatient Behavioral Health Claims

Required Documentation for BH Outpatient Claims

To ensure proper consideration of outpatient behavioral health services provided on the same day AHCCCS Fee-for-Service effective with claims submitted on or after May 3, 2023, behavioral health providers are required to submit the following documentation with the submission of the claim for all services billed on each date of service:

- ***Signed Consent to Treat form***,
- ***Comprehensive Assessment***,
- ***Treatment plan***, and
- ***Medical record documentation***.

This requirement is for but not limited to Behavioral Health Residential Facility (B8), Integrated Clinic (IC), Behavioral Health Outpatient Clinic (77) and Clinic (05).

*Reporting same day services on separate claim submissions can result in denial of services

Required Documentation for BH Outpatient Claims

Treatment plan - A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

The service and/or treatment plan shall be based on a current assessment and/or specific treatment need (e.g., out of home services, specialized behavioral health treatment for substance use). The service or treatment plan shall identify the services and supports to be provided, according to the covered, medically necessary services and services specified in AMPM Policy 310-BB Transportation

Required Documentation for BH Outpatient Claims

Medical record documentation - All communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 12- 2291.

Required Documentation for BH Outpatient Claims

Signed Consent to Treat Form - A signed copy of the member's consent to treatment for the services billed.

Comprehensive Behavioral Assessment - is the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health. disorder exists, if

there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long-term goals.

Documentation Review for Behavioral Health Outpatient Claims

- The quickest and most efficient way to attach your documentation for review is to use the Transaction Insight Portal (TIBCO).
- For payment reviews, documentation is required and to help expedite the review process, we suggest that providers insert a “title sheet” identifying each document type that is uploaded followed by the documents.
- All combined services rendered on each day billed to FFS will require documentation to include physical services rendered and any services units billed.




DFSM Provider Education and Training Unit

DFSM Provider Education and Training

Our goal is to help providers understand billing policy and successful claim submission for the FFS program.

- The provider training team offers eLearning and video training presentations on specific topics which are in a self-paced format that allows providers to access trainings.
- We encourage the attendance of billing staff and agencies, practitioners and others.

DFSM Provider Education and Training

The provider training schedules are posted quarterly on the DFSM Provider Education Web page and registration is required to attend.

- DFSM Provider Training includes at any time and provide important information about how to use the AHCCCS Online Provider portal and the Transaction Insight Portal, recorded webinars and job aids for FFS providers.
- Courses can be attended remotely from any location via Zoom. To register for a session, click on the "Zoom Registration Link".
- For additional training videos, providers can visit the AHCCCS Medicaid YouTube Channel.

IHS 638 Provider Billing and Policy Resources

AHCCCS FFS Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual:

- https://www.azahcccs.gov/shared/MedicalPolicyManual/
- https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/MemoUnwindingFluandCovidAIRs.pdf

Questions?

Thank You.