CLAIMS CLUES

A Publication of the AHCCCS Division of Fee-For-Service-Management

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Overpayments

Per the Provider Billing Manual, Chapter 4: General Billing Rules - A provider must notify AHCCCS of an overpayment on a claim by submitting an adjustment to the paid claim. Providers should attach documentation substantiating the overpayment, such as an EOB, if the overpayment was due to payment received from a third party payer.

The claim will appear on the Remittance Advice showing the original allowed amount and the new (adjusted) allowed amount. The claim must be adjusted and the overpaid amount will be recouped.

Do NOT send a check for the overpayment amount.

Fee-For-Service (FFS) Prior Authorization Information and Reminders:

General:

- Providers can now use the Web Portal Attachment feature to upload supporting documents with their authorization request, rather than faxing documentation. Use of the Web Portal is the preferred method of submission for authorization requests. Uploading documents increases efficiency in the process as it links your documents directly to your authorization.

- FFS PA staff will not provide member eligibility or authorization status by phone as this information is available online 24 hours a day/7 days a week at: https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f.

- Providers requiring training on how to submit authorizations using the AHCCCS Web Portal can request training by emailing a request to: ProviderTrainingFFS@azahcccs.gov

Member Calls:

- Please do not refer members to the FFS Prior Authorization phone line. Providers can verify the status of their authorization requests 24 hours a day/7 days a week online. Providers should advise members of the authorization status and follow up as needed with the Prior Authorization area.

Expedited Requests:

- For requests that meet expedited criteria, providers should indicate "Expedited" on the request and call the PA Line 602-417-4400 to notify PA staff once the expedited request and accompanying supporting documentation has been submitted for review. Expedited requests will be reviewed to verify that following standard processing time-frames for non-expedited requests could ***seriously jeopardize the FFS member's life or health, or ability to attain, maintain, or regain maximum function.*** Note: Non-Expedited requests marked as expedited will be processed in the time-frame designated for non-expedited requests.

Eligibility:

- Providers should verify member eligibility prior to contacting the FFS Prior Authorization, or Transportation area. Eligibility can be verified at: https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

The health plan contact information shown below is available at:
https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx

Health Plans are listed in random order

Acute Care/Integrated Health Plans

HP ID	Health Plan Name	Contact Phone	Website Address
010306	MERCY CARE PLAN	602-263-3000	http://www.mercycareplan.com
010789	MERCY MARICOPA RBHA	800-564-5465	http://www.mercymaricopa.org
010795	MERCY MARICOPA INTEGRATED	800-564-5465	http://www.mercymaricopa.org
078999	MERCY MARICOPA INTEGRATED	800-564-5465	http://www.mercymaricopa.org
010145	CRS PARTIAL ACUTE	800-348-4058	http://www.uhccommunityplan.com
010158	UNITEDHEALTHCARE	800-348-4058	http://www.uhccommunityplan.com
010497	HEALTH CHOICE AZ	480-968-6866	http://www.healthchoiceaz.com
010700	HEALTH CHOICE INTEGRATED	877-923-1400	http://www.healthchoiceintegratedcare.com
010705	HEALTH CHOICE RBHA	877-923-1400	http://www.healthchoiceintegratedcare.com
010715	HEALTH CHOICE INTEGRATED	877-923-1400	http://www.healthchoiceintegratedcare.com
010422	HEALTH NET ACCESS	888-788-4408	http://www.healthnetaccess.com
010299	PHOENIX HEALTH PLAN	602-824-3700	http://www.phoenixhealthplan.com
010166	DCS/CMDP	602-351-2245	https://dcs.az.gov/cmdp
010383	MARICOPA HEALTH PLAN	800-582-8686	http://www.mhpaz.com
010314	UNIVERSITY FAMILY CARE	800-582-8686	http://www.ufcaz.com
010725	CENPATICO INTEGRATED CARE	866-495-6738	http://www.cenpaticointegratedcareaz.com
010735	CENPATICO INTEGRATED CARE	866-495-6738	http://www.cenpaticointegratedcareaz.com
010730	CENPATICO RBHA	866-495-6738	http://www.cenpaticointegratedcareaz.com
010115	CRS FULLY INTEGRATED	800-348-4058	http://www.uhccommunityplan.com
010254	CARE 1ST ARIZONA	602-778-1800	http://www.care1st.com

Long Term Care Health Plans (Program Contractors)

HP ID	Health Plan Name	Contact Phone	Website Address
110306	MERCY CARE PLAN - LTC	602-263-3000	http://www.mercycareplan.com
110007	LTC DD DES	602-542-6857	https://www.azdes.gov/ddd/
110050	UNITEDHEALTHCARE LTC	800-293-3740	http://www.uhccommunityplan.com
110088	BRIDGEWAY HLTH SOLUTION-L	866-475-3129	http://www.bridgewayhs.com

Transport:

- The NEMT provider rendering services to a FFS plan member must submit the authorization request for the transport. Facilities cannot submit an authorization request on behalf of the NEMT provider; however, facilities can obtain the NEMT provider's authorization number to include on faxed documentation supporting medical necessity of NEMT requests. Facilities faxing in supporting documentation must use the completed Medical Documentation Form as their cover sheet. FFS forms can be found at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html
- NEMT providers should verify mileage prior to requesting authorization. Transport staff use Google Maps to verify mileage. If an NEMT provider requests mileage that differs significantly from the mileage indicated by Google Maps, justification must be provided to explain the discrepancy.
- Please indicate whether the trip times indicated on the Trip Ticket are during AM hours or PM hours.

Medical Prior Authorization:

End Stage Renal Disease (ESRD) procedure code updates:
CPT codes ***for some*** ESRD related procedures changed effective 01/01/17. Please be sure to review the new CPT codes and bill appropriately.

REMINDER: The following procedures do not require fee for service (FFS) authorization:

- Professional and facility component for dialysis shunt placement (including FESP members on Extended Services for ESRD)
- Professional and facility component for outpatient arteriovenous graft placement for dialysis (including FESP members on Extended Services for ESRD)
- Professional and facility component for outpatient thrombectomies of dialysis shunts (including FESP members on Extended Services for ESRD)
- Professional and facility component for outpatient thrombectomies of arteriovenous grafts for dialysis (including FESP members on Extended Services for ESRD)

- Professional and facility component for outpatient angioplasties of dialysis shunts or grafts (including FESP members on Extended Services for ESRD)

Contrast Materials:
HCPC codes for contrast materials do not require authorization. Please contact Claims Customer Service if you receive a denial for authorization on codes Q9951 – Q9983.

DFSM Training Schedule

On **Thursday March 09, 2017**, the Division is offering a training session on "*How to submit and obtain a Prior Authorization"* from 3:00 – 4:00PM at 701 East Jefferson Street, Phoenix, AZ 85034 on the 3rd Floor, Gold Room.

On **Thursday March 30, 2017**, the Division is offering a training session on "*ALTCS Dental Benefit"* from 2:00 – 4:00PM at 701 East Jefferson Street, Phoenix, AZ 85034 on the 3rd Floor, Gold Room.

Here is the link to training schedules and power point presentations from prior trainings:

https://tst.azahcccs.gov/Resources/DFSMTraining/index.html

UPDATE: AHCCCS - Constant Contacts replaces ListServ:

In an ongoing effort to communicate information in an efficient manner, AHCCCS has instituted an email tool that targets specific business areas. Interested users may sign up to receive important information from AHCCCS. Constant Contacts replaced ListServ and all existing subscriptions were automatically transitioned to Constant Contacts.

New Users - To subscribe, please follow the instructions below:

1. Click on the link: https://visitor.r20.constantcontact.com/d.jsp?llr=wfkoa9yab&p=oi&m=1126154315958&sit=dxzftp4kb&f=eb307415-6a96-41fd-9bc5-55152f560cd6
2. Please complete the required fields.
3. Check all applicable email lists to receive AHCCCS DFSM Notifications/Updates.

Users wanting to unsubscribe from a particular list can do so, at any time, using the ✉ **SafeUnsubscribe®** link, found at the bottom of every email.

Claim Reminders:

Recipient Enrollment - Should be verified prior to the submission of a claim. This can eliminate unnecessary claim denials and delay of reimbursement. Recipient eligibility can easily be verified using the Online tool or through the AHCCCS IVR system.

Prior Authorization and Service Plan Denials – Before submitting a claim, check the authorization to verify the dates of services and CPT/HCPCS codes match the approved authorization.

Missing Emergency Criteria - Emergent claims must be submitted with the appropriate Emergency Indicator - UB-04 FL14 = 1 and CMS 1500 BOX 24C = Y.

Documentation –Submit all medical records and itemized statements with the initial claim, to ensure adjudication in a timely manner.

Duplicate Claim Denials – Using the AHCCCS online claim status tool is an easy and effective way to check claim status to prevent duplicate claim submissions and denials.

Ordering / Referring Provider Errors – AHCCCS requires the ordering/referring Provider NPI to be entered in field 17 on the CMS 1500 claim form. Refer to the FFS Provider Manual Chapter 10, page 26 for more detailed information.

Ordering Provider Qualifier - CMS 1500 claims submitted without the appropriate ordering provider qualifier "DN Referring Provider, DK Ordering Provider, DQ Supervising Provider" will deny.

Multi-Page CMS 1500 Claims – On multiple-page claims, the total charge for all items should be listed on the last page only. If a total charge amount is entered in field 28 on each individual page of the CMS 1500 form, the claim will be entered as a single claim.

UB Medical Review - Suggested Documentation

Outpatient/ ER Visits

- H&P
- Physician Assessment
- Physician Progress Notes
- Labs; Pertinent imaging tests (US, CT, MRI, etc)
- Medication records (to include the route of administration)

Outpatient Observation Stay

- H&P
- Physician Assessment
- Physician Progress Notes

- Labs; Pertinent imaging tests (US, CT, MRI, etc)
- Operative report
- MD Assessment & Pathology Report (cholecystectomy pt's mostly)
- Order for Observation Stay

Inpatient Stay

- ED Records
- H&P
- Physician Progress Notes
- Labs; Pertinent imaging tests (US, CT, MRI, etc)
- Operative report
- Physician Assessment
- Pathology Reports
- Case manager/ social service notes if inpatient stays
- Discharge Summary

Dialysis Pt's

IZ is a must

Items that are not needed

Please do not send:

- Orders other than observation order
- Discharge informational instructions meant for the patient
- Administrative/eligibility paperwork

1500 Claims Documentation Needed for Emergency Department (ED) Visits

All claims for FES services must contain documents that substantiate that the service provided was an emergency

ED record to include

- Physician notes (ED course, assessment/plan)
- Imaging
- Labs
- Procedure reports
- Medication records (to include the route of administration)

Items that are not needed:

Please do not send:

- Orders other than observation order
- Discharge informational instructions meant for the patient

- Administrative/eligibility paperwork

Outlier Claims

If submitting a claim for outlier consideration please submit the following documentation as listed below, along with the documentation required for UB claims review:

Please submit the following documentation if these items are billed on the IZ:

- Medication Administration Record (MAR)
- Operating room and anesthesia times. (Need the operative report and anesthesia records as they contain some of the charges/supplies/implants/medications that might not be listed elsewhere)
- All other minor procedures (bronchoscopy, laceration repair, lumbar puncture, PICC insertion, etc.)
- High dollar radiology (CT's, MRI's, MRA's, Nuclear Med scans, IR (Interventional Radiology).
- High dollar medical supplies
- Echocardiogram
- Cardiac Cath records
- Ventilator days
- Nitric Oxide days
- Dialysis records and CRRT
- Blood administration (copy of the blood administration tag that has the date, start/stop times, and signature of administrator)
- PACU in/out times
- Perfusion
- Cardiac Arrest reports
- If Observation Days are billed then physicians' orders must be verified per policy
- Emergency Room records (procedures performed and meds given in ER may not be listed anywhere else).

Contacts, Links and Resources:

- For technical assistance regarding claims issues and training, please email ProviderTrainingFFS@azahcccs.gov

- Dental authorization requests containing Radiographs should be mailed, with a completed FFS Authorization Request Form to:

AHCCCS DFSM – Prior Authorization: Dental
Mail Drop # 8900
701 E. Jefferson Street
Phoenix, AZ 85034

- Fee-For-Service Authorization Request Forms can be found at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

- Please direct Prior Authorization or Claims/Billing inquiries to:

  Fee-For-Service Prior Authorization Line: 602-417-4400
  Fee-For-Service Claims Customer Service: 602-417-7670

- For questions regarding the provider registration process, please call 602-417-7670. Applications can be faxed to 602-256-1474.

- For technical assistance with your AHCCCS online web portal, please call AHCCCS ISD Customer Support Desk at 602-417-4451

- Requests for duplicate copies of the paper Remittance advice should be sent to AHCCCSWARRANTINQUIRIES@AZAHCCCS.GOV.