AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES
A Publication of the AHCCCS DFSM Claims Department

June 2018

Behavioral Health Prior Authorization Requests

The online PA submission process is now available for Tribal Regional Behavioral Health Authority (TRBHA) member inpatient admissions to Level 1 facilities.

With AHCCCS Online authorization submissions, it is not necessary to fax an Authorization Request Form to AHCCCS. Providers may directly enter their authorization requests through the AHCCCS Online portal, receive a pended authorization number, and use the attachment feature to upload the supporting documents directly with their requests.

Providers who require training on submission of authorization requests using the AHCCCS Web Portal can request training through ProviderTrainingFFS@azahcccs.gov

Note: If submission of a Prior Authorization request or documentation is not possible due to internet outage or other unforeseen events, then it can be done through the fax method. If the documents are faxed, the Prior Authorization Request Form must continue to be utilized.

Online Prior Authorization (PA) Submission Requirements for FFS Providers Effective 7/1/18

AHCCCS registered providers, including behavioral health providers, are now able to submit prior authorization requests for acute services* via the AHCCCS Online Provider Portal.

***Note:**

- Authorization requests for long term care (non-acute) services for Tribal ALTCS plan members must be submitted to the member's Tribal Case Manager.

PROVIDER EDUCATION DATES

- Third Party Liability
  6/7/2018
  11:30-12:00 PM
- Online Claim Submission: Professional Claims
  6/14/2018
  12:00 – 1:00 PM
- Online Claim Submission: Institutional Claims
  6/21/2018
  11:30 – 12:30 PM
- Online Claim Submission: Dental Claims
  6/28/2018
  11:30 – 12:30 PM

ELECTRONIC PAYMENT SIGN UP

Contact:
ISDCustomerSupport@azahcccs.gov
-OR-
Call 602-417-4451

CONTACTS

- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670
- Provider Registration Process Questions - (602) 417-7670
  Fax Applications (602) 256-1474
- Technical Assistance with Online Web Portal Please email ProviderTrainingFFS@azahcccs.gov

Online Prior Authorization Continued

- Federal Emergency Services Plan (FESP) members: Online authorization submission does not apply. Do not submit online authorization requests. Please refer to the information in the FESP section at the end of this article for instructions and requirements.

Over the next two months, May and June 2018, AHCCCS is transitioning to an all online PA submission process (excluding exceptions noted above). Providers who are not already submitting their PA requests online should begin submitting their requests online at this time. Provider training on the online submission process will be held in May and June, 2018. For additional information, please email ProviderTrainingFFS@azahcccs.gov.

Effective 7/1/18, AHCCCS registered providers will be expected to submit their PA requests online via the AHCCCS Online Provider Portal. Providers who submit their authorization requests online will automatically receive a pended authorization number that will serve as verification of receipt of the request, and allow them to check the status of their request via the online portal. Providers are also able to attach their clinical documentation directly to their online request, so faxing requests is no longer necessary.

Providers who continue to submit PA requests via fax after 7/1/18 will receive a notification on their return fax indicating that their request should be submitted online.

Note: If submission of a Prior Authorization request or documentation is not possible due to internet outage or other unforeseen events, then it can be done through the fax method. If the documents are faxed, the Prior Authorization Request Form must continue to be utilized.

Effective 8/1/18, PA staff will discontinue faxing responses to fax authorization submissions. Providers should use the online system to submit and verify status of authorizations submitted. PA staff will direct callers seeking authorization status to the online system for status verification.

Federal Emergency Services Plan (FESP) Member Prior Authorization Requirements

Providers should not submit and/or should discontinue submission of routine PA requests for Federal Emergency Services Plan (FESP) members. Emergency services provided to FESP members do not require prior authorization. Providers should continue to submit Initial Dialysis Case Creation forms for enrollment of FESP members with end stage renal disease (ESRD) who require dialysis three times per week or more, via fax, as specified on the Initial Dialysis Case Creation form.

Providers who request verification that there is no FESP prior authorization requirement can access this information by viewing FESP policy information. PA staff will discontinue faxing responses to routine PA requests for FESP members, effective 5/1/18.

Medical Authorization Reminders

General Reminders

- **Effective May 01, 2018** the FFS prior authorization area will no longer send responses to FES authorization requests. Providers seeking to verify current FES authorization requirements can view this information on the FFS Prior Authorization web page.
- **Effective August 1, 2018** the FFS prior authorization area will no longer send fax responses to faxed authorization requests. Providers should use the online system to submit and verify status of authorizations submitted.
- Authorization requests submitted podiatrists require submission of documentation indicating who the referring PCP is. A podiatrist cannot self refer a patient to themselves or another DPM.
- Hospitals submitting authorization requests for inpatient admissions must determine whether they will be billing a behavioral health principle diagnosis or a physical health principle diagnosis on their claim. The authorization entered online should be submitted with billing codes that are appropriate for the behavioral or physical health service that will be billed. Revenue billing codes are used to authorize behavioral health hospital admissions, and DRG is used for medical hospital admissions.

Web Portal

- Multiple clinical documents uploaded using the Web Portal Attachment feature should be uploaded as a single file.
- All hospital admission notifications and/or authorization requests for hospital admissions must be accompanied by the facility's face sheet verifying the member's admitting diagnosis, and the history and physical document for the admission.
- Hospital authorizations pended for a discharge date should be updated online by facilities. Facility providers must attach the discharge summary using the web portal attachment feature.

- Hospitals should use the appropriate physical health or behavioral health diagnosis when requesting authorizations for inpatient admissions. The claim billed by the facility must match the authorized dates and accommodation type indicated on the authorization. The entire stay must be billed as either behavioral health or physical health. The provider can not bill both for the same admission. More information related to DRG billing.
- The status of all prior authorization requests should be checked using the Web Portal. To manage the volume of incoming authorization calls the area receives, prior authorization staff will no longer provide authorization status or issue standard authorizations to callers.
- *Urgent/Expedited medical requests should be submitted online with supporting documentation, **AND** a call must be made to the FFS Prior Authorization line to notify PA staff that an expedited request has been submitted.

***Note:** Failure to submit requests in a timely manner and/or submission of requests on short notice does not constitute an urgent request. An urgent/expedited request can take up to three working days to review. Requests submitted as urgent that are determined not to be urgent in nature will be processed within standard timeframes.

The Updated AHCCCS Daily Trip Report is Now Available!

The Arizona Health Care Cost Containment System (AHCCCS) is pleased to announce that the **AHCCCS Daily Trip Report**, for use with **Non-Emergency Medical Transportation (NEMT) services**, has been updated.

Effective July 15th, 2018, all NEMT providers will be required to use the updated version of the AHCCCS Daily Trip Report. There will be a 60 day grace period beginning on May 15th, 2018 (when the trip reports were posted online) to allow providers to transition to the new version of the trip report.

After July 15th, 2018 claims submitted with the old version may be returned to the provider. This can result in claim denials.

The AHCCCS Daily Trip Report and instructions for filling out the AHCCCS Daily Trip Report are both available on the AHCCCS website in the following locations:

- Exhibit 14-1, in the Fee-For-Service Provider Billing Manual;
- Exhibit 11-1, in the IHS/Tribal Provider Billing Manual; and
- On the NEMT Provider webpage

The AHCCCS Daily Trip Report is available in both PDF and Excel file formats.

- **NOTE:** The AHCCCS Daily Trip Report is available as an Excel file, however it may not be altered. The Excel file has been provided, per provider request, so that the additional information section may be expanded, if needed.

  Providers **must** convert the Excel file to a PDF before submitting back to AHCCCS.

Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Report will be denied.

- Please note that different versions of the Daily Trip Report may ***not*** be used or submitted. The attachment in the billing manuals is the ***only version*** that may be submitted.
- Providers are not permitted to create their own versions of the Daily Trip Report for submission. **Only the AHCCCS approved Daily Trip Report can be used.**

The AHCCCS Daily Trip Report may be filled out in either blue or black ink.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, so long as all federal and state requirements for the protection of member information are taken, including but not limited to HIPAA compliance and adherence to the AHCCCS Security Rule Compliance Summary Checklist (found in ACOM Policy 108, Attachment A).

If the AHCCCS Daily Trip Report is filled out electronically it may be submitted by printing it out and mailing it in, or electronically submitting it through the 275 provider portal as a PDF file.

continued on next page

- AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.
- AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was only included online per provider request.
- AHCCCS **will** accept PDF files of the AHCCCS Daily Trip Report.

DFSM Provider Training will offer two additional training sessions for the updated AHCCCS Daily Trip Report. The trainings will be held on June 12, 2018 and on July 10, 2018.

If you have questions please feel free to contact us at ProviderTrainingFFS@azahccs.gov.

638 FQHC's

AHCCCS has established a new provider type that will allow Tribal 638 Clinics (currently Provider Types 05 or 77) to elect to be recognized as a 638 FQHC (Federally Qualified Health Center). The new 638 FQHC provider type designation is C5 and will be available with an April 1, 2018 effective date.

Our latest training on 638 FQHC's goes over the logistics relating to provider registration, billing updates, and questions that the Tribal partners may have. Please see the latest training posted on the AHCCCS Webpage at DFSM Trainings.

Additional information can be found on the IHS/Tribal Provider Billing Manual, Chapter 20 Chapter 20, 638 FQHC.