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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

October 2021

CMS Extension of "Four Walls" Grace Period for IHS and Tribal 638 Facilities

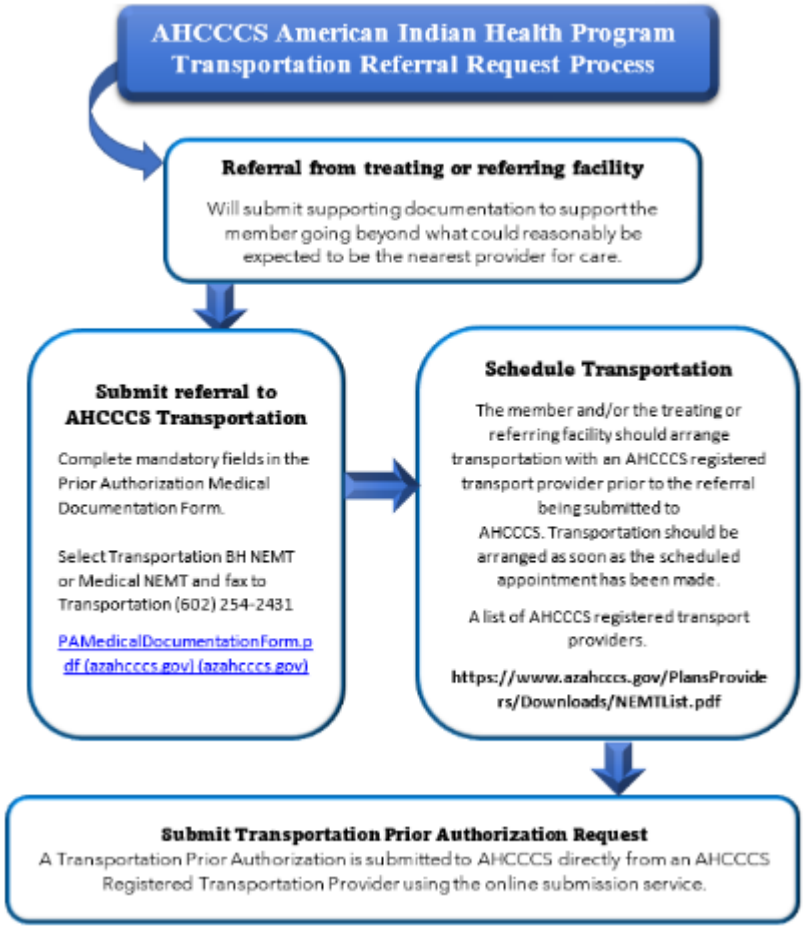
On October 4, 2021, the Centers for Medicare and Medicaid Services (CMS) released an informational bulletin that extended the grace period previously granted to Indian Health Service (IHS) facilities, and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), which permits IHS/Tribal facilities to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate (AIR)) for services provided outside of the "four walls" of the facility.

Extension of the grace period will allow states and Tribes to continue the work needed to make an informed decision about the Tribal FQHC option described in a January 15, 2021 Informational Bulletin (referred to in that CIB as "the Tribal FQHC option") and take steps to effectuate that option.

The bulletin extends the grace period to end nine months after the end of the COVID-19 public health emergency.

Learn more in this pdf Further Extension of Grace Period Related to the "Four Walls" Requirement

AIHP Transportation Request Process



ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address of servicedesk@azahcccs.gov

TRAINING AND CONTACTS

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website

The DFSM Provider Training Team's Fourth Quarter Training Schedule is posted on the DFSM Provider Training web page.

For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at ProviderTrainingFFS@azahcccs.gov

- Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website.
- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5
- Provider Registration – Fax Applications (602) 256-1474

ELECTRONIC PAYMENT SIGN UP

Electronic Payment Sign Up (Remittance Advice Sign Up/835)
ISDCustomerSupport@azahcccs.gov
OR call 602-417-4451

COVID FAQ

FAQs on the AHCCCS website.

Please note that these materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

Transportation Requests

Transportation requests should not be included in the meals and lodging requests, since doing so will delay the authorization. They need to be submitted separately.

Transportation should be arranged as soon as the scheduled appointment has been made. The member and/or the treating facility should arrange transportation with an AHCCCS registered transport provider.

Prior authorization is required for non-emergency transportation more than 100 miles one way or roundtrip.

AHCCCS requires a referral with a letter of medical necessity from the referring facility if services are not available or there is a medical reason for the member to receive services beyond the closest facility.

The referral can be submitted to AHCCCS via fax at 602 254-2431.

The information should be sent using the AHCCCS Fee For Service Prior Authorization Medical Documentation Form.

Transportation Passes/Bus Passes

Effective 10/1/2021, providers with a Category of Service (COS) 31 may offer Public Transportation options to FFS members (such as a bus pass) when they travel to and from an AHCCCS approved service, in accordance with AMPM 310-BB.

The following shall be considered when offering public transportation to a member:

1. Location of the member to a transportation stop.
2. Location of the provider of services to a transportation stop.
3. The public transportation schedule in coordination with the member's appointment.
4. The ability of the member to travel alone on public transportation.
5. Member preference

Provider types that are eligible to claim reimbursement for public transportation passes include 02, 05, 13, 14, 25, 27, 29, 41, 77, 81, 85, 86, 87, A3, A4, A6, B7, BC, C2, and C5.

Please note:

- Transportation passes may be up to 1 month in duration.
- Replacement or duplicate transportation passes are not eligible for Medicaid reimbursement.
- There shall be a continuous need for transportation to Medicaid reimbursable services consistent with the length of the purchased transportation pass.
- Providers shall determine the appropriate type/duration of public transportation pass to issue to members in accordance with the member's treatment plan and existing future appointment dates.

Billing for Transportation/Bus Passes

- Bill using code A0110 for the net cost of the transportation pass, not to exceed the cost of a 30-day pass.
- Submitted Claims must include the following documentation.
  - Copy of public transportation pass,
  - Itemized receipt specifying cost of public transportation pass,
  - Pricing that corresponds with the price of the pass in the geographic areas of issuance, and
  - Completed Public Transportation Pass form to include the following:
    - Provider's name and ID#,
    - Public Transportation pass type (daily, weekly, or monthly),
    - Price of the Public Transportation pass,
    - Date of issuance,
    - Name, title, signature, and signature date of person issuing Public Transportation pass to the member,
    - Member name, AHCCCS ID#, signature and signature date.
- Public Transportation Pass Form:

Electronic Visit Verification (EVV)

For information on Electronic Visit Verification please visit the AHCCCS website

If you are one of the provider types listed, and provide a service listed at one of the location codes listed under the information for Providers and MCOs tab (shown below), then EVV applies to you.

You must meet all three criteria (provider type, service code, and place of service) in order to meet the requirement to comply with EVV.

EVV applies to the following provider types, services rendered, and places of service:

Provider Description	Provider Type
Attendant Care Agency	PT 40
Behavioral Outpatient Clinic	PT 77
Community Service Agency	PT A3
Fiscal Intermediary	PT F1
Habilitation Provider	PT 39
HomeHealth Agency	PT 23
Integrated Clinic	PT IC
Non-Medicare Certified HomeHealth Agency	PT 95
Private Nurse	PT 46

Service	HCPCS Service Codes	DDD Focus Codes
Attendant Care	S5125	ATC
Companion Care	S5135	
Habilitation	T2017	HAH, HAI
Home Health Services (aide, therapy, and part-time/intermittent nursing services)		
Nursing	G0299 and G0300	
Home Health Aide	T1021	
Physical Therapy	G0151 and S9131	
Occupational Therapy	G0152 and S9129	
Respiratory Therapy	S5181	
Speech Therapy	G0153 and S9128	
Private Duty Nursing (continuous nursing services)	S9123 and S9124	HN1, HNR
Homemaker	S5130	HSK
Personal Care	T1019	
Respite	S5150 and S5151	RSP, RSD
Skills Training and Development	H2014	

Place of Service Description	POS Code
Home	12
Assisted Living Facility	13
Other	99

Emergency Triage, Treat and Transport (ET3)

Emergency Triage, Treat and Transport (ET3) is a program designed to allow greater flexibility for ambulance providers registered with AHCCCS as Emergency Transportation providers (Provider Type 06) to address health care needs following a 9-1-1 call.

AHCCCS intends to implement ET3 as of October 1, 2021, pending CMS approval.

The three components of ET3 are:

6. **Transport of Member to Alternate Destination** (e.g., urgent care center, BH provider, PCP's office, FQHC/RHC, or specialist)
7. **Treatment in Place by a Qualified Health Care Practitioner *In* Person** (e.g. EMS personnel provide treatment at member's existing location, using standing orders)
8. **Treatment in Place/Triage by Qualified Health Care Practitioner** (e.g. medical triage of member via telehealth, with EMS personnel assisting as needed)

To provider and bill for ET3 services a provider must:

1. Be registered with AHCCCS as Provider Type 06; and
2. Be responding to a "call" initiated by an emergency response system ("9-1-1" call, fire, police, or other locally established system for medical emergency calls); and
3. Upon arrival at the scene, the emergency team's field evaluation determines that the member's needs are non-emergent, but medical necessary; and
4. Follow all requirements as outlined in AMPM 310-BB.

To become an AHCCCS-registered provider type 06, ambulance providers must have received a Certificate of Necessity (CON) from ADHS.

Tribal providers who choose not to receive a CON from ADHS may become an AHCCCS-registered provider type 06 by signing the AHCCCS attestation of CON equivalency.

Details regarding requirements for Transport to an Alternate Destination and Treatment in Place can be found on the DFSM Provider Training web page, on the AHCCCS ET3 Updates web page, and in Chapter 14 of the Fee-for-Service Provider Billing Manual, Transportation.

Additional information can be found at the following links:

- ET3 FAQs
- ET3 Billing Presentation

COVID-19 Information

AHCCCS is responding to an outbreak of respiratory illness, called COVID-19, caused by a novel (new) coronavirus. Health officials urge good hand washing hygiene, covering coughs, and staying home if you are sick.

To address Medicaid-related questions from providers and contractors about COVID-19, AHCCCS has developed a list of Frequently Asked Questions Regarding Coronavirus Disease 2019 (COVID-19), updated regularly as more information becomes available.

COVID-19 FAQs

Find out more on our website. Learn how to protect yourself and stop the spread of COVID-19. Visit azdhs.gov/COVID19 and cdc.gov/COVID19.

If you are an AHCCCS member who is experiencing flu-like symptoms, please call the 24-hour Nurse Line for your health plan. Phone numbers can be found on the AHCCCS website.

Tribal ALTCS Digital Tool Box

The Tribal ALTCS Digital Tool Box can be found at the following link on our website.

Transaction Insight Portal – Important Information for Users Who Select Non-Person Entity

Attention All Transaction Insight (TI/TIBCO) Portal / Web Upload Attachment Users

This is an **important notice** for providers who log onto the Transaction Insight Portal (also known as TIBCO or the TI Portal) to upload attachments, such as medical records and the Daily Trip Report

If you select **Non-Person Entity (2)** and then enter in information into the **Provider First Name** field, this will cause an error and your attachments will not link to the claim.

This will cause your claim to be denied for missing documentation.

AHCCCS has been seeing multiple errors amongst providers who are submitting documentation as a Non-Person Entity (2). Do not enter any values in the Provider First Name when submitting documentation as a Non-Person Entity.

INCORRECT

Provider Entity Type Qualifier: Person (1) Non-Person Entity (2)

Provider Last or Organization Name: Organization Name

Provider First Name: Organization Name (If you put something here, the documentation may not attach and the claim could deny.)

CORRECT (Provider First Name must be blank/empty)

Provider Entity Type Qualifier Person: (1) **Non-Person Entity (2)**

Provider Last or Organization Name: Organization Name

Provider First Name:

The Provider First Name field **must** be left blank when a Non-Person Entity is chosen. The below image shows the correct way to do this in the portal.

Please also review Page 8 (Submitter Last or Organization Name) in the guide:

Transaction Insight Web Upload Attachment Guide

If you encounter problems logging on to the TI Portal, please contact EDI Customer Support at servicedesk@azahcccs.gov
Please click on the link below to download the latest training on the new web upload attachment layout.

- New TI Portal User Guide

Any additional questions regarding training on the TI portal, please contact:

ProviderTrainingFFS@azahcccs.gov

Prior Authorization Updates and Reminders

Continuation of Temporary FFS PA Lift Effective 08/01/21 to Current

In accordance with the information provided in the Fee For Service Memo dated August 20, 2021, the

effective date for the following changes is 08/01/21:

- Effective 8/1/2021 all non-emergency medical transportation (NEMT) over 100 miles will require prior authorization. All NEMT prior authorization requests must be received prior to the date of service to be considered timely.
- Temporarily waived prior authorization (PA) requirements have been continued for physical health admissions to acute hospitals, long term acute hospitals (LTACs), acute rehab facilities, Nursing Facilities (NFs/SNFs), and Assisted Living Facilities (ALFs).
- Please note that the temporary prior authorization lift does not apply to behavioral health admissions. Authorization requirements remain in place for BH admissions to acute hospitals, residential treatment facilities (RTCs), and behavioral health residential facilities (BHRFs).

Behavioral Health Hospital Admission vs Physical Health Hospital Admission for AIHP and/or TRBHA FFS Members

The primary diagnosis (behavioral health vs. physical health) will determine the process used to review inpatient hospital authorization requests for authorization and to reimburse the corresponding claims. The diagnosis type (behavioral health or physical health) on the claim must match the diagnosis type on the authorization requested by the provider for the claim to pay. Providers billing for an inpatient

behavioral health (BH) admission to a hospital must first submit a BH authorization request, which requires submission of an online authorization request to the FFS BH PA area with the applicable BH diagnosis, the required Certificate of Necessity, treatment plan, progress notes, discharge summary, and any other documentation that is requested by the BH PA team to establish medical necessity for the BH admission and continued stay. See the FFS BH PA Criteria webpage for more information on BH PA documentation requirements.

The claim billed for an inpatient BH hospital admission must have a corresponding approved BH authorization on file or it will deny. An authorization for a medical admission (requested with a medical diagnosis) will not correspond with a claim for the same admission that is billed with a BH diagnosis and will deny. An authorization for a BH admission will not correspond with a claim billed for the same admission with a medical diagnosis and will also deny. The servicing provider must determine the admission type (behavioral health or physical health) and is required to submit the request for prior authorization in accordance with the type of claim that they intend to bill. The documentation submitted by the service provider must support the authorization request and claim billed. If this does

not occur, the provider may be required to correct the authorization or claims submission for reimbursement to occur.

Providers billing for a physical health admission to an acute hospital must submit the facility face sheet, history and physical, discharge summary, and any additional documentation requested by the medical PA area to establish medical necessity for the admission. Please note the temporary PA Lift for inpatient physical health admissions. There is no PA requirement for physical health inpatient hospital

admissions during the temporary PA lift. Requests submitted for physical health inpatient hospital authorization requests submitted during the timeframe of the temporary FFS PA Lift will be revoked. Please review the FFS Memo for effective dates for the temporary FFS PA Lift.

Note: Providers entering a request for an inpatient BH hospital admission must use Event type BI.

Providers entering a request for an inpatient physical health hospital admission must use Event type IP.

For questions regarding PA please contact the PA Line at 602-417-4400 or 800-433-0425 (outside the Phoenix area).