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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

August 2023

Important: Effective June, 9, 2023 Provider Moratorium

Behavioral Health Outpatient Clinic (77), Integrated Clinic (IC), Non-Emergency Medical Transportation (28), Community Service Agency (A3) and Behavioral Health Residential Facility (B8)

In accordance with Section 42 CFR 455.470, I, Carmen Heredia, Director of the Arizona Health Care Cost Containment System (AHCCCS), will implement for 6 months a statewide moratorium on the enrollment of Behavioral Health Outpatient Clinic (IC), Integrated Clinic (IC), Non-Emergency Medical Transportation (28), Community Service Agencies (A3), and Behavioral Health Residential Facility (B8) providers.

This moratorium will expire on December 9, 2023. At the Director's (or designee) discretion, this moratorium exempts provider 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) and shall be effective on June 9, 2023.

This action is necessary to safeguard AHCCCS members, public funds and to maintain the fiscal integrity of the AHCCCS program.

Important: Behavioral Health Billing Codes Documentation Requirements

DFSM released a updated billing and documentation communication on July 14, 2023. The communication listed current HCPCS codes that require the submission of the "consent to treat form, treatment plan, progress notes and all medical documentation for all services billed on the claim submission. We have provided the link to the copy of this memo release in a training presentation format.

Memo Release Date July 14, 2023 Outpatient Behavioral Health Billing Codes

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

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: servicedesk@azahcccs.gov

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

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

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).

DFSM New Training Tutorials!

The Division of Fee-for-Service Management (DFSM) provider training unit has a variety of training topics relating to prior authorization, claim submission and (TIBCO) documentation and more. We have added several new training resources for Fee-for-Service (FFS) providers to use. These quick guides will provide direct "How to" step by step instructions that are user friendly with more training updates to come. We invite you to participate in our live webinars and as new topics are added to check the DFSM Provider Training Web Page often for updates.

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

Quick Guide - How to Complete the Participating Provider Reporting Information

Quick Guide - How to Add the Missing Activity Information on the Prior Authorization

Updated Training Presentation:

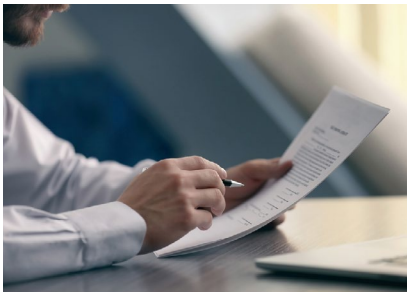
Behavioral Health Residential Facility (B8) Claim Submission Training

Correcting Claim Submission Errors Voids and Replacements Training

How To Verify Member Eligibility Using the AHCCS Online Provider Portal

AHCCCS Provider Enrollment Portal and Basic Provider Information

Required Documentation For Outpatient Behavioral Health 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; a copy of the most recent comprehensive assessment, treatment plan, and the medical record documentation for the services billed on the service date. This requirement is for but not limited to Behavioral Health Residential Facility (B8), Integrated Clinic (IC), and Behavioral Health Outpatient Clinic (77)

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

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

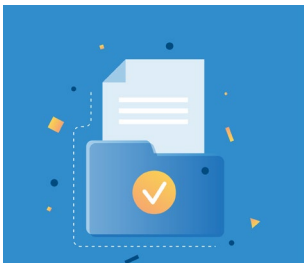
Comprehensive Behavioral Assessment - is the ongoing collection and analysis of an individual's medical, psychological, psychiatric, and social conditions in order to initially determine if a health. disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual's service plan is designed to meet the individual's (and family's) current needs and long term goals.

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 specified in AMPM Policy 310-BB Transportation

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.

Documentation Review for Behavioral Health Outpatient Claims



The easiest 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.

Important: AHCCCS Changes Enrollment Procedures for the American Indian Health Program (AIHP)

The Arizona Health Care Cost Containment System (AHCCCS) will no longer accept requests for enrollment into the American Indian Health Program (AIHP) over the phone. This is a change to the enrollment procedures for individuals selecting AIHP as their assigned Medicaid health plan, and is an additional measure to prevent fraudulent enrollment.

The American Indian Health Program Change Request Form on the American Indian Health Program web page now reflects this change, and all new enrollment requests must be submitted in writing to AHCCCS by fax or email by an Indian Health Service (IHS), Tribally owned/and or operated 638 facility, or Urban Indian Health Organization on behalf of a member.

While the majority of Medicaid members in Arizona are enrolled in a managed care health plan, American Indians/Alaska Natives always have the option to enroll in managed care or AIHP, the Fee-for-Service Medicaid program for American Indians/Alaska Natives in Arizona. These members have the option to move from managed care into AIHP at any time.

If anyone is asked or coerced to enroll in AIHP fraudulently, report it to AHCCCS using the online Report Fraud web page or by calling 602-417-4045 or, outside of Arizona, 888-ITS-NOT-OK (888-487-6686).

Any AHCCCS member who needs help because of a sober living home closure can call 2-1-1 (press option 7).

Participating Provider Reporting Requirements Edit Denial Codes H482.1 and H482.7

The following provider types, Outpatient Behavioral Health Clinic (77), Clinic (05) and Integrated Clinic (IC) must report on all claims submitted to FFS the individual providers participating in the care/services. Claims that do not include the required participating provider information will deny and the submitter must correct the fields and submit a replacement claim and include all required documenation with the replacement claim.

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

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

Providers can refer to the Quick Guide - How to Complete the Participating Provider Reporting Information.

Provider Type 02 Hospital - Prior Authorization Submission Reminders

Hospitals must submit a complete prior authorization request and receive a provisional affirmation decision as a condition of payment. DFSM has noticed an increase in prior authorization submissions from acute care hospitals that are **Incomplete**. An incomplete PA request is one that is missing the ***Event and or Activity information or both.***

The Prior Authorization submission process has three steps that must be completed.

- **Case Creation**
- **Event Type**
- **Activity Type**

Providers must submit prior authorization requests via the AHCCCS Online Provider portal and include all relevant medical documentation that will allow the PA team to make a decision.

AHCCCS Online Provider Portal Password Reset Requests

The provider training team cannot assist with reseting a password. Password reset requests must be sent to Servicedesk@azahcccs.gov or providers may use the "Password" reset option.

AHCCCS Online Provider Portal Registering Under the Group Billing Provider (01) NPI

Registering or setting up the account under the Group Billing Provider type (01) NPI is the easiest way to add multiple service providers to the group.

To use the AHCCCS Online Provider Portal, you must have an active account. Accounts are created by the user and not assigned by AHCCCS. Access to use the AHCCCS Online Provider Portal is only available to providers that are enrolled with AHCCCS Fee-for-Service and have an active account. The account administrator (Master Account holder) will have the ability to grant system access to users.

- URL AHCCCS Online Portal https://azweb.statemedicaid.us/Help/LearnMore.aspx
- To create an account, click on the Register link under the "New Account" menu and follow the prompts.

You will only have access to view your organization's claims and prior authorizations by the individual under which the account is created, or an affiliated provider.

For privacy reasons, providers are restricted from viewing claims and prior authorizations submitted by other providers, unless a provider **group affiliation is established**.

How to Register Your Group Billing Account On the AHCCCS Online Portal

Creating an account under a Group Billing NPI (provider type 01), rather than under each individual service provider NPI, will allow the account holder to view and submit claims and prior authorizations for all providers associated with the Group Billing NPI and related Tax Identification number (TIN). This association is often created for multiple service providers that are employed by a group practice (PT 01) and are using the same TIN. The service provider must have a valid Group Billing Affiliation on file with the specific group billing provider.

Getting Started:

Using the AHCCCS Online Provider Portal, verify the following information:

- Verify that each individual service provider is assigned the same Tax ID number as the Group Billing provider and is linked to the Group Billing ID.

To set up the Group Billing account, the Master Account holder must register an AHCCCS Online account under the Group Billing NPI and related Tax ID. Setting up the registration in this manner will link the individual service provider(s) NPI to the group billing provider NPI on the AHCCCS Online Provider portal. Once these steps are completed, the service provider's NPI will show in the "drop-down" box for you to us.

How to Verify if the Service Provider is linked to the Group Billing Provider

1. Select Provider Verification.
2. Enter the Group Billing NPI.
3. Select search option.
4. Click on the Provider/Group/CCA Affiliations tab. Under the heading Provider Affiliations, you will see all providers that have a group billing affiliation on file under the group billing NPI.

After verifying the service provider NPI is linked to the group billing NPI, go to the AHCCCS Online Provider Portal and select Register for an AHCCCS Online account, remember to use the Group Billing NPI number.

Important Master Account Holder Changes

Master account holders who are planning to leave the organization should make sure **BEFORE** they leave to designate another account holder to a Master Account status to prevent disruption in service for the provider.

Notification of Account Access by the United States Postal Service (USPS)

When a **MASTER** account is created you will be prompted to select the address from the drop-down list which contains the valid addresses on record with AHCCCS for your provider ID number.

- You must select the address for the location in which you receive mail.
- The authentication code will be mailed to you via **USPS the following business day**.

The authentication code is necessary to activate the Master account for the first time, without this code you cannot sign on to the Online portal. If you have not received the letter with your authentication code within five to seven business days, please submit an service ticket request to Customer Support Center at servicedesk@azahcccs.gov. Please do not include personal or sensitive information such as usernames or passwords.

*(NOTE: As a security protocol, AHCCCS will **NOT** provide the activation code via text, email, phone call or fax).*

15 Day Activation Time Limit

The **authentication code** must be entered exactly as it appears in the letter (upper/lower case/numbers/ special characters). If the Master account is not activated within 15 days of creation, it will be deleted from our system. During this time, no other Master accounts can be created and do not attempt to create a Master account unless you are authorized to do so as

90 Day Account Lockout

If the Master account is not accessed for more than 90 days, the account will automatically be locked. The master account holder will receive email alerts that will be sent to the email address registered with the account, prior to the account being locked.

Creating Multiple Master Accounts

To create additional Master accounts, an existing Master account holder simply promotes an Individual account to a Master. Once the Master account is activated, the Master account holder will have the ability to activate new Individual accounts.

- All Master account holders will receive an email each time an Individual account is created. This email is sent to notify the Master that the account was created and is awaiting activation.
- If an active Master account does not exist for a given provider, Individual accounts cannot be created.

Individual Account Information

Individual accounts can be created regardless of whether a master account already exists for a provider. However, you cannot use an individual account until a master account holder activates it.

When the registration process is completed for an Individual account holder, **an email will be sent to the Master account holder(s) for the same provider**, if a Master account exists. The purpose of the email is to notify the Master account holder(s) that a new Individual account has been created and is awaiting activation.

- The account will remain inactive for up to 120 days unless it is activated by a Master account holder.
- If the 120 days expires without activating the account, it will be deleted from our system.