

Revisions: 1/11/2019; 10/1/2018; 4/13/2018; 3/1/2018

General Information

AHCCCS has liability for payment of benefits after Medicare and all other first- and third-party payer benefits have been paid. Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

Providers who qualify for Medicare payment, but have not applied to Medicare, must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

AHCCCS maintains a record of each member's coverage by Medicare and Other coverages. If a member's record indicates first- third-party coverage but no Medicare and/or insurance payment is indicated on the claim, the claim will be denied.

Timely Filing

The initial claim *must* be submitted to AHCCCS *within twelve months of the date of service* for Title XIX member and *within six months of the date of service* for Title XXI (KidsCare) members, even if payment from Medicare or Other Insurance has not been received.

If a claim is originally received with the initial time frame (12 months for Title XIX members and 6 months for Title XXI members), the provider has up to 12 months from the date of service to correctly resubmit the claim with the Medicare/Other Insurance payment Remit/EOB. This must occur within 12-months of the date of service, which is the clean claim time frame.

Refer to Chapter 4, General Billing Rules, of the IHS/Tribal Provider Billing Manual for timely filing requirements and instructions for *replacing* (resubmitting) a claim. Failure to replace a claim correctly may result in a “timely filing” denial.

Definitions

“In addition to the definitions in A.R.S. §36-2901, 36-2923 and 9 A.A.C. 22 Article 1, the following definitions apply to this Article:

Absent Parent	An individual who is absent from the home and is legally responsible for providing financial and/or medical support for a dependent child, as defined by A.A.C. R9-22-1001.
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Coordination of Benefits	The activities involved in determining Medicaid benefits (COB) when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.
Cost Avoidance	To deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C. R9-22 Article 10.
First Party Liability	The obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member. Refer to A.A.C. R-9-22-1001 Definitions.
Post-Payment Recovery	Subsequent to payment of a service by a Contractor, efforts by that Contractor, to retrieve payment from a liable third-party. “Pay and Chase” is one type of post-payment recovery.
Third-Party	An individual, entity or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.
Third Party Liability	Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

Acronyms

For purposes of this chapter the following abbreviations are defined:

- EOMB The EOMB is an Explanation of Medicare Benefits.
- EOB The EOB is an Explanation of Benefits by First- and Third-Party payers (i.e. Other Payers).
- RA The RA stands for Remittance Advice.

First- And Third-Party / Other Coverage

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted, per A.R.S. §36-2946.

Under state and federal law and R9-22-1003 (E), AHCCCS must pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement from the First- or Third-Party payer (Post-Payment Recovery) when:

1. The claim is for prenatal care for pregnant women; or
2. Preventive pediatric services, including EPSDT services and administration of vaccines under the Vaccines For Children (VFC) Program; or
3. The liability is from an absent parent whose obligation to pay support is being enforced by Division of Child Support Enforcement; or

Per R9-22-1002, AHCCCS is not the payer of last resort (AHSSS will be the primary payer) when the following entities are the third-party:

1. The payer is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Medical services provided through schools under the federal Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq.

Coordination of Benefits (COB)

For information on Medicare COB please refer to the Medicare heading within this chapter.

Coordination of benefits with a First-Party Payer includes, but is not limited to the following:

- Private health insurance;
- Employment-related disability and health insurance;
- Long-term care insurance;
- Other federal programs not excluded by statute from recovery;
- Court ordered or non-court ordered medical support from an absent parent;
- State worker's compensation;
- Automobile insurance, including underinsured and uninsured motorists insurance;
- Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
- First-party probate estate recovery; and/or
- Adoption-related payment.

Coordination of benefits with Third Party Payers includes, but is not limited to the following:

- Motor vehicle injury cases,
- Other casualty causes,
- A tortfeasor,
- Restitution recoveries, and/or
- Worker's compensation cases.

The AHCCCS Administration's reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the first- or third-party liability.

An AHCCCS registered provider agrees to accept the Capped Fee-For-Service schedule as payment in full.

If the first- or third-party coverage paid more than the Capped Fee-For-Service scheduled amount then no further reimbursement is made by AHCCCS.

For example, a provider bills \$4,500.00 for a surgical procedure:

- The first-party plan allowed \$1,388.23, paid \$1,110.58. and shows a 20% coinsurance amount of \$277.65
- The AHCCCS Capped Fee-For-Service schedule allows \$753.21 for the surgery.

There will be no AHCCCS payment, as the provider has already been paid more than the Capped Fee-For-Service scheduled amount. The provider must accept the \$1,110.58 as payment in full and cannot balance bill the member for any amount.

When the first-party payer is an HMO-type health plan, the same coordination of benefits process would apply.

For example, a contracted HMO provider bills \$150.00 for an office visit.

- The HMO plan benefit has a member co-pay of \$30.00 and the plan pays the contracted provider \$50.00.
- The AHCCCS Capped FFS schedule allows \$41.39 for the office visit.

There will be no AHCCCS payment, as the provider has already been paid more than the AHCCCS Capped FFS rate. The provider must accept the \$50.00 as payment in full. AHCCCS does not reimburse co-pays, deductibles or coinsurance amounts.

Should more than one coverage plan make payment and the total paid by the multiple coverage plans is more than the AHCCCS Capped Fee-For-Service schedule then there

will be no AHCCCS payment and the provider cannot balance bill the member for any amount.

If the first- or third-party payer denies a covered service the provider must follow the plan's appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

A.A.C. R-22-1003 Cost Avoidance:

- Section A advises that the Administration's reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability.
- Section C, advises that the requirement to "cost avoid" applies to all AHCCCS-covered services under Article 2 of the A.A.C. chapter. The only exception provided by Rule is that the Administration shall pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement when:
 1. The claim is for labor and delivery and postpartum care; or
 2. The liability is from an absent parent, and the claim is for prenatal care or EPSDT services.

AHCCCS shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is submitted (see exceptions 1 – 5 on page 3) without the required other coverage payment EOB/remit/information.

If the probable existence of a First- or Third-party's liability cannot be established or if Post-Payment Recovery is required then the claim will be adjudicated and AHCCCS will follow the Post-Payment Recovery process (Pay and Chase).

MEDICARE

AHCCCS Medicare Eligibility Definitions

In reference to QMB claims: If a Medicare provider is not an AHCCCS registered provider, AHCCCS will permit the provider to register as an AHCCCS registered provider for the adjudication of the claim for the QMB cost-sharing amount. AHCCCS will notify the provider of the process for registering. If a provider is unwilling to become an AHCCCS registered provider then no payment can be made.

QMB Only – a **Qualified Medicare Beneficiary (QMB)** under the Federal QMB program. This is a person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.

AHCCCS can reimburse the provider for the Medicare deductible, coinsurance, and copay.

If Medicare denies the service and upholds the denial upon the provider's appeal, then AHCCCS makes no payment. Refer to Arizona Administrative Code (A.A.C.) R9-29-301.

Balance billing of **QMBs** is prohibited by Federal Law. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost sharing.

QMB Dual – this individual qualifies under the federal QMB program and Medicaid (AHCCCS).

Per A.A.C. R9-29-302:

1. AHCCCS will pay the following costs for FFS members when the services are received from an AHCCCS registered provider and the service is covered:
 - a. By Medicare only, then AHCCCS pays only the Medicare deductible/coinsurance/copay;
 - b. By Medicaid only, then AHCCCS pays the FFS rate; or
 - c. By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible/coinsurance/copay.
2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

A.A.C. R9-29-302.E. advises: "A QMB Dual eligible member who receives services under 9, A.A.C. 22, Article 2 or 9, A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges."

Non-QMB Dual – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as "Dual Eligible").

Per A.A.C. R9-29-303:

1. AHCCCS will pay the following costs for FFS members when services are received from an AHCCCS registered provider and the service is covered:
 - a. By Medicare only, then AHCCCS shall not pay the Medicare deductible or coinsurance or copay;
 - b. By Medicaid only, then AHCCCS pays the FFS rate; or
 - c. By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible, coinsurance or copay.
2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

Guidelines for “Dual Eligible” Members

A Medicare provider must accept Medicare allowable as the total compensation for services rendered. Based on the member’s eligibility, when appropriate, AHCCCS may reimburse up to the Medicare deductible, coinsurance or copay for services, including members enrolled with a Medicare Advantage plan. Contact the Medicare Advantage HMO plan for information regarding covered services and prior authorization requirements.

Services that are not Medicare covered, but are AHCCCS covered, may be reimbursed by AHCCCS if the service is medically necessary and meets the AHCCCS eligibility and reimbursement requirements.

If Medicare denies a covered service based on medical necessity or if the service was not delivered in the appropriate setting, the service will not be paid by AHCCCS.

If Medicare denies a covered service the provider must follow the Medicare appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of Medicare’s final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

If a member is eligible for Medicare Part D then AHCCCS does not cover prescription medications or Part D copay amounts.

AHCCCS will not pay for more than the member’s financial responsibility for the service (e.g., any deductible, coinsurance, and/or co-pay as indicated above).

Medicare Crossover Claims

AHCCCS has established an automated crossover process for fee-for-service claims.

When a provider submits a claim to Medicare for an AHCCCS member the claim is automatically crossed over to AHCCCS when Medicare issues payment. Providers should not submit claims to AHCCCS for paid Medicare claims for Dual eligible AHCCCS members or QMB members. For information on the FQHC/RHC exception, refer to FFS Chapter 10 Addendum – FQHC/RHC.

All crossover claims are identified on the provider’s Medicare Remittance Advice (RA).

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within the timely filing requirements. A copy of the Remittance Advice (RA)/Explanation of Medical Benefits (EOMB) must accompany the

claim to AHCCCS. Refer to Chapter 4, General Billing, of the IHS/Tribal Provider Billing Manual for timely filing requirements and the claim replacement process.

Filing Paper or Online Claims After Medicare/First- and Third-Party Payer Payments

The EOMB, EOB, and RA show payment/denial details of a provider's claim for services.

Denied Medicare claims are not automatically crossed over to AHCCCS. Read the Medicare RA/EOMB carefully to determine if the claim crossed over to AHCCCS or if the provider must submit the claim and the Medicare RA/EOMB to AHCCCS. Read the Medicare reason codes carefully to determine if the Medicare appeal process must be followed before AHCCCS can determine reimbursement.

Adjusted Medicare claims are not automatically crossed over to AHCCCS at this time. The provider must submit a replacement claim to AHCCCS with a copy of the original Medicare RA/EOMB and the adjustment RA/EOMB with all of the reason codes displayed. For additional information on replacing (resubmitting) a claim, please refer to Chapter 4, General Billing Rules, of the IHS/Tribal Provider Billing Manual.

Claims submitted with only the Medicare adjustment RA/EOMB may be denied by AHCCCS as incomplete. If the Medicare RA/EOMB is submitted to AHCCCS without the reason code page(s) the claim may be denied as incomplete.

Providers *must* submit a *separate RA/EOMB/EOB with each claim form*. If a provider submits multiple claims for a member but includes only one copy of the RA/EOMB or EOB, the payment document will be attached to the claim with highest coinsurance and deductible amount. The other claims in the package will be denied for lack of a Medicare RA/EOMB or Other Payer's RA/EOB.

Always attach a copy of the Medicare / Third Party Payer's RA/EOB to **each** claim submitted.

Always include the Medicare Remittance Advice Reason Code (RARC)/ Claim Adjustment Reason Code (CARC) key page(s) for the RA/EOMB.

Always include the Remark/Reason Code key page(s) for the Other payer's RA/EOB.

Never submit double-sided pages, as the back side of the page will not be scanned and the claim will be denied as incomplete.

Note: Failure to submit the remark/reason code key page(s) with the RA/EOMB/EOB are considered incomplete claims and will result in claim denial.

UB-04 Claims with Medicare and/or Other Payer

When a provider finds it necessary to file a UB-04 claim with AHCCCS for a member who also is covered by Medicare and/or other payer, the provider must report Medicare and/or other payer information on the claim to AHCCCS.

For members and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill AHCCCS for the coinsurance and deductible as shown on the Medicare RA/EOMB. Providers must attach a copy of the Medicare RA/EOMB to the UB-04 claim.

1. Medicare Part A
 - a. Report the Part A deductible and coinsurance (if applicable) amounts and appropriate value codes in Fields 39A and 40A.
 - b. Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance.

Example: Provider reports Medicare Part A deductible of \$812 and no coinsurance.

	39 VALUE CODE		40 VALUE CODE		41 VALUE CODE	
	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT
a	A1	812	00			
b						
c						
d						

2. Medicare Part B - Inpatient

- a. Report Medicare Part B as the payer in Field 50A and the Part B paid amount in Field 54A.

NOTE: Please note that field 50 is to be used for the reporting of TPL. If there is a Third Party Payer *and* Medicare Part B, the TPL can be reported in Field 50A and Medicare Part B can be reported in Field 50B.

Example: Provider reports Medicare Part B Inpatient payment of \$312.

50 PAYER	51 PROVIDER NO.	52 REL 53 ASG INFO BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE

A MEDICARE PART			312	00		
B						
C						

3. Medicare Part B - Outpatient

- a. Report the Part B deductible (if applicable) and coinsurance amounts and appropriate value codes in Fields 39B and 40B.
- b. Use value code B1 to indicate Part B deductible and B2 for Part B coinsurance.

Example: Provider reports outpatient Part B coinsurance of \$125.

	39 VALUE		40 VALUE CODE		41 VALUE CODE	
	CODE	AMOUNT	CODE	AMOUNT	CODE	AMOUNT
a						
b	B2	125 00				
c						
d						

4. First- and Third-party Payers

- a. Report the other payer’s name(s) in Fields 50A and (if needed) 50B and the payment amount(s) in Fields 54A and (if needed) 54B. (List all First- and Third-Party payers & payments)
- b. Attach a copy of the payer’s RA/EOB to the UB-04 claim. If more than one Other Payer is listed, then include RA/EOB for each Other Payer listed.

Example: Provider reports a first- and third-party payment total of \$1,275.00.

50 PAYER	51 PROVIDER NO.	52 REL 53 ASG		54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
		INFO	BEN				
A XYZ Insurance				1,225	00		
B Acme Benefits				50	00		
C							

Do not “zero fill” the payment amount fields on hospital inpatient and outpatient claims, dialysis facility claims, and hospice claims. If a claim is denied by Medicare or Other Payer, providers must submit documentation of the denial with the UB-04 claim to AHCCCS.

Nursing Facility Claims with Medicare/Other Insurance

AHCCCS is responsible for reimbursement of Medicare coinsurance minus any Other Payer payment, minus the member’s share of cost (SOC).

When a nursing facility submits a claim to Medicare Part A intermediaries for an AHCCCS member who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment.

Nursing facilities should not submit claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS members or QMB members. All Medicare crossover claims are identified on the provider’s remittance advice.

When a member has exhausted the Medicare benefit for nursing facility coverage, the nursing facility must submit a claim to AHCCCS. The facility should bill with the appropriate Value Code and “zero fill” the Medicare fields, and submit the claim within the appropriate time frame. Leaving the fields blank will cause the claim to be denied. Zeros indicate that no payment was received.

Example: The provider reports no payment received from Medicare.
 Value Code A2 = Medicare Part A Coinsurance

	39 VALUE CODES			40 VALUE CODES			41 VALUE CODES		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A2	00	00						
b									
c									

If payment from Medicare or Other first- or third-party payer is received later, the provider must submit an adjustment claim with the RA/EOMB/EOB reflecting the payment. Refer to Chapter 4 of the Fee-For-Service Provider Billing Manual, General Billing Rules, for additional information on how to submit claim adjustments.

Denied and adjusted Medicare claims also are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within the timely filing requirements.

A copy of the Medicare RA/EOMB and/or the Other Payer’s RA/EOB must be submitted with the claim to AHCCCS.

FQHC/HRC Claims with Medicare/Other Insurance

Refer to the Chapter 10 Addendum FQHC/RHC for specific Fee-for-Service (FFS) billing instructions.

Retroactive Posting of Medicare Eligibility

Occasionally, AHCCCS learns that a member is eligible for Medicare after payment has been made to the provider. When that happens, AHCCCS recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

AHCCCS contracts with Health Management Systems, Inc. (HMS) to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

AHCCCS will systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. With retroactive Medicare postings AHCCCS may recoup overpayments where Medicare information was not previously reported.

When AHCCCS recoups, providers should bill Medicare and follow the procedure outlined earlier in this chapter.

References

The following references pertain to QMB Payments:

- 42 USC 1396a(a)(10)(E)
- 42 USC 1396d(p)
- 42 USC 1396(a)(n)(2)
- CMS –MMCO – CM Informational Bulletin – Payment of Medicare Cost Sharing for Qualified Medicare Beneficiaries (QMBs) dated June 7th, 2013
- Center for Medicaid and CHIP Services MMCO – CMCS Informational Bulletin on Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs) dated January 6th, 2012
- CMS QMB FAQs dated September 9th, 2017
- Additional CMS QMB Program information can be found at:
<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html>
- From Medicare.gov- Medicare Savings Program Overview

<https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html#collapse-2614>

- From CMS January 2012 QMB Informational Bulletin, Background on QMBs and Benefits
<http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-01-06-12.pdf>
- From Qualified Medicare Beneficiary Program – FAQ on Billing Requirements (July 2018)
<https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf>
- From CMS Medicare Learning Network Booklet
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf
- <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-06-07-2013.pdf>

Revision History

Date	Description of changes	Page(s)
1/11/2019	<p>The AHCCCS Medicare Eligibility definition section was updated with the following: “In reference to QMB claims: If a Medicare provider is not an AHCCCS registered provider, AHCCCS will permit the provider to register as an AHCCCS registered provider for the adjudication of the claim for the QMB cost-sharing amount. AHCCCS will notify the provider of the process for registering. If a provider is unwilling to become an AHCCCS registered provider then no payment can be made.”</p> <p>QMB Only definition updated to include copays (see definition for details). References for copay payment added.</p> <p>QMB Dual definition updated to include copays (see definition for details)</p> <p>Non-QMB Dual definition clarified (no changes, just re-ordered for clarity)</p> <p>References section added</p> <p>Professional Claims section removed</p>	<p>5</p> <p>5</p> <p>6</p> <p>6</p> <p>6-7</p> <p>13-14</p>
4/13/2018	<p>The Timely Filing section was updated.</p> <p>The Third-Party definition was updated to match the updated rule reference and R9-22-1001 changes.</p> <p>The Third Party Liability definition was updated to match the</p>	<p>1</p> <p>2</p> <p>2</p>

updated rule reference and R9-22-1001 changes.	2
An acronyms section was added.	3
Clarification was added to the First-And Third Party /Other Coverage section.	3
The reference to R9-22-1002 was updated to match the updated rule.	3
An updated reference to the updated rule R9-22-1003 on Cost Avoidance was added.	5
Clarifications and examples were added to the Professional Claims section.	8-10
Clarifications and examples were added to the UB-04 Claims with Medicare and/or Other Payer section updated.	10-12 12-13
FQHC/HRC Claims with Medicare/Other Insurance section added.	13
Retroactive Posting of Medicare Eligibility section updated.	13-14
Formatting	All