



Medical Equipment & Appliances, Medical Supplies, Orthotics and Prosthetics

October 2021

About This Course

These materials are designed for the AHCCCS Fee-For-Service programs, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

This presentation will cover general information on Durable Medical Equipment (DME), medical equipment and supplies, and orthotics and prosthetics.

If you have any questions about this training presentation, please email the provider training unit: ProviderTrainingffs@azahcccs.gov



Medical Equipment (DME) & Medical Supplies

Medical Equipment and Medical Supplies

Medical Equipment & Supplies

AHCCCS covers medically necessary Medical Equipment, Medical Appliances and Medical Supplies (including incontinence briefs), and under the home health services benefit, that are suitable for use in any Setting in Which Normal Life Activities Take Place, when the following conditions are met:

- a. Provided in Settings in Which Normal Life Activities Take Place,
- b. Ordered by the member's physician or beginning March 1, 2020 ordered by the member's:
 - i. Nurse practitioners,
 - ii. Physician assistants, or
 - iii. Clinical nurse specialists, as a part of the plan of care and is reviewed by the practitioner annually,
- c. Authorized as required by AHCCCS, Contractor, or Contractor's designee, and
- d. Face-To-Face encounter requirements for FFS Programs are followed and documented

Medical Equipment and Medical Supplies

Medical Equipment & Supplies

The term “medical equipment” refers to both medical equipment and appliances. Any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic, and

1. Is customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness, disability, or injury,
2. Can withstand repeated use, and
3. Can be reusable by others or removable.

NOTE: Medical Equipment & Supplies are often referred to as Durable Medical Equipment (DME)

Medical Supplies

Health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].

Medical Equipment and Medical Supplies

What else should a provider know about Medical Equipment & Supplies?

- Medical Equipment and Medical Supplies cannot be limited to members who are homebound.
- Coverage of Medical Equipment is not restricted to the items covered as DME in the Medicare program.
- Coverage of Medical Equipment and Supplies cannot be contingent upon the member needing nursing or therapy services.

Medical Equipment and Medical Supplies

What else should a provider know about Medical Equipment & Supplies?

- Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary equipment can be obtained at no cost. The total expense of renting the equipment shall not exceed the purchase price (i.e. if AHCCCS can purchase the equipment for less than the rental fee, AHCCCS will purchase the item).
- Refer to [AMPM Policy 310-P, Medical Equipment, Medical Appliances & Medical Supplies](#) for complete information regarding coverage of medical equipment and supplies, including face-to-face requirements.



Face-to-Face Requirements

(For medical equipment and supplies)

Face-to-Face Requirements

Face-to-Face

Effective date of service 10/1/17, in accordance with CFR § 440.70, the initiation of medical equipment and supplies will be subject to face-to-face encounter requirements for the FFS population.

- The face-to-face encounter may occur through telehealth.
- Face-to-face encounter requirements apply for the initiation of services only.
- An additional face-to-face encounter is only required if a new medical equipment, supply, or appliance is needed.

Face-to-Face Requirements

Face-to-Face

The face-to-face encounter must meet the following criteria:

1. It must relate to the primary reason the member requires the medical equipment and/or supplies.
2. It must occur no more than six months prior to the start of services.

Face-to-Face Requirements

Face-to-Face

The face-to-face encounter must meet the following criteria (continued):

3. The face-to-face encounter must be conducted by one of the following:
 - a. The ordering physician,
 - b. A nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law,
 - c. A physician assistant under the supervision of the ordering physician, or
 - d. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

Note: For the purposes of the face-to-face requirement the ordering physician can be a podiatrist, for services within their scope of practice.

Face-to-Face Requirements

Face-to-Face

The face-to-face encounter must meet the following criteria (continued):

4. The non-physician practitioner specified above, who performs the face-to-face encounter, must communicate the clinical findings of the face-to-face encounter to the ordering physician.
5. The clinical findings must be incorporated into a written or electronic document in the member's record. Regardless of which practitioner performs the face-to-face encounter, the physician responsible for ordering the medical equipment and/or supplies must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes within the medical record.

Face-to-Face Requirements

Face-to-Face

The face-to-face encounter must meet the following criteria (continued):

6. The ordering physician must also document on the prescription order the face-to-face encounter details, including date of encounter, the diagnosis, and the practitioner who conducted the encounter.

Face-to-Face Requirements

What do Face-to-Face Requirements NOT Apply To?

Face-to-Face Requirements do not apply to:

- Renewals, repairs, and the need for ancillary equipment
- Orthotics
- Prosthetics



Orthotics & Prosthetics

Orthotics & Prosthetics

Orthotics

Devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, or prevent or correct physical deformity or malfunction, (42 CFR 440.120, A.A.C. R9-22-212).

Prosthetics

Devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed, or malfunctioning portion of the body, such as artificial upper and lower limbs (A.A.C. R9-22- 212).

Orthotics & Prosthetics

Orthotics & Prosthetics

AHCCCS covers medically necessary orthotic and prosthetic devices, when

- a. Prescribed by a Primary Care Provider (PCP), attending physician, or practitioner, or
- b. Prescribed by a specialist upon referral from the PCP, attending physician, or practitioner, and
- c. Authorized as required by AHCCCS, Contractor, or Contractor's designee.

Note: PA is required for the purchase of orthotic and prosthetic devices exceeding \$300.00.

Orthotics

Orthotics

Orthotic devices are covered for member when medically necessary as specified below:

- a. Orthotics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430.
- b. Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:
 - i. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines,
 - ii. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
 - iii. The orthotic is ordered by a Physician or PCP.

Prosthetics

Prosthetics

Prosthetics are covered for member when medically necessary as specified below:

- a. Prosthetics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430, and
- b. b. Prosthetics are covered for AHCCCS members age 21 and older when medically necessary for rehabilitation, except as specified in Exclusions within [AMPM 310-JJ, Orthotics and Prosthetics.](#)



Prior Authorization

Preferred Method of Submission

Use of the [AHCCCS Online Provider Portal](#) is the preferred method of submitting prior authorization requests for Fee-For-Service members. Online submission allows PA staff to process authorization requests efficiently and quickly.

Providers may directly enter their authorization requests through the [AHCCCS Online Provider Portal](#) to receive a Pended Authorization Number or Case Number. They may also use the Attachment feature to upload supporting documents directly with their request.

Preferred Method of Submission

Prior Authorization status should be checked using the [AHCCCS Online Provider Portal](#).

- NOTE: prior authorization staff no longer provide authorization status updates or issue standard authorizations over the phone.
- Providers who would like ***immediate*** information, can access the provisional authorization number and track the authorization status *in real time* on the AHCCCS Online Provider Portal.

If submission for a prior authorization request or Documentation is not possible due to internet outage or other unforeseen events, then it can be done via fax. If the documents are faxed, the [Prior Authorization Request Form](#) must continue to be utilized.

When is Prior Authorization Required?

When is Prior Authorization Required?

1. PA is required for the purchase of orthotic and prosthetic devices exceeding \$300.00.
2. The following requirements apply to medical equipment and supplies services:
 - a. PA is required for the purchase of medical equipment exceeding \$300.00.
 - b. PA is required for all medical equipment rentals and repairs,
 - c. PA is required for consumable medical supplies (as defined in AMPM Policy 310-P) exceeding \$100.00,
 - d. For members age 21 and over, PA is required for medically necessary incontinence supplies. These incontinence supplies are covered when necessary to treat a condition. In addition, PA requirements for incontinence briefs for ALTCS members age 21 and over are described in AMPM Policy 310-P,
 - e. Refer to AMPM Policy 430 for PA requirements and criteria for coverage of incontinence briefs for members under the age of 21, and
 - f. All rental equipment and repairs require PA.

Prior Authorization

When is Prior Authorization NOT Required?

PA is not required for:

- a. Oral supplements for ALTCS members, and
- b. Apnea management and training for premature babies up to one year of life.

Prior Authorization

Documentation Requirements

At the time of a PA request, certain information shall be provided, including:

- a. Prescription or order with ordering provider's name, and dated signature with credentials listed,
- b. Diagnosis indicated by ordering provider,
- c. Description of medical condition necessitating the supplies/equipment, and medical justification for supplies/equipment with anticipated outcome (medical/ functional),
- d. Clinical documentation, including documentation of the face-to face encounter requirements and timeframes (AMPM Policy 310-P),

Prior Authorization

Documentation Requirements (Continued)

At the time of a PA request, certain information shall be provided, including:

- e. Description of supplies/equipment requested,
- f. Duration for use of equipment,
- g. Full purchase price plus any additional costs and expected cost if rented,
- h. Provider identification number, and
- i. Home evaluation, when requested by DFSM.

Prior Authorization

Documentation Requirements (Continued)

For members age 21 and older, requests for authorization of incontinence supplies shall include the following information:

- a. Diagnosis of a dermatologic condition or other medical/surgical condition requiring medical management by incontinence supplies as dressings,
- b. Defined length of treatment anticipated, and
- c. Prescription for specific incontinence supplies.

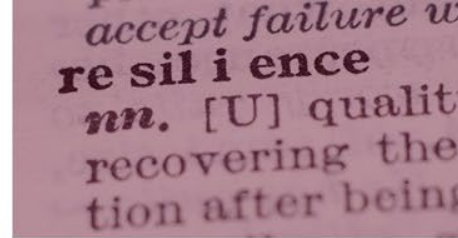
NOTE: For ALTCS members age 21 and older, refer to AMPM Policy 310-P for complete information on coverage requirements. Incontinence supplies for Tribal ALTCS members are authorized by the Tribal ALTCS case manager.

Prior Authorization

Where Can I Find More Information?

For a comprehensive list of prior authorization requirements refer to:

- [AMPM 820 - FFS Prior Authorization Requirements](#) at:
 - <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/800/820.pdf>
- [Chapter 8, Prior Authorizations](#), of the Fee-For-Service Provider Billing Manual at:
 - <https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFSChap08PriorAuthorizations.pdf>
- The [Fee-For-Service Prior Authorization Requirements web page](#) at:
 - <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>



Members with Dual Eligibility or TPL

Third Party Liability

How Does the Process Work?

For members that have a primary insurance, AHCCCS will be the last payer to consider reimbursement of the claim. (Except for the exceptions listed under federal or state law.)

- A copy of the primary payer's Explanation of Benefits (EOB) will be required for consideration of the claim, ***even when the service provided is a non-covered service for the primary payer.***
- Even if a provider has the reasonable expectation that a service will *not* be reimbursed under the member's primary payer (such as their health plan), a claim must still be submitted to that primary payer to obtain a formal determination (such as a denial/EOB).
- This denial/EOB must then be submitted to AHCCCS with the claim.

Responsibility to Appeal

Appealing the Primary Payer is the Provider's Responsibility

If the first- or third-party payer (such as a health plan) denies a claim for a covered service, then the provider must follow that health plan's appeal process.

The provider **must** exhaust all remedies before the claim can be submitted to AHCCCS, and before AHCCCS can consider the covered service.

Once all other payer sources have been utilized, then the provider **must** submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission. If this is not done, then the claim submitted to AHCCCS may deny.

TPL and Payment Amounts

Reimbursement

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 rate as payment in full.

- Note: For IHS/638 Providers, the All-Inclusive Rate (AIR) is considered the Capped Fee-For-Service rate, for claims for offered services that meet AIR reimbursement criteria.

TPL and Payment Amounts

How Does Reimbursement Work When Fee Schedules Have Different Allowed Amounts?

Insurance payers may have a different fee schedule or allowed amount assigned to each CPT/HCPCS code. Some payers allowed amounts may be higher or lower than others.

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

- **IMPORTANT:** AHCCCS *will not* issue a payment when the primary insurance payer's payment exceeds the AHCCCS allowable amount.

If the primary insurance allowed amount is **less than** the AHCCCS allowed amount, it is possible that a payment will be considered (based on review).

TPL and Payment Amounts

How Does Reimbursement Work When Fee Schedules Have Different Allowed Amounts?

Sometimes members have 3 or more coverage plans.

Should more than one coverage plan make payment and the total amount paid by *all the coverage plans* is more than the AHCCCS Capped Fee-For-Service fee schedule amount, then there will be no AHCCCS payment.

- **IMPORTANT:** The provider cannot balance bill the member for any amount. Arizona Revised Statute §36-2903.01(K) prohibits providers from billing AHCCCS members, including QMB Only, for AHCCCS-covered services.

RECAP

It is important for providers to understand the following:

1. If a member has a TPL (such as Medicare), they must submit the claim to the TPL/Medicare first.
2. If the claim is denied, the provider **must exhaust all appeals options with the TPL/Medicare.** A provider cannot receive a denial, then submit a claim to AHCCCS without first doing this. AHCCCS will deny the claim in these situations.
3. If the TPL/Medicare claim has been denied, **and the provider has exhausted all appeals options with TPL/Medicare,** a provider must know the claim will not crossover to AHCCCS automatically. This means that if a provider would like additional consideration, a provider must submit the following to AHCCCS:
 - The Claim
 - The EOB
 - Copy of the Final Appeal Decision by Medicare

TPL and Payment Amounts

Training Opportunities

The Division of Fee-for-Service Management's (DFSM) Provider Training Team offers a TPL-specific training for providers.

For additional questions please visit the [DFSM Provider Training webpage](#).

- Under Trainings by Subject, select “Third Party Liability” for a PDF copy of the training; *or*
- Under Training Schedule, sign up for the next group TPL training session.



Billing Overview

Billing

General Billing Requirements

Medical equipment and appliance revenue codes are not reimbursable to hospitals on the UB-04 claim form.

Items must be correctly coded as medical/surgical supplies, or if medical equipment and appliances, billed on the CMS 1500 claim form.

Billing

Modifiers

Procedures related to medical equipment and appliances cannot be interpreted without modifiers that describe the type of service and payment arrangement made. Without an appropriate modifier the claim will be denied.

Modifier	Description
LL	Lease/Rental
NR	New (When Rented)
NU	New Equipment
RA	Replacement of Medical Equipment and Appliance Item
RB	Replacement of Part of a Medical Equipment and Appliance

Billing

Apnea Monitors

Providers who bill for apnea management, training, and the use of the apnea monitor must use procedure codes E0618 (apnea monitor, without recording feature) or E0619 (apnea monitor, with recording feature) and the RR modifier.

The RR modifier is to be used when DME is rented.

The total charge billed to AHCCCS must include the management, training, and use of the apnea monitor. Apnea management and training services may not be billed using procedure code 94799 (Unlisted pulmonary service or procedure).

Billing

Ventilators

Ventilators are rented on a month-to-month basis. AHCCCS does not cover the purchase of ventilators. Section 1834(a)(3) of the Social Security Act classifies ventilators as items requiring frequent and substantial servicing in order to avoid risk to the patient's health.

To ensure that members have equipment that is functioning and serviced frequently, these devices may only be rented. Devices that produce positive airway pressure (PAP), including continuous positive airway pressure (CPAP) and bi-level respiratory assist (Bi PAP) devices, are excluded from this rental requirement and purchase may be covered, if medically necessary.



AHCCCS Online Provider Portal

There are 6 Tabs that must be completed in order to submit for covered services.

1. Submitter
2. Billing Provider
3. Rendering Provider

4. Patient / Subscriber
5. Claim Information & Attachments
6. Service Lines

Entering Prior Authorization

Prior Authorization

- Members that are enrolled in an AHCCCS FFS Program, such as the American Indian Health Program (AIHP) shall have their provider request Prior Authorization through the AHCCCS Online Provider Portal.
- Members that are enrolled in the ALTCS program (Tribal ALTCS) shall have their Tribal Case Manager issue Prior Authorization (Service Plan Authorization).
 - **IMPORTANT NOTE:** Please note that 'How to Submit for Prior Authorization' is covered in a separate presentation. See the DFSM Provider Training web page.

Entering Prior Authorization

Prior Authorization

- A pended PA number may be assigned to prior authorization requests after they are reviewed.
- Once reviewed either an approval or a denial will be issued, or the authorization will be pended for additional information to substantiate compliance with AHCCCS criteria.
- AHCCCS generates a PA confirmation letter with appropriate approval, denial, or pending information. The letter is mailed to the provider by the next working day.

Entering Prior Authorization

Prior Authorization

- When a PA is denied concurrently, AHCCCS also generates a Notice of Action letter that is mailed to the member within three working days of the request. No denial letters are sent to members for services that are denied retrospectively.
- Per A.A.C. R9-22-703 (D)(3) all services reimbursed, whether prior authorized or not, are subject to post-payment audit and recoupment if DFSM determines that the services were not medically appropriate.

General Billing Information

- **Claim Form:** CMS 1500 Claim Form (Professional)
- **Diagnosis Code:** ICD-10
- **Revenue Code:** N/A
- **CPT/HCPCS Codes:** The appropriate CPT/HCPCS Code for the service provided. AHCCCS hosts a coding resource webpage on the Medical Coding Resources webpage at:
 - <https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html>
- **Modifiers:** The appropriate modifiers should always be used, in accordance with national coding standards.

General Billing Information

On a CMS-1500 Claim Form:

- CPT and HCPCS procedure codes must be used to identify all services.
- For detailed, step-by-step instructions on how to fill out the CMS 1500 Claim Form please visit Chapter 5, of the FFS Provider Billing Manual at:
 - <https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFSChap05.pdf>

Claim Submission

Please note that the following slides contain only a *brief* overview of use of the AHCCCS Online Provider Portal, for submitting *general Professional Claims*.

- The screenshots utilized are not specific for DME Suppliers.
- The screenshots utilized are shown *only as an educational tool*, to assist the provider in visualizing the various screens used to submit a claim.

A comprehensive training on professional claim submission can be found on the [DFSM Provider Training Team's web page](#).

Claims Submission Page

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

Payer/Receiver Electronic Transmitter Identification Number: 866004791

NOTE: You cannot view the processing status of claims submitted by other users.

Enter New Claim

Type of Claim: Professional ←

Click on the drop down and select Professional, Click “

View Claim Processing Status

Submission Date(s): -

Submitter Tab

Professional Claim Submission

[Help](#)
* Indicates a required field.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
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Submitter

Organization Name: NEMT TEST Verify Provider Information

Electronic Transmitter ID Number: 99222

Information Contact Name: Provider, Training

Information Contact Telephone Number: 602-417-4000

Confirm the Submitter information is correct
Then Click the Providers tab at the top of the page

Billing Provider

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	Rendering Provider	Referring Provider	Service Facility				
Billing Provider							
* Tax ID: <input type="text"/> <input type="radio"/> SSN <input checked="" type="radio"/> EIN							
Provider Commercial Number: <input type="text"/>							
* CMMS National Provider ID (NPI): <input type="text"/> <input type="button" value="Find"/>							
* Entity Type: <input type="radio"/> Person <input checked="" type="radio"/> Non-Person Entity							
Health Care Provider Taxonomy Code: <input type="text"/>							
Provider Name: NEMT TEST							
Information Contact Name:							
Information Contact Telephone Number: 6024177000							
Service Locator Code/Address: <input type="text" value="01"/> <input type="button" value="v"/> 701 E JEFFERSON PHOENIX, AZ 85034							
* Pay-To Locator Code/Address: <input type="text" value="01"/> <input type="button" value="v"/> 701 E JEFFERSON PHOENIX, AZ 85034							

**DO NOT CLICK
SAVE OR SUBMIT**

Rendering Provider Tab

The process for completing the Rendering Provider Tab is almost identical to the Billing Tab. Enter the rendering provider's NPI in the appropriate field. If the rendering provider does not have a NPI, enter their 6-digit AHCCCS Provider ID and leave the NPI field blank.

[Help](#)

* Indicates a required field.

The screenshot shows a software interface with several tabs: Submitter, Providers, Patient/Subscriber, Ambulance, Other Payer, Attachments, and Claim In. The 'Providers' tab is active, and the 'Rendering Provider' sub-tab is selected and highlighted with a red box. Below the tabs, there are several input fields and buttons:

- Provider Commercial Number:** A field containing six hash symbols (#####) with a red asterisk indicating it is required. A blue arrow points to this field from a callout box.
- CMMS National Provider ID (NPI):** An empty input field with a red asterisk indicating it is required. A blue arrow points to this field from a callout box.
- Entity Type:** Radio buttons for 'Person' and 'Non-Person'.
- Provider Name:** An empty input field.
- Health Care Provider Taxonomy Code:** An empty input field.
- Find:** A yellow button to search for provider information.
- Buttons:** 'Save', 'Submit', and 'Cancel' buttons at the bottom. The 'Save' and 'Submit' buttons are crossed out with red X's.

Three callout boxes provide instructions:

- Top Right Callout (Blue box):** "Providers without an NPI will use their AHCCCS 6 digit AHCCCS provider number in the Provider Commercial Number field. Leave the NPI field blank." A blue arrow points from this box to the Provider Commercial Number field.
- Bottom Left Callout (Blue box):** "If you do have an NPI enter the number in the CMMS National Provider ID field. Click Find when you have completed the required fields." A blue arrow points from this box to the CMMS National Provider ID field.
- Bottom Right Callout (Red box):** "Click 'Find' -Provider information should be displayed." A red arrow points from this box to the Find button.

Patient/Subscriber Tab

Click on the [Payer Responsibility](#) drop down. Providers must determine the AHCCCS payment after Medicare and all other first and third party payers.

This mock claim identifies AHCCCS as the Primary Payer and highlights P-Primary.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Insured or Subscriber							
* Member ID Number/Date of Birth: <input type="text" value="A#####"/> <input type="text" value="DD/MM/CCYY"/> <input type="button" value="Find"/>							
Person Name: AHCCCS, SEDONA							
Gender: F							
Residential Address: 701 E JEFFERSON ST PHOENIX, AZ 85038							
* Payer Responsibility: <input type="text" value="P - Primary"/> ▼							
NOTE: AHCCCS no longer accepts ADOC claims.							

Attachments Tab

The Attachment tab is the only way to notify the AHCCCS processing system that you are submitting an Electronic attachment with the claim. From the time of claim submission, providers have [15 days](#) to upload attachments using the Transaction Insight Portal.

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Claim Attachments							
	Report Type **		Report Transmission **		Control Number **		
1	B4 - Referral Form	▼	EL - Electronically Only	▼	A0934000709232019		
2		▼		▼			
3		▼		▼			
4		▼		▼			
Attachments (1-10):		▼		▼			
5		▼		▼			
6		▼		▼			
7		▼		▼			
8		▼		▼			
9		▼		▼			
10		▼		▼			

Control Number (PWK number)

Example of a PWK number using a member's AHCCCS ID and the Date of Service

AHCCCS ID (9-character AHCCCS ID)

A12345678

The A in AHCCCSID must be in uppercase

Date of Service

01/03/18

PWK for Claim 1, Document 1

A1234567801032018

Different AHCCCS ID member with the Same Date of Services

AHCCCS ID (9-character AHCCCS ID)

A87654321

The A in AHCCCSID must be in uppercase

Date of Service

01/03/18

PWK for Claim 2, Document 2

A8765432101032018

The combination of the member's AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.

Claim Information Tab

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
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Claim Information

Original Reference Number: Replacement Void

Prior Authorization Number:

* Patient Control Number:

(Accident)

Payment Other Accident Auto Accident

(State)

No

* Provider Accept Assignment: Assigned Accepted on Clinical Lab Services Only Not Assigned

* Benefit Assignment: Yes No Not Applicable

* Release of Information Consent: Informed Consent Yes

The Patient Control Number is **NOT** the same thing as the PWK number. The Patient Control Number is a number that the provider uses internally.

If your office doesn't use a patient control number, you may enter the members AHCCCS ID or First/Last Name, etc.

Enter your office account number for the patient. For this training the AHCCCS ID will be used.

Claim Information Tab

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
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Claim Information

Original Reference Number: Replacement Void

Prior Authorization Number:

*** Patient Control Number:**

Medical Record ID Number:

Initial Treatment Date:

Date of Current Injury: (Accident)

**** Patient's Condition Related To:** Employment Other Accident Auto Accident

***** Place in which accident occurred:** (State)

Special Program Indicator:

*** Provider Signature on File:** Yes No

*** Provider Accept Assignment:** Assigned Accepted on Clinical Lab Services Only Not Assigned

*** Benefit Assignment:** Yes No Not Applicable

*** Release of Information Consent:** Informed Consent Yes

Claim Information Tab

- Provider Signature on File
- Provider Accepts Assignments - Click yes if you are accepting payment from AHCCCS
- Benefit Assignments - Mark yes if member has indicated that payment should go directly to the provider.
- Release of Information Consent - A signed statement by the patient authorizing the release of medical data to other organizations.

Service Lines Tab

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)							
* Standard: X ICD-9 <input checked="" type="radio"/> ICD-10		* Diagnosis Codes: 1 <input type="text" value="R6889"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/>					
		7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/>					
Service Line							
* Diagnosis Code Pointers: 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/>							
* Service Dates: <input type="text" value="09/23/2019"/> - <input type="text" value="09/23/2019"/>							
* Line Charges: \$ <input type="text" value="14.54"/>				* Place of Service Code (POS): <input type="text" value="99 - OTHER UNLISTED FACILITY"/>			
* Quantity: <input type="text" value="2"/> <input type="radio"/> Minutes <input checked="" type="radio"/> Units				Modifier Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/>			
* HCPCS Code: <input type="text" value="A0120"/>				Prescription Date: <input type="text"/>			
National Drug Code: <input type="text"/>				**Prescription #/Identifier: <input type="text"/> <input type="text"/>			

Service Line

* **Diagnosis Code Pointers:** 1 2 3 4 5 6 7 8 9 10 11 12

* **Service Dates:** 09/23/2019 - 09/23/2019

* **Line Charges:** \$ 14.54

* **Place of Service Code (POS):**

* **Quantity:** 2 Minutes Units

Modifier Codes: 1 2 3 4

* **HCPCS Code:** A0120

Prescription Date:

National Drug Code:

****Prescription #/Identifier:**

****NDC Quantity/Measure:**

Taxonomy Code: (Performing HC Provider)

Immunization Batch Number:

Patient Count:

Indicators: Emergency EPSDT

Provider Control Number:

****Other Payer:** Primary ID Paid Amount \$ Units Procedure Code/Qualifier

****Medicare:** Paid Amount \$ Units Procedure Code/Qualifier

Other Adjustment(s): Medicare Deductible \$ Medicare Coinsurance \$ Medicare Copay \$

****Durable Medical Equipment:** HCPCS Purchase Price \$ Rental Price \$ Length of Medical Necessity

Last Name First Name City

Add

** All or none of the information is required for the line or group.

When done, click the **ADD** button to clear the screen and allow you to enter a new service line if applicable.

Professional – Service Lines Finalizing the Claim

*** All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	H	CPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount
X/1	10/1/2020	10/1/2020	99		99214						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	UN	100.00		0		
X/2	10/1/2020	10/1/2020	99		69200						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	UN	150.00		0		
																									Totals: \$250.00		\$0.00		\$0.00	

After all services lines are entered, review the claim information, if okay, Click the “Submit” Button.

Save Submit Cancel

Professional - Service Lines – Continued

Add

** All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Medicare Coinsurance Amount	Medicare Copay Amount	Other Payer ID																					
1	9/23/2019	9/23/2019	03	A0120						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	UN	14.54		0																										
																							Totals:	\$14.54	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00																						

Top screen The Service Line will allow you to continue to Add more lines unless you click the edit or the remove button

Bottom screen When you have entered all Service Lines whether you edited or removed items, you will have the option to Update the changes

Update

** All or none of the information is required for the line or group.

Line No.	Begin Date	End Date	POS	HCPCS	Mod 1	Mod 2	Mod 3	Mod 4	NDC Code	NDC Units	Diag 1	Diag 2	Diag 3	Diag 4	Diag 5	Diag 6	Diag 7	Diag 8	Diag 9	Diag 10	Diag 11	Diag 12	Min./Units	Type	Line Charges	Medicare Paid Amount	Units	Proc Code	Medicare Deductible Amount	Medicare Coinsurance Amount	Medicare Copay Amount	Other Payer ID																				
1	9/23/2019	9/23/2019	03	A0120	-	-	-	-	-	0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	UN	14.54		0																									
																							Totals:	\$14.54	\$0.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00																					

Confirmation Screen

Claim Entry Confirmation

Transmission Status:	Successful
Claim Type:	Professional
Patient Account Number:	A09340007
Confirmation Code:	P-297

Attachments

You can go to the 275 portal to upload your document by clicking on the attachment link

Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

View Claim

Enter New Claim

- 1 This is the Claim Entry Confirmation screen
- 2 The Transmission status will let you know the claim was submitted successfully
- 3 You have 2 options: View Claim to give you a summary of the claim that will be sent to AHCCCS or Enter New Claim
- 4 Select the "View Claim" button



DFSM Provider Education and Training Unit

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
 - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

Prior Authorization Questions?

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
 - <https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/>
- DFSM Prior Authorization Web Page:
 - <https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html>

Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548

NOTE: Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.

Policy Information

AHCCCS FFS Provider Billing Manual:

- <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>

AHCCCS IHS/Tribal Provider Billing Manual:

- <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html>

AHCCCS Medical Policy Manual

- <https://www.azahcccs.gov/shared/MedicalPolicyManual/>
- [AMPM Policy 310-P, Medical Equipment, Medical Appliances & Medical Supplies](#)
- [AMPM 310-JJ, Orthotics and Prosthetics](#)
- [AMPM 820 - FFS Prior Authorization Requirements](#)
- [AMPM 430 - EPSDT Services](#)

Questions?

Thank You.