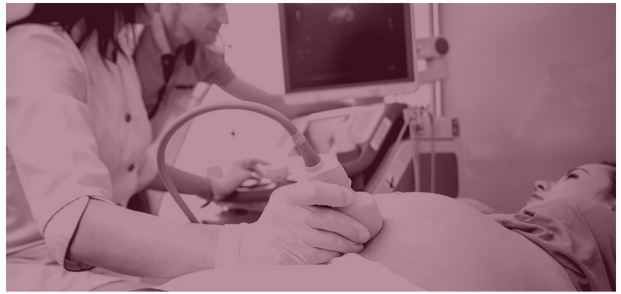





Federal Emergency Services Program (FESP)

Medical Services Overview

DFSM Provider Training Team

June 2021

AHCCCS
Arizona Health Care Cost Containment System

About this Presentation

This presentation is a brief overview of the Federal Emergency Services (FES) Program.

The topics covered in this presentation are:

- Federal Definition of an “Emergency Service” under the FES Program
- Claim submission and billing requirements
- Medical Review and Documentation
- Post Payment Review

Questions about this presentation can be submitted via email to providertrainingffs@azahcccs.gov

What is the FES Program?

What is FES?

AHCCCS provides emergency health care services through the Federal Emergency Services Program for qualified and nonqualified aliens, as specified in 8 USC 1611 et seq. who meet all requirements for Title XIX eligibility as specified in the State Plan except for citizenship.

FES only covers emergency services that fully meet the Federal Definition of an “emergency service”.

What is the Federal Definition of an Emergency Condition?

Emergency Medical or Behavioral Health Condition for a FESP Member

The sudden onset of a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member's health in serious jeopardy (this includes serious harm to self for purposes of behavioral health).
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
4. Serious physical harm to another person (for behavioral health condition).

What is NOT an Emergency Condition?

Emergency Medical or Behavioral Health Condition for a FESP Member

Note, that a condition manifesting itself by only Chronic symptoms is **NOT** an Emergency Medical or Behavioral Health Condition, even though the absence of medical care might lead to one of the adverse consequences listed in the definition of Emergency Medical or Behavioral Health Condition.

What is the FES Program?

Who Qualifies for Enrollment in the FES Program?

Members that are eligible to be enrolled in the FES program are Arizona residents, who are qualified and nonqualified aliens as specified in 8 USC 1611 et seq., who meet all requirements for Title XIX (Medicaid) eligibility as specified in the Arizona State Plan except for citizenship.

FES Program Coverage

Services and Limitations

- Emergency services, that are ***AHCCCS covered services*** will be considered only.
- FES members are only eligible to be enrolled in the FFS program.
- Claims for services are reimbursed by the AHCCCS Administration on a Fee-For-Service basis.
- Emergency services do not require a prior authorization, with the exception of outpatient Dialysis services (see FES Dialysis Presentation).
- All services must fully meet the Federal definition of an “emergency medical or behavioral health condition” to be covered.
- Coverage determination is based upon medical review and all services must meet the federal definition of an emergency service to be covered.

Medical Claims Review

Medical Review

With the stipulation that only emergency services are covered under the FES program, this includes services provided in any setting (i.e. inpatient, outpatient or physician office)

How does the administration determine if services are covered?

- Each claim is reviewed on its own merits.
- Medical review is performed by a team of professional nurse reviewers.
- Medical documentation is required with each claim submission.
- Providers also have an option to allow AHCCCS “remote” access to health records.
- Medical records must support the emergent nature of the services provided.
- ***All claims submitted to FFS are subject to retrospective review to determine if an emergency existed at the time of service and to ensure that emergency criteria were met.***

FES and Completing the Claim Forms

Claim Form Requirements

AHCCCS FFS program requires all claims for services provided to a FESP member to be submitted to AHCCCS with the appropriate “emergency indicator” codes marked on each claim submission. Marking the claim “urgent” is not sufficient.

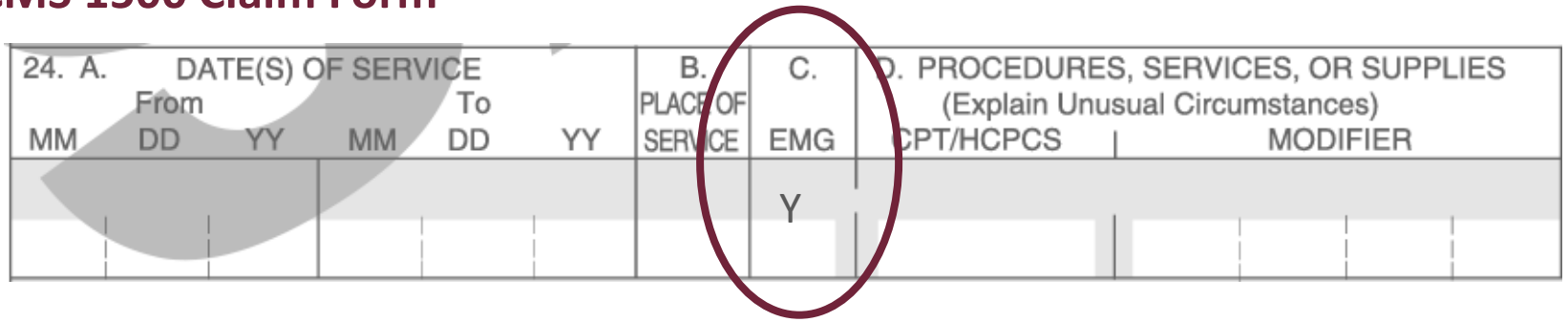
CMS 1500 Claim Form: For services billed on the CMS 1500 (professional) claim form, the EMG indicator field (24C) must be marked “Y”. Paper submissions must include a “Y” in the EMG indicator field 24C. EDI submissions must be marked “emergent”.

UB-04 Claim Form: For services billed on the UB-04 (institutional) claim form, the “Type of Admission” field (14) must be entered with admit type code “1” to indicate “Emergency“ visit. EDI submissions must be marked “emergent”. Urgent “2” is not sufficient.

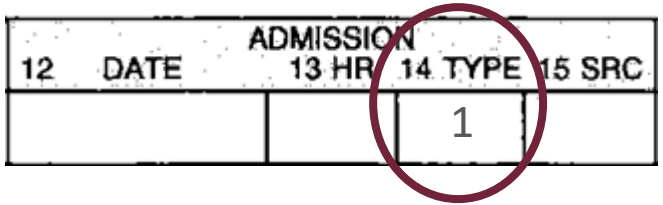
Claim Forms and Emergency Indicators

Claim Form Requirements

CMS 1500 Claim Form



UB-04 Claim Form



Knowledge Recap

FESP Recap

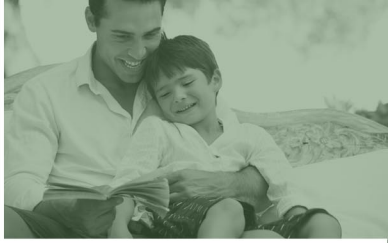
- All services must meet the *federal definition* of emergency services in order to be considered for reimbursement.
- Prior Authorization is never required for FES members, except for dialysis.
- All claim submissions must include the appropriate “emergency’ status indicators.
- Medical documentation is required with each claim submission or AHCCCS must have remote access to the provider’s health records.
- All claims are subject to retrospective review.

Federal Emergency Services Program (FESP)

Additional Resources

To view additional information, refer to the AHCCCS Fee-for-Service Provider Billing Manual and to the AHCCC Medical Policy Manual by clicking on the links below.

Chapter 8, Prior Authorizations	Chapter 10, Individual Practitioner Services
Chapter 15, Dialysis Services	Chapter 18, Federal Emergency Services
Chapter 19, Behavioral Health Services	AMPM Chapter 1100, FES Program Overview
AMPM 310 K - Hospital Inpatient Services	

DFSM Provider Education and Training Unit

AHCCCS
Arizona Health Care Cost Containment System

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.

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/IHStriballbillingManual.html

AHCCCS Medical Policy Manual

- https://www.azahcccs.gov/shared/MedicalPolicyManual/

Thank You.