mercy care

Mercy Care Claims Processing Manual

Visit: **www.MercyCareAZ.org**

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CHAPTER 1 – GENERAL CLAIMS PROCESSING INFORMATION

1.0 – MC Website

Mercy Care's (herein MC) website is available at **www.MercyCareAZ.org** and includes information for:

- Mercy Care Complete Care (herein MCCC)
- Mercy Care Long Term Care (herein MCLTC)
- Mercy Care RBHA (herein MC RBHA)
- Mercy Care DD (herein MC DD)
- Mercy Care Advantage (herein MCA)
- Arizona Department of Child Safety Comprehensive Health Plan (herein MC DCS CHP) – Effective 4/1/2021

The website contains valuable information for both providers and members. Some of the key information for our providers includes the following:

MC Provider Manuals

MC has provider manuals available on our website for your review:

- **Mercy Care Provider Manual**
  - Chapter 100 – Mercy Care Provider Manual – General Terms
  - Chapter 200 - Mercy Care Complete Care, Mercy Care DD, and Mercy DCS CHP Provider Manual – Plan Specific Terms
  - Chapter 300 - Mercy Care Long Term Care Provider Manual – Plan Specific Terms
  - Chapter 400 – Mercy Care RBHA Provider Manual – Plan Specific Terms
- **Mercy Care Advantage Provider Manual**

The MC Provider Manuals all contain valuable information regarding details about the different lines of business, as well as provider responsibilities.

Provider Notifications

Provider Notifications contain recent changes that we want to alert providers to. These could include new regulatory changes, new processes we have established, upcoming events (webinars & forums), and additional provider education. Provider Notifications are available on the **Newsletter and notices** page on our website. The MC Provider Educator can also be contacted at: **MCProviderEducation@mercycareaz.org**

Provider Forms
The MC website contains plan specific provider forms that are available for your use. These may be accessed by clicking **here**.

News and Events
Under the **Events** page on our website, it includes training event information from outside agencies that you may want to be aware of.

MC's Provider Newsletter and Provider notices for all plans can be found on the **Newsletter and notices** page on our website.

1.1 – Claims Mailing Addresses, Electronic Vendors and Contact Information

Paper Claim Submissions

Claims	Plan Name	Mail To
Medical	MCCC MCA MCLTC El Paso, TX 79998-2975 MC DD MC DCS CHP	Claims Department P.O. Box 982975
	MC RBHA	Claims Department P.O. Box 982976 El Paso, TX 79998-2976
Dental	MCCC MCA MCLTC MC DD MC RBHA	Liberty Dental Plan Attention: Claims P.O. Box 401086 Las Vegas, NV 89140
Refunds	All Lines of Business	Mercy Care Attention: Finance Dept. P.O. Box 90640 Phoenix, AZ 85066

When mailing in a paper claim, a completed claim form needs to be filled out. Complete instructions for filling out a **UB-04** claim or a **CMS 1500 (02/12)** form is included in section **1.2 – Form Types and Instructions**.

- Claims must be legible and suitable for imaging and/or microfilming for permanent record retention. Complete ALL required fields and include additional documentation when necessary.
- The claim form may be returned unprocessed (unaccepted) if illegible or poor-quality copies are submitted or required documentation is missing. This could result in the claim being voided in our system. A clean claim submission will need to be made within timely filing guidelines to prevent the claim from being denied.

Electronic Claim Submissions

Please refer to section **1.3 – Electronic Tools and Availity** for vendor information on submitting your electronic claims.

Family Planning Questions

Please refer to section **2.14 - Family Planning Claims** for additional information regarding family planning. If you have authorization or claims questions related to family planning, please call:

Aetna Medicaid Administrators, LLC
Phoenix: 602-798-2745
Outside Phoenix: 888-836-8147

Calling the Claims Inquiry Claims Research (CICR) Department

You may contact the CICR Department by calling **602-263-3000** or **800-624-3879** toll-free.

CICR is available to:

- Answer general questions about claims.
- Assist in resolving problems or issues with a claim, including an incorrect payment amount.
- Assist with claim denials.
- Provide an explanation of the claim adjudication process.
- Help track the disposition of a particular claim, including conducting a check tracer.
- Correct errors in claims processing.
- Assist with coordination of benefits questions.
- Assist with data entry errors.
- Assist with remittance advice or negative balance questions.

- Assist in answering general eligibility questions affecting claims, however, providers must call our Member Services Department at **602-263-3000** or **800-624-3879** toll-free to have eligibility corrected.
- Assist in answering general prior authorization questions affecting claims, however, providers must call our Prior Authorization Department at **602-263-3000** or **800-624-3879** toll-free to have a prior authorization corrected.
- Assist in answering general provider set-up questions, including pay to issues affecting a claim, however, providers must call our Provider Relations Department at **602-263-3000** or **800-624-3879** toll-free to correct a provider record.
- Assist with claim status calls. Claim status calls are limited to 3-member status requests during our peak business hours (between 10:00 a.m. to 3:00 p.m.) Unlimited status requests will be answered during non-peak hours. **Availity** is available 24/7 for providers to check the status of claims. We strongly encourage our providers to use **Availity** for status of claims. It is convenient and you can use it during off hours. Using **Availity** will make better use of your time and allow us to focus on more complex claim questions for both you and other providers calling in. Please refer to section **1.3 – Electronic Tools and Availity**, for more tools available to you.

Please be prepared to give the CICR Customer Service Representative the following information:

- Organization Name
- Phone number
- NPI/TIN/PIN
- Claim number (if available)

Additionally, to meet HIPAA standards our CICR Department is required to validate three pieces of information on the member you are calling about. If the caller is unable to verify the required information, the CICR Customer Service Representative will only provide general information such as the claim billing address, etc. Information required is as follows:

- Member name and AHCCCS member identification number
- Member's date of birth
- Date of service

Network Management Representative Assignment

Please contact your Network Management Representative for questions you have concerning:

- Recent practice or provider updates
- Forms
- To find a participating provider or specialist
- Termination from practice

- Notifying the plan of changes to your practice
- Tax ID change
- Obtaining a Login ID for **Availity**
- Electronic Data Information, Electronic Fund Transfer, Electronic Remittance Advice

To determine who your Provider Relations Representative is, please access **our network** page on our website. Please scroll to the bottom of the page and under the button named **Provider Relations**, you will be able to find a current listing of Provider Relations Representatives.

1.2 – Form Types and Instructions

When submitting paper claims, they must be submitted using the correct claim form type. Below please find a listing of appropriate form types to be used by specific provider types.

Service	Claim Form
Medical and Professional Services	**CMS 1500 (02-12)**
Family Planning Services – Medical	**CMS 1500 (02-12)**
Family Planning Service – Hospital Inpatient	**UB-04 (CMS-1450)**
Family Planning Service - Outpatient or Emergency Obstetrical Care	**CMS 1500 (02-12)**
Obstetrical Care	**CMS 1500 (02-12)**
Hospital Inpatient, Outpatient, Skilled Nursing Facility and Emergency Room Services	**UB-04 (CMS-1450)**
Dental Services that are Considered Medical Services (Oral Surgery, Anesthesia)	**CMS 1500 (02-12)**

MC follows AHCCCS instructions on how to fill out each claim form type. This information is available in the **AHCCCS Fee for Service Provider Billing Manual**. Please review each section for detailed billing instructions:

- ***Chapter 5 – Billing on the CMS 1500 Claim Form***
- ***Chapter 6 – Billing on the UB-04 Claim Form***
- ***Chapter 7 – Billing on the ADA 2012 Claim Form***

1.3 – Electronic Tools and Availity

MC strives to continually improve service to our participating network. One way to help improve service is to offer electronic tools to expedite service to our network.

MC offers multiple tools to allow our participating provider network to submit and receive electronic transactions and reports. Electronic transactions and reports reduce the volume of paper and costs associated with such transactions. As a state and federally funded program, MC and contracted providers have the fiduciary responsibility to reduce costs. We are working closely with providers to encourage utilization of electronic tools.

Currently MC offers several electronic tools to our participating provider network to help reduce the administrative burden and costs associated with paper transactions, including:

- Electronic Claims Submission
- Electronic Funds Transfer
- Electronic Remittance Advice

Electronic Claim Submissions (EDI)

The benefits of electronic claims submissions include:

- Accurate submission and immediate notification of submission errors (level 2 report)
- Faster processing resulting in prompt payment
- MC pays transaction costs

To submit electronic claims, you need the following:

- Agreement with an electronic clearinghouse vendor
- Software in your office or facility to transmit electronic claims MC works with the vendors noted in the table below.

		Online Claim Submission		Batch Claim Submission			
Clearing House	**Online (Y/N)**	**Online Cost**	**Online Daily Limit**	**Batch (Y/N)**	**Batch Cost**	**Batch Daily Limit**	**Contact Info**
Office Ally	**Yes**	**Free**	**NA**	**Yes**	**Free**	**NA**	**http://www.officeally.com/ 1-360-975-7000**
Optum (formerly Change Health care)	**Yes**	**Charge**	**NA**	**Yes**	**Charge**	**NA**	**https://business.optum.com/en/ 1-866-817-3813**
Availity	**Yes**	**Free**	**NA**	**Yes**	**Free**	**NA**	**http://www.availity.com/ 800-282-4548**
SSI	**Yes**	**Charge**	**NA**	**Yes**	**Charge**	**NA**	**http://www.thessigroup.com/ 1-800-356-0092**

Coordinating Benefits Electronically

MC accepts secondary claims payment information via EDI submission. There are specific reporting fields that need to be completed for that information to be passed into our claims processing system for claim adjudication. You should work with your internal clearinghouse to determine how to send the information to them. MC's clearinghouse currently passes the information to us using HIPAA compliant 837 transmissions.

Electronic Funds Transfer (EFT)

The benefits of electronic funds transfer include:

- Automatic deposit of payment for covered services
- Faster receipt of payment
- No paper checks to deposit
- Easier verification of payment

Please see** the ***ERA/EFT Registration Services **section (below) for instruction on how to sign up.**

Please Note:

MC's check run schedule is three days per week runs will be on Mondays, Wednesdays, and Fridays with PAID dates the following business day. The schedule may vary with holidays.

Electronic Remittance Advice (ERA)*

The benefits of electronic remittance advice include:

- Electronic file of processed claims from MC
- Electronically post payments to your Practice Management system
- Faster reconciliation of account receivables
- Simplified reconciliation process
- Received day after electronic funds transfer

Please see** the ***ERA/EFT Registration Services **section (below) for instruction on how to sign up.**

You may request ERA without having EFT, however, we strongly encourage you have EFT to take full advantage of all electronic processes.

You have the option of having your vendor pick up the file for you or you may pick up the file yourself through Payment Manager.

****ERA/EFT Registration Services***

MC utilizes an EFT/ERA Registration Services (EERS) process which is a better and more streamlined way for our providers to access payment services.

What is EERS?

EERS offers providers multiple ways to set up EFT and ERA in order to receive transactions from multiple payers. If a providers' tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the provider for multiple payers. Providers can also complete registration using a national provider identifier (NPI) for payment across multiple accounts.

How does it work?

ECHO Health processes and distributes MC claims payments to providers. To enroll in EERS, visit the **ECHO portal**. Providers can manage electronic funds transfer (EFT) and electronic remittance advice (ERA) enrollments for multiple payers on a single platform.

Sign up for EFT

To sign up for EFT, providers will need to provide an ECHO payment draft number and payment amount as part of the enrollment authentication (for security reasons). Find the ECHO draft

number on all provider Explanation of Provider Payments (EPP), typically above your first claim on the EPP. If a provider has not received a payment from ECHO before, the provider will have received a paper check with a draft number that can be used to register after receiving their first payment.

Update your payment or ERA distribution preferences
Providers can update preferences on the dedicated **ECHO portal**.

Use our portal to avoid fees
Fees apply when providers choose to enroll in ECHO's ACH all payer program. The **ECHO portal** can be used for no-fee processing. Providers can confirm they are on the portal when they see "Aetna Better Health" at the top left of the page.

There may be a 48-hour delay between the time a payment is received, and an ERA is available.

Questions related to EFT/ERA
Providers can contact ECHO via email at **allpayer@echohealthinc.com** or by phone at 1-888-834-3511 for questions. Providers can also contact their **Network Management representative**.

Additional ECHO resources
ECHO portal guide
ECHO Frequently Asked Questions
ECHO EFT/ERA Companion Document Supplemental Guide

Historic remittance advices from Change Healthcare are accessible via the Availity Portal. These remits will be available in PDF format and can be retrieved using your normal lookup process within the portal. This enhancement applies to all Change Healthcare remits, providing a convenient way to access and review historical remits you might have missed.

Availity
How to Use Availity
MC also provides a secure web-based platform that enables us to communicate healthcare information directly with providers via **Availity**. Users can perform transactions, download information, and work interactively with member healthcare information. The following information can be attained from **Availity**:

- **Member Eligibility Search** – Verify current eligibility on one or more members. Please note that eligibility may also be verified through the AHCCCS website.

- **Panel Roster** – View the list of members currently assigned to the provider as the primary care provider (PCP).
- **Provider List** – Search for a specific health plan provider by name, specialty, or location.
- **Claims Status Search** – Search for provider claims by member, provider, claim number, or service dates. Only claims associated with the user's account provider ID will be displayed.
- **Remittance Advice Search** – Search for provider claim payment information by member name, member ID, provider name, provider ID, date of service, or date range or specific claim number. Only remits associated with the user's account provider ID will be displayed.
- **Authorization List** – Search for provider authorizations by member, provider, authorization data, or submission/service dates. Only authorizations associated with the user's account provider ID will be displayed.
- **HEDIS** – Check the status of the member's compliance with any of the HEDIS measures. "Yes" means the member has measures that they are not compliant with; "No" means that member has met the requirements.
- **Fee Schedule:** Look up rates by service code listed under the "Applications" section.
- **Provider Notifications & Resources:** Review up-to-date information on new regulatory guidelines, new processes and upcoming events.

For registration information regarding **Availity**, please see our website page.

Once you have received your log in you may use **Availity** by clicking on the link.

1.4 – Clean Claim Definition

Medicaid

MC follows the AHCCCS regulatory definition of a Clean Claim. A "Clean Claim" is defined as a claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. §36-2904.

The receipt date of the claim is included in the MC claim number assigned and reflects the date the claim was received (Julian Date) through the mail or received electronically through direct electronic submission or received by our designated clearinghouse.

MCA

MCA follows the CMS regulatory definition of a Clean Claim. A "Clean Claim" is one that does not require MCA to investigate or develop on a prepayment basis. Clean claims must be filed within the timely filing period.

The following bullets are some examples of what are considered clean claims:

- The claim will pass all edits and are processed electronically;
- The claim does not require external development;
- Claims subject to medical review and complete medical evidence is attached by the provider or forwarded simultaneously with EMC records in accordance MCA instructions;
- Are developed on a post-payment basis; and,
- Have all basic information necessary to adjudicate the claim, and all required supporting documentation.

The receipt date of the claim is included in the MC claim number assigned and reflects the date the claim was received (Julian Date) through the mail or received electronically through direct electronic submission or received by our designated clearinghouse.

1.5 – Regulatory Turnaround Times

Both MC and MCA are subject to regulatory requirements regarding the turnaround time of claims from the date the claim is originally received by the plan to the date when the claim is adjudicated. These turnaround times are as follows:

For Medicaid

- 95% of all clean claims must be adjudicated within 30 days of receipt of the clean claim for all form types (Professional/Institutional).
- 99% of all clean claims must be adjudicated within 60 days of receipt of the clean claim for all form types (Professional/Institutional).

For MCA

- 95% of all clean claims must be adjudicated within 30 days of receipt of the clean claim for all form types (Professional/Institutional).
- 100% of all clean claims must be adjudicated within 60 days of receipt of the clean claim for all form types (Professional/Institutional).

1.6 – Interest Payments

In the absence of a subcontract specifying other late payment terms, MC is required to pay interest on late payments as specified below:

For Medicaid

Hospital Clean Claims – MC is required to pay slow payment penalties (interest) on payments made after 60 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the

61st day until the date of payment (A.R.S. §36-2903.01).

Long Term Care Clean Claims - For authorized services submitted by a licensed skilled nursing facility, an assisted living facility/center, Long Term Care provider, or a home and community based Long Term Care provider, MC is required to pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month (prorated daily) from the date the clean claim is received until the date of payment (A.R.S. §36-2943.D).

Non-Hospital Clean Claims – MC is required to pay interest on payments made after 45 days of receipt of the clean claim. Interest shall be paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment. The Contractor shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).
MC shall pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute date unless additional information is provided as part of the dispute, in which case the clean date is reflective of the dispute received date). Interest is paid based on the difference between the original paid amount and the additional payment. Interest is reported on your remittance advice.

For MCA
The following applies to all claim types. Interest must be paid on clean claims if payment is not made within the applicable number of calendar days (i.e., 30 days) after the date of receipt of the claim. The applicable number of days is also known as the payment ceiling. As an example, a clean claim is received on March 1, 2015, must be paid before the end of business on March 31, 2015. Interest is not payable on the following claim types:

- Claims requiring external investigation or development by MCA.
- Claims on which no payment is due;
- Full denials;
- Interim claims; and
- HH PPS RAPs.

Interest is paid at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment.
This rate is determined by the Treasury Department on a 6-month basis, effective every January 1 and July 1. You may access the **Prompt Pay Rates** by clicking on the link. Interest is calculated using the following formula:

Payment amount X rate X days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment. Interest is reported on your remittance advice.

For additional information regarding interest payments on non-clean claims, please see the **Medicare Claims Processing Manual, Chapter 1**, under Section 80.2.2 – Interest Payment on Clean Non-PIP Claims Not Paid Timely.

1.7 – Prompt Payment Discount

The prompt payment discount only applies to MC Medicaid lines of business and is mandated by regulatory requirement.
In the absence of a subcontract specifying otherwise, MC Medicaid lines of business must apply a quick pay discount of 1% on hospital claims paid within 30 days of the date the clean claim was received (A.R.S. §36-2903.01.G). This only applies to in-state hospitals. It does not apply to out of state hospitals.

1.8 – Timely Filing

Claim Submission and Processing Guidelines
Initial Claim Submission (New Day Claims)
Initial claims must be submitted to MC within **150 days** of the date of service (DOS) or discharge date, regardless of whether payment has been received from Medicare or other insurance carriers.

Coordination of Benefits (COB)

- **First-time submissions**: Must be submitted within **150 days** from the DOS, even if payment from Medicare or another insurer has not yet been received.
- **Secondary submissions**: Must be submitted within **150 days** from the last DOS or the date of the primary carrier's Explanation of Benefits (EOB).

Prior Quarter Coverage (PQC) / Prior Period Coverage (PPC)

- **Initial clean claims**: Must be submitted within **150 days** from the AHCCCS eligibility posting date.
- **Adjustments to paid claims**: Must be submitted within **12 months** from the eligibility posting date.

Corrected Claims / Resubmissions

If the initial claim was submitted timely, providers have up to **12 months** from the DOS or discharge date to submit a corrected claim.

Claims may exceed the 12-month resubmission timeframe only if:

- The claim is received within **6 months** of the Medicare EOB, or
- The claim is received within **60 days** of an adverse action (e.g., recoupment) initiated by MC.

Claims Involving Multiple AHCCCS Contractors

If a claim is recouped by one AHCCCS Contractor because it is the responsibility of another (the "responsible Contractor"), the provider may submit a clean claim to the responsible Contractor within the following timeframes (whichever is latest):

- **60 days** from the date of recoupment,
- **12 months** from the date of service, or
- **12 months** from the AHCCCS eligibility posting date.

The responsible Contractor must not deny the claim for untimely filing if submitted within these timeframes.

Claim Disputes

Per A.R.S. §36-2903.01(B)(4) and A.A.C. R9-34-405(A), all claim disputes must be submitted in writing and received within:

- **12 months** from the date of service,
- **12 months** from the AHCCCS eligibility posting date, or
- **60 days** from the date of payment, denial, or recoupment of a timely claim—whichever is later.

Disputes submitted outside of these timeframes cannot be processed. Providers are encouraged to review their records to ensure compliance.

Claim Recoupments

- Adjustments completed within **30 days** of the original payment do not require AHCCCS prior approval.
- Recoupments may be initiated within **one year** of the original payment date.
- AHCCCS approval is required for any net recoupment of **$50,000** or more on the same claim, for the same provider, within the same contract year.

Unless a contract specifies otherwise, MC ensures that for each form type: (Professional/Institutional) 95% will be adjudicated within 30 days of receipt of the clean claim, otherwise claim shall not pay if either of the following occurs:

- Claims initially submitted more than five months (150 days) after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later; or
- If a claim is originally received within the 5-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, MC is not liable for payment. This information is available in the **AHCCCS Fee For Service Manual, Chapter 4, General Billing Rules**.

When MC is the secondary insurer:
MC is always the payer of last resort. It is critical that you identify any other available insurance coverage for the patient and bill the other insurance as primary. For example, if Medicare is primary, MC is secondary.

- File an initial claim with MC if you have not received payment or denial from the other insurer before the expiration of your required filing limit. Make sure you are submitting timely to preserve your claim dispute rights.
- Upon the receipt of payment or denial by the other insurer, you should then submit your claim to MC, showing the other insurer payment amount or denial reason, if applicable, and enclosing a complete legible copy of the remittance advice or Explanation of Benefits (EOB) from the other insurer.
- When a member has other health insurance, such as Medicare, a Medicare HMO or a commercial carrier, MC will coordinate payment of benefits.
- In accordance with requirements of the Balanced Budget Act of 1997, MC will pay co-payments, deductibles and/or coinsurance for AHCCCS Covered Services up to the lower of either MC's fee schedule or the Medicare/other insurance allowed amount.

Claims should be resubmitted within one year from the last date of service or 60 days from the date of the other insurance explanation of benefits, whichever is later once the other insurance explanation of benefits is received.

Claim payment requirements pertain to both contracted and non-contracted providers.

For MCA:

- Section 6404 of the Patient Protection and Affordable Care At of 2010 (ACA) states that claims with dates of service on or after January 1, 2010, received later than one year beyond the date of service will be denied by MCA for timely filing.

1.9 – National Correct Coding Initiative

Medicaid lines of business, and MCA, in accordance with AHCCCS, follow the same standards as CMS's Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on the Correct Coding Initiative, please review the **CMS National Correct Coding Initiative Edits** web page.

MC utilizes ClaimsXten as our comprehensive code auditing solution that will assist payors with proper reimbursement, along with Cotiviti. Correct Coding Initiative guidelines will be followed in accordance with both AHCCCS and CMS, in addition to pertinent coding information received from other medical organizations or societies.

ClearClaim is a web-based stand-alone code auditing reference tool designed to approximate code editing based on national standards and MC's comprehensive code auditing solution through ClaimsXten. For further information regarding ClearClaim, please review the disclaimer in the application. It enables MC to share with our providers the claim auditing rules and clinical rationale inherent in ClaimsXten.

Providers will have access to ClearClaim through Availity. ClearClaim coding combinations can be used to review the rationale for editing after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim so that the provider can view claim auditing rules and clinical rationale beforehand.

Further detail on how to use ClearClaim can be found on the application itself by using the help link. Clear Claims Connection can be found after logging in to Availity. For additional information regarding Availity, please refer to section **1.3 – Electronic Tools and Availity**.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive codes. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure, or
- Are necessary to accomplish the comprehensive procedure, or
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of **incorrect coding** include:

- "Unbundling" - Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service to use an additional code when one higher level, more comprehensive code is appropriate.

MC follows National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) guidelines for MCA. MC may also choose to apply these guidelines to Medicaid lines of business as applicable.

Coding Resources and Common Physical Health Modifiers

MC follows our regulators' coding practices and guidelines (both CMS and AHCCCS).
It is important to follow all coding guidelines to avoid claim denials.

In conjunction with the **Mercy Care Website** and Provider Manuals, you should also reference the **AHCCCS Website,** as well as the **CMS Website,** for additional detailed coding information.

Important resources for your use should include the following:

- Current Procedural Terminology (CPT) Manual
- ICD-10-CM Manual
- HCPCS Level II Manual

It is important to follow coding guidelines outlined in the above manuals to avoid claim denials. Appropriate modifiers must be billed to reflect services provided and for claims to pay appropriately. MC can request copies of operative reports or office notes to verify services provided. Common modifier issue clarification is below:

> **Modifier 59 – Distinct Procedural Services** - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 59 cannot be billed with Evaluation and Management (E/M) codes (99201-99499).
>
> In addition, there are HCPCS modifiers for selective identification of subsets of Distinct Procedural Services (59 modifier) as follows:

XE – Separate Encounter
XS – Separate Structure
XP – Separate Practitioner
XU – Unusual, Non-Overlapping Service

Modifier 25 – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service - must be attached to a component code to indicate that the procedure was distinct or separate from other services performed on the same day and was not part of the comprehensive service. Medical records must reflect appropriate use of the modifier. Modifier 25 is used with E/M codes and cannot be billed with surgical codes.

Modifier 50 – Bilateral Procedure - If no code exists that identifies a bilateral service as bilateral, you may bill the component code with modifier 50. MC follows the same billing process as CMS and AHCCCS when billing for bilateral procedures. Services should be billed on one line reporting one code with a 50 modifier.

Modifier 51 – Multiple Procedures – When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines) are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or services(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes. MC follows multiple surgical reduction rules and it's important to know when this is needed.
Providers should list the principal procedure on the first line of the **CMS 1500 (02/12)** claim form and list the secondary surgeries on subsequent lines with modifier 51, unless the code is an add-on code.

- The principal procedure is reimbursed at 100% of the provider's contracted rate or billed charges, whichever is less.
- Each secondary surgical procedure is reimbursed at 50% of the provider's contracted rate or billed charges, whichever is less.

If a claim is received without modifiers to indicate secondary procedures, MC's bundling system, ClaimsXten, identifies the first procedure on the claim as the principal procedure.

All other surgical procedures, if identified as part of multiple surgical reduction, will have the 51-modifier appended to it and paid at 50% of the provider's contracted amount or billed charge, whichever is less.

Modifier 57 – Decision for Surgery – This must be attached to an E/M code when a decision for surgery has been made. MC follows CMS guidelines regarding whether the E/M service will be payable based on the global surgical period. CMS guidelines found in the Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners indicate:

"*Carriers pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier "-57" to indicate that the service resulted in the decision to perform the procedure. Carriers may not pay for an evaluation and management service billed with the CPT modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.*"

EP Modifier – Service provided as part of a Medicaid early periodic screening diagnosis and treatment [EPSDT] program – must be appended to EPSDT services to receive additional developmental screening tool payment. For additional information, please refer to **Chapter 3 – Early Periodic Screening, Diagnostic and Treatment (EPSDT)**.

SL Modifier – State Supplied Vaccine – If a vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code. For additional information please refer **3.4 – Vaccine for Children Program**.

Modifier AS – Assistant Surgeon - Per coding standards and guidelines, modifier 80 (Assistant Surgeon) has been end dated as of 03/31/2015 by both AHCCCS and CMS for the following provider types:

- 09 - certified nurse midwife
- 19 – registered nurse practitioner
- 18 - physician's assistant
- 82 – surgical first assistant

These provider types are to use the modifier AS. For all other provider types, an 80 modifier (Assistant Surgeon) is appropriate to use for claims meeting Assistant Surgeon criteria.

Modifier GC – Service has been performed in part by a resident under the direction of a teaching physician -

Correct Use

- Append to service that has been completed by a resident in a teaching facility under direction and supervision of a teaching physician.
    - Medicare does not pay for any service furnished by a medical student as defined in **Internet Only Manual (IOM), Claims Processing Manual 100-04, Chapter 12, Section 100.**
- Append in second modifier field when supervising/teaching anesthesiologist is involved in two concurrent anesthesiology cases with one resident (or "fellow"), he/she may bill usual base units and time for amount of time present with resident throughout pre, intra, and post anesthesia care.

Incorrect Use

- Appending to the service when a teaching physician is not involved with any part of care.

Teaching Physician Documentation

Teaching physicians shall personally document that they performed the service or were physically present during key or critical portions of the service and their participation in the management of the patient. The physician can refer to the resident's documentation, however, a statement by the attending (teaching) physician is required and must include essential and independent documentation to tie into the resident's documentation. Without such documentation, no reimbursement can be made.

Examples

- Acceptable
    - Patient become hypoxic and hypotensive. I spent 4 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's assessment and plan of care.
- Unacceptable
    - I saw the patient and agreed with the resident.

Modifier Rates and Fee Schedule

MC's fee schedules are large as they contain both AHCCCS' and MC's fee schedules. There are certain modifiers that affect payment and imply a percentage rate payable for the service. Our claims system applies these percentage rates when billed with these modifier codes. This percentage is used industry-wide and includes the following basic information.

Here are the codes that will always pay a percentage but are not visible in our fee schedules:

Modifier	Pay Percent	Modifier Description
-50	150.00	Bilateral procedure
-51	50.00	Multiple procedures
-54	80.00	Surgical care only
-55	15.00	Postoperative management only
-62	62.50	Two surgeons
-66	33.00	Surgical team
-78	80.00	Unplanned Return to the Operating/Procedure Room by the Same
-80	20.00	Assistant surgeon
-81	20.00	Minimum assistant surgeon
-82	20.00	Assistant Surgeon (when qualified resident surgeon not available)
-90	70.00	Reference (Outside) Laboratory
-AS	20.00	Physician assistant, nurse practitioner, or clinical nurses
-FX	80.00	X-ray taken using film
-FY	93.00	X-ray taken using computed radiography technology/cassette-based imaging
-JW	0.01	Drug amount discarded/not administered to any patient
-PA	0.01	Surgical or other invasive procedure on wrong body part
-PB	0.01	Surgical or other invasive procedure on wrong patient
-PC	0.01	Wrong surgery or other invasive procedure on patient
-QK	50.00	Medical direction of two, three or four concurrent anesthesiologists
-QX	50.00	CRNA service: with medical direction by a physician
-QY	50.00	Medical direction of one CRNA
-UN	50.00	Two patients served
-UP	33.33	Three patients served
-Z3	25.00	Secondary Surgery (pay 50PCT) (3rd Procedure)

Please refer to your Current Procedural Terminology (CPT) or HCPCS Volume II manual for further detail on all modifier usage.

1.10 – Resubmission Process

Providers have 12 months from the date of service to request a resubmission or reconsideration of a claim, otherwise it will be denied for timely filing. A request for review or reconsideration of a claim does not constitute a claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

When filing resubmissions or reconsiderations, please include the following information:

- Use the Resubmission Form located under the **Forms** section of MC's website.
- An updated copy of the claim. All lines **must** be rebilled or a copy of the original claim (reprint or copy is acceptable) must be submitted.
- A copy of the remittance advice on which the claim was denied or incorrectly paid.
- Any additional documentation required.
- A brief note describing requested correction.
- Clearly label as "Resubmission" or "Reconsideration" at the top of the claim in black ink and mail to appropriate claims address.

Resubmissions and reconsiderations can be submitted electronically.

If billing a resubmission electronically, you must submit with:

- **Professional Claims** - A status indicator of 7 in the submission form location and the Original Claim ID field needs to be filled out.
- **Facilities** – In the Bill Type field, the last number of the 3-digit code should be a 7.

You may submit attachments for your resubmission claims via **Availity**.

When submitting paper resubmissions, failure to mail and accurately label the resubmission or reconsideration to the correct address will cause the claim to deny as a duplicate. The resubmission mailing address is:

Mercy Care Complete Care, Mercy Care Long Term Care, Mercy Care DD, and Mercy Care DCS-CHP:

Claims Department

Attention: Resubmissions
P.O. Box 982975
El Paso, TX 79998-2975

Mercy Care ACC-RBHA:

Claims Department
Attention: Resubmissions
P.O. Box 982976
El Paso, TX 79998-2976

1.11 – Recoupments

The recoupment of a claim may occur from time to time when needed.

Adjustments to Claims

Any time a claim requires adjustment, our claims system will reverse the original claim and repay on a secondary claim. The difference in payment between these two claims is what you will be paid on your remit. There may be times where the difference in payments results in the provider owing us monies, rather than MC owing additional monies to the provider. This is referred to as a negative balance. Any negative balances will be carried over to the next check run and offset by new claims that are submitted from the provider. Please always refer to the upper right-hand corner summary box of your remit for this important information. The Ending Balance section will be the indicator to let you know that you have a negative balance.

Remits may be accessed through **Availity.** Please refer to section **1.3 – Electronic Tools and Availity** in this document for more information.

We recommend that providers wait until all negative balances are recouped before they start to reconcile their AP system.

Recoupment Reasons

Recoupments may occur for the following reasons (this list is not all inclusive but contains most common reasons):

- Encounter errors from AHCCCS requiring a corrected claim from the provider.
- Provider billing errors.
- Claims processing or provider set-up errors in our system.
- Inadequate and untimely notification to MC of changes by the provider such as:
    - New ownership
    - Change in Tax ID

- New physicians with new NPIs

If you have a large negative remit and agree with the amounts, it is best to send us a check for the overpayment. Once received, we will credit this in, which will reduce your negative balance back to zero.

1.12 – Overpayments

Under **Section 6402 of the Patient Protection and Affordable Care Act** it states:
"Section 6402 of the Patient Protection and Affordable Care Act (PPACA) amends the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions that enhance the federal government's ability to discover and prosecute provider fraud, waste, and abuse. Among the provisions that may have a significant impact on States are newly imposed requirements for health care providers to report any overpayments from Medicaid and Medicare.

Under a new Section 1128J(d) of the SSA, any provider of services or supplies under Medicaid or Medicare must report and return "overpayments," which the statute defines as "any funds that a person receives or retains under either program "to which the person, after applicable reconciliation, was not entitled[.]" A "person" is defined as "a provider of services, supplier, Medicaid managed care organization…, Medicare Advantage organization…, or [Medicare Part D Prescription Drug Plan] sponsor[.]" PPACA § 6402(a). It does not include a beneficiary.

The overpayment must be returned within 60 days from the date the overpayment was "Identified," or by the date any corresponding cost report was due, whichever is later. This provision of the law became effective May 22, 2010.

To properly return an overpayment, the individual who has received an overpayment must:

> *return the payment to the Secretary of the Department of Health and Human Services (Secretary), the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned the reason for the overpayment in writing.*

Failure to return an overpayment has severe consequences. *If an overpayment is retained beyond the 60-day deadline, PPACA Section 6402 makes clear that it will be*

considered an "obligation" under the FCA. As amended by the Fraud Enforcement Recovery Act of 2009 (FERA), the FCA subjects a person to a fine and treble damages if he or she knowingly conceals or knowingly and improperly avoids or decreases an "obligation" to pay money to the federal government. PPACA treats Medicaid and Medicare overpayments alike in stating that failing to refund an overpayment will be considered an "obligation" under the FCA."

Whether an overpayment is identified directly by the provider, or an overpayment request letter is sent to the provider by MC, the refund along with any supporting documentation should be sent to:

Mercy Care
Attention: Finance Department
P.O. Box 90640
Phoenix, AZ 85066

1.13 – Medical Necessity Reviews

MC medical directors conduct medical review for each case with the potential for denial of medical necessity. The CRN (inpatient) or the prior authorization nurse (outpatient) reviews the documentation for evidence of medical necessity according to established criteria. When the criteria are not met, the case is referred to an MC medical director. The medical director reviews the documentation, discusses the case with the nurse and may call the attending or referring physician for more information. The requesting physician may be asked to submit additional information. Based on the discussion with the physician or additional documentation submitted, the medical director will decide to approve, deny, modify, reduce, suspend, or terminate an existing or pending service.

Important to Note: Medical Necessity reviews do not take the place of obtaining Prior Authorization when required.

Utilization management decisions are based only upon appropriateness of care and service. MC does not reward practitioners, or other individuals involved in utilization review, for issuing denials of coverage or service. The decision to deny a service request will only be made by a physician.

For inpatient denials, hospital staff is verbally notified when MC is stopping payment. The hospital will receive written notification with the effective date of termination of payment or reduction in level of care. The attending or referring physician may dispute the finding of the medical director informally by phone or formally in writing. If the finding of the medical director

is disputed, a formal claim dispute may be filed according to the established MC claim dispute process.

There may be times where a medical necessity review is requested by the provider following the denial of a claim. In those cases, a request for a medical necessity review, along with appropriate documentation supporting medical necessity should be submitted through the claim's resubmission process. The claims will be forwarded to our clinical staff for further review. If medical necessity is established for the claim, the claim will be reprocessed for payment.

1.14 – Claim Disputes/Appeals

MC Claim Disputes/Appeals

The provider claim dispute process affords providers the opportunity to challenge a decision by MC that impacts the provider. Providers may file a claim dispute based on:

- Claim Denial
- Recoupment
- Dissatisfaction with Claims Payment
- Imposition of a sanction

Claim Resolution Pathway and Definitions

Providers must follow a structured pathway when seeking resolution for payment discrepancies or claim denials. While the overall process is designed to align with federal and state regulatory expectations, it includes both **informal** and **formal** steps. Understanding the distinction between these two steps is essential for compliance and efficient resolution.

- **Claim Reconsideration**
  An information request initiated by a provider to review a claim that was denied or paid incorrectly. Reconsiderations are typically resolved through claims adjustment or reprocessing and do not constitute a formal dispute or appeal.
  Purpose: To correct clerical errors, submit missing documentation, or address processing issues.
  Timeframe: Must be submitted within 12 months from the date of service contingent upon the original claim being submitted timely.
- **Provider Dispute/Appeal**
  A formal written challenge submitted by a provider regarding the denial or payment of a claim. For regulatory purposes, the terms *dispute* and *appeal* are synonymous and refer to the same formal process.
  Purpose: To contest a claim decision after informal resolution attempts (i.e., reconsideration) have failed.

Timeframe: Must be filed within the later of:

- 12 months from the date of service,
- 12 months from the date eligibility was posted, or
- 60 days from the date of denial of a timely claim submission.

Claim Resolution Process

1. **Step 1: Claim Reconsideration (Informal Strongly Encouraged)**
   Providers are expected to initiate a reconsideration request before pursuing formal dispute or appeal channels. This step allows for information resolution and often avoids the need for legal or administrative escalation. Most payment discrepancies and denials can be resolved through claims adjustment or reprocessing.
2. **Step 2: Formal Dispute/Appeal**
   If the reconsideration does not result in a satisfactory outcome, providers may file a formal dispute or appeal. This process is governed by applicable federal and state regulations and must include all relevant documentation, and a clear statement of the relief requested.

It's important to note that once a claim is disputed/appealed, it can no longer go through the resubmissions process. It must go through the next step, which is for State Fair Hearing. The fax number for State Fair Hearing Claim Disputes/Appeals is 860-907-3511.

Please reference Chapter 18 in the General Terms Chapter 100 version of the Provider Manual for more information on claim disputes/appeals.

MCA Claim Disputes/Appeals

Contracted providers with MCA do not have Claim Dispute/Appeal rights. They must submit claims that they are disputing through the resubmission process.

1.15 – Diagnosis Coding

ICD-10 code sets should be used for billing services to MC.

Manifestation Codes

There are certain diagnosis codes, called manifestation codes that cannot be billed as the primary diagnosis. Manifestation codes describe the manifestation of an underlying disease, not the disease itself, and therefore should not be used as a principal diagnosis.

MC's system will deny a claim where a manifestation code is billed as the primary diagnosis code. Please ensure that you review ICD-10 codes before billing to ensure that manifestation codes are not used as primary billing codes.

1.16 – National Drug Code Claim Requirements

MC follows all AHCCCS guidance regarding the provider's responsibility to bill NDC as follows:

The billing requirements for drugs administered in outpatient clinical settings are in accordance with and support of the Federal Deficit Reduction Act of 2005, which mandates that all providers submit the National Drug Code (NDC) on all claims with procedure codes for physician-administered drugs in outpatient clinical settings. These services are currently represented on submitted claims using the Healthcare Common Procedure Coding System (HCPCS) codes.

Background

The Deficit Reduction Act of 2005 (DRA) included new provisions regarding State collection of data for the purpose of collecting Medicaid drug rebates from drug manufacturers for physician-administered drugs. Section 6002 of the DRA adds section 1927(a)(7) to the Social Security Act to ***require*** States to collect rebates on physician-administered drugs. For Federal Financial Participation (FFP) to be available for these drugs, the State must provide collection and submission of utilization data to secure rebates. Since there are often several NDCs linked to a single HCPCS code, the Centers for Medicare, and Medicaid Services (CMS) deem that the use of NDC numbers is critical to correctly identify the drug and manufacturer to invoice and collect the rebates.

NDC Definition

The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. The first 5 digits identify the labeler code representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer. Some packages will display less than 11 digits, but leading "0's" can be assumed and need to be used when billing. For example:

XXXX-XXXX-XX = 0XXXX-XXXX-XX XXXXX-
XXX-XX = XXXXX-0XXX-XX XXXXX-XXXX-X
= XXXXX-XXXX-0X

The NDC is found on the drug container, i.e., vial, bottle, tube. The NDC submitted to MC must be the actual NDC number on the package or container from which the medication was administered. Claims may ***not*** be submitted for one manufacturer when a different

manufacturer's product was administered. It is considered a fraudulent billing practice to bill using an NDC other than the one assigned to the drug administered.

When submitting a Medicaid claim for administering a drug, providers must submit the 11-digit NDC **without dashes or spaces** between the numbers. Claims submitted with NDCs in any other configuration may fail.

Providers of "physician-administered" drugs

Providers of "physician-administered" drugs include any AHCCCS registered provider whose license and scope of practice permits the administration of drugs, such as a medical doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), Ambulatory Surgery Centers (ASCs), Hospital Outpatient Clinic/Services and Skilled Nursing Facilities (SNFs).

Exception: IHS/tribally operated 638 facilities reimbursed at the federally the published all-inclusive rate.

HCPCS codes and CPT codes that will require the NDC information on the claim submission

Drugs billed using HCPCS codes include:

- C, J, Q and S codes as applicable.
- Some A codes require NDC information while others do not.
- "Not otherwise classified" (NOC) and "Not otherwise specified" (NOS) drug codes (e.g., J3490, J9999, and C9399).
- CPT codes, 90281-90399 for immune globulins.
- CPT codes 90476-90749 for vaccines and toxoids.

To comply with this mandate, providers **must** do the following:

- Providers **must** submit a valid 11-digit NDC when billing a HCPCS drug or CPT procedure code as defined above.
- The qualifier "N4" must be entered in front of the 11-digit NDC. The NDC will be submitted on the same detail line as the CPT/HCPCS drug procedure code in the pink shaded area.

Revenue Center Codes affected

To support the NDC claims submission requirements, the following Revenue Center Codes may require a CPT or HCPCS code for administration of the drug and reporting of the specific NDC and quantity:

- 0250-259

- 0262
- 0263
- 0331
- 0332
- 0335
- 0634-0637

NDC quantity to be billed and claims elements required

NDC units are based on the numeric quantity administered to the patient and the unit of measurement. The actual metric decimal quantity administered, and the unit of measurement is required for billing. If reporting a fraction, use a decimal point. The units of measurement codes are as follows:

- NDC of the drug administered as described above.
- NDC Unit of Measure:
  - **F2** = International Unit.
  - **GR** = Gram - usually for products such as ointments, creams, inhalers, or bulk. This unit of measure is typically used in the retail pharmacy setting.
  - ML = Milliliter - for drugs that come in vials which are in liquid form.
  - UN = Unit (each) - for unit of use preparations, generally those that must be reconstituted prior to administration.
- Quantity administered equals number of NDC units.

Note: Provider must also continue to submit Revenue Codes, HCPCS Codes and related service units in addition to the required NDC information.

HCPCS to NDC quantity conversion examples:

Note: Payment is based on the quantity of J codes units administered.

HCPCS	NDC	QUANTITY CONVERSION
J9305	00002762301	HCPCS code is per 10 mg and the product comes as a dry power injection 500mg. NDC units are “each vial” Dose was 100 mg, for example HCPCS quantity = 10 and the NDC quantity = 100/500 = 0.2 Enter: N400002762301 UN0.2 on the CMS 1500 (02/12).

J3110	00002897101	HCPCS code is for 10mcg, and the product comes as 250mdg/ml NDC units are ml. Dose was 750 mcg. HCPCS quantity = 75 and the NDC quantity =3 Enter: N400002897101 ML3 on the **CMS 1500 (02/12)**.
J1745	57894003001	HCPCS code is for 10 mg and product comes as 100mg powder for injection. NDC units are "each vial". Dose was 200 mg. HCPCS quantity = 20 (20 X 10mg) = 200mg and the NDC quantity is 2. This is true even if the dry powder was reconstituted to 20 ml. Enter: N457894003001 UN2 on the **CMS 1500 (02/12)**.

Paper Billing Instructions

All institutional (UB04/837I) and professional (CMS-1500/837P) claims must include the following information:

- NDC and unit of measurement for the drug billed.
- HCPCS/CPT code and units of service for the drug billed; and
- The actual metric decimal quantity administered.

UB04 Claim Form

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above).
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.
- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

CMS 1500 (02/12) Claim Form

To report the NDC on the CMS 1500 (02/12) claim form, enter the following information:

- In Field 24A of the CMS 1500 (02/12) form in the shaded area, enter the NDC Qualifier of 4 in the first 2 positions, followed by the 11-digit NDC (no dashes or spaces) and then a space and the NDC Units of Measure Qualifier, followed by the NDC Quantity. All should be left justified in the pink shaded area above the Date of Service.
- The billed units in column G (Days or Units) should reflect the HCPCS units and not the NDC units. Billing should not be based off the units of the NDC. Billing based on the NDC units may result in underpayment to the provider.

Note: Submission of multiple NDCs per HCPCS is not allowed.

Electronic Billing Instructions

837 Claims Submission for NDC:

837 Drug Identification			
Loop	**Segment**	**Field Name**	**Requirement**
2410	LIN02	Prod/Serv ID Qualifier	A value of "N4" is expected
2410	LIN03	Prod/Service ID	An 11-digit NDC number is expected and will be mapped to the CPDNDC Prod/Service ID
2410/2400	CTP04/SV104	Quantity	The quantity is expected and will be mapped to CPDNDC quantity. If the unit price on segment CTP03 is different than the unit price on the SV102, then map CTP04, otherwise map SV104.
2410/2400	CTP05/SV103	Composite Unit of Measure	The composite unit of measure is expected and will be mapped to CPDNDC composite unit of measure. If the unit price on segment CTP03 is different than the unit price on the SV203, then map CTP04, otherwise map SV103.

Note: Submission of multiple NDCs per HCPCS is not allowed.

Remittance Advice if NDC is Submitted Incorrectly

If the NDC billing information is missing or invalid, claims may fail. The claim will need to be resubmitted with the required NDC information and/or correct number of units within the time allowed for potential payment.

For Your Information: Vendor software submitters please check with your vendor to ensure your software will be able to capture the criteria necessary to submit the 837 with the required NDC information.

Please Note: Claims lines billed with an inappropriate NDC or no NDC when required will result in a denial from MC.

1.17 – Unlisted and Non-Specific CPT and HCPCS Codes Subject to Prepayment Review

MC lines of business has changed the way unlisted and non-specific CPT and HCPCS codes are reviewed and paid. Below please find our listing of unlisted and non-specific CPT and HPCPS Codes subject to prepayment review. Please note that not all unlisted codes may be covered by AHCCCS.

Unlisted and Non-Specific CPT and HCPCS Codes Subject to Prepayment Review

Code	Code Description
01999	UNLISTED ANESTHESIA PROCEDURE
15999	UNLISTED PROCEDURE EXCISION PRESSURE ULCER
17999	UNLISTED PROCEDIRE SKIN MUC MEMB & SUBQ TISSUE
19499	UNLISTED PROCEDURE BREAST
20999	UNLISTED PROCEDURE MUSCSKELETAL SYSTEM GENERAL
21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE
21299	UNLISTED CRANIOFACIAL & MAXILLOFACIAL PROCEDURE
21499	UNLISTED MUSCULOSKELETAL PROCEDURE HEAD
21899	UNLISTED PROCEDURE NECK/THORAX
22899	UNLISTED PROCEDURE SPINE
22999	UNLISTED PROC ABDOMEN MUSCULOSKELETAL SYSTEM
23929	UNLISTED PROCEDURE SHOULDER
24999	UNLISTED PROCEDURE HUMERUS/ELBOW
25999	UNLISTED PROCEDURE FOREARM/WRIST
26989	UNLISTED PROCEDURE HANDS/FINGERS

27299	UNLISTED PROCEDURE PELVIS/HIP JOINT
27599	UNLISTED PROCEDURE FEMUR/KNEE
27899	UNLISTED PROCEDURE LEG/ANKLE
28899	UNLISTED PROCEDURE FOOT/TOES
29799	UNLISTED PROCEDURE CASTING/STRAPPING
29999	UNLISTED PROCEDURE ARTHROSCOPY
30999	UNLISTED PROCEDURE NOSE
31299	UNLISTED PROCEDURE ACCESSORY SINUSES
31599	UNLISTED PROCEDURE LARYNX
31899	UNLISTED PROCEDURE TRACHEA BRONCHI
32999	UNLISTED PROCEDURE LUNGS & PLEURA
33999	UNLISTED CARDIAC SURGERY
36299	UNLISTED PROCEDURE VASCULAR INJECTION
37501	UNLISTED VASCULAR ENDOSCOPY PROCEDURE
37799	UNLISTED PROCEDURE VASCULAR SURGERY
38129	UNLISTED LAPAROSCOPY PROCEDURE SPLEEN
38589	UNLISTED LAPAROSCOPY PROC LYMPHATIC SYSTEM
38999	UNLISTED PROCEDURE HEMIC OR LYMPHATIC SYSTEM
39499	UNLISTED PROCEDURE MEDIASTINUM
39599	UNLISTED PROCEDURE DIAPHRAGM
40799	UNLISTED PROCEDURE LIPS
40899	UNLISTED PROCEDURE VESTIBULE MOUTH
41599	UNLISTED PROCEDURE TONGUE FLOOR MOUTH
42299	UNLISTED PROCEDURE PALATE UVULA
42699	UNLISTED PROCEDURE SALIVARY GLANDS/DUCTS
42999	UNLISTED PROCEDURE PHARYNX ADENOIDS/TONSILS
43289	UNLISTED LAPAROSCOPIC PROCEDURE ESOPHAGUS
43499	UNLISTED PROCEDURE ESOPHAGUS
43659	UNLISTED LAPAROSCOPIC PROCEDURE STOMACH
43999	UNLISTED PROCEDURE STOMACH
44238	UNLISTED LAPAROSCOPY PROC INTESTINE EXCEP RECTUM
44799	UNLISTED PROCEDURE SMALL INTESTINE
44899	UNLISTED PROC MECKEL'S DIVERTICULUM & MESENTERY
44979	UNLISTED LAPAROSCOPY PROCEDURE APPENDIX
45399	UNLISTED PROCEDURE COLON
45499	UNLISTED LAPAROSCOPY PROCEDURE RECTUM

45999	UNLISTED PROCEDURE RECTUM
46999	UNLISTED PROCEDURE ANUS
47379	UNLISTED LAPAROSCOPIC PROCEDURE LIVER
47399	UNLISTED PROCEDURE LIVER
47579	UNLISTED LAPAROSCOPY PROCEDURE BILIARY TRACT
47999	UNLISTED PROCEDURE BILIARY TRACT
48999	UNLISTED PROCEDURE PANCREAS
49329	UNLISTED LAPAROSCOPIC PROC ABDOMEN PERTONEUM & OMENTUM
49659	UNLISTED LAPS PROC HERNIOPLASTY HERNIORRHAPHY HERNIOTOMY
49999	UNLISTED PROCEDURE ABDOMEN PERITONEUM & OMENTUM
50549	UNLISTED LAPAROSCOPY PROCEDURE RENAL
50949	UNLISTED LAPAROSCOPY PROCEDURE URETER
51999	UNLISTED LAPAROSCOPY PROCEDURE BLADDER
53899	UNLISTED PROCEDURE URINARY SYSTEM
54699	UNLISTED LAPAROSCOPY PROCEDURE TESTIS
55559	UNLISTED LAPROSCOPY PROCEDURE SPERMATIC CORD
55899	UNLISTED PROCEDURE MALE GENITAL SYSTEM
58578	UNLISTED LAPAROSCOPY PROCEDURE UTERUS
58579	UNLISTED HYSTEROSCOPY PROCEDURE UTERUS
58679	UNLISTED LAPAROSCOPY PROCEDURE OVIDUCT/OVARY
58999	UNLISTED PROC FEMALE GENITAL SYSTEM NONOBSTETRICAL
59897	UNLISTED FETAL INVASIVE PROC W/ULTRASOUND
59898	UNLISTED LAPAROSCOPY PROC MATERNITY CARE & DELIVERY
59899	UNLISTED PROCEDURE MATERNITY CARE & DELIVERY
60659	UNLISTED LAPAROSCOPY PROCEDURE ENDOCRINE SYSTEM
60699	UNLISTED PROCEDURE ENDOCRINE SYSTEM
64999	UNLISTED PROCEDURE NERVOUS SYSTEM
66999	UNLISTED PROCEDURE ANTERIOR SEGMENT EYE
67299	UNLISTED PROCEDURE POSTERIOR SEGMENT
67399	UNLISTED PROCEDURE EXTRAOCULAR MUSCLE
67599	UNLISTED PROCEDURE ORBIT

67999	UNLISTED PROCEDURE EYELIDS
68399	UNLISTED PROCEDURE CONJUNCTIVA
68899	UNLISTED PROCEDURE LACRIMAL SYSTEM
69399	UNLISTED PROCEDURE EXTERNAL EAR
69799	UNLISTED PROCEDURE MIDDLE EAR
69949	UNLISTED PROCEDURE INNER EAR
69979	UNLISTED PROCEDURE TEMPORAL BONE MIDDLE FOSSA
76496	UNLISTED FLUOROSCOPIC PROCEDURE
76497	UNLISTED COMPUTED TOMOGRAPHY PROCEDURE
76498	UNLISTED MAGNETIC RESONANCE PROCEDURE
76499	UNLISTED DIAGNOSTIC RADIOGRAPHIC PROCEDURE
76999	UNLISTED ULTRASOUND PROCEDURE
77299	UNLISTED PROC THER RADIOL CLINICAL TX PLANNING
77399	UNLISTED MEDICAL RADJ DOSIM TX DEV SPEC SVCS
77499	UNLISTED PROCEDURE THERAPEUTIC RADIOLOGY TX MGMT
77799	UNLISTED PROCEDURE CLINICAL BRACHYTHERAPY
78099	UNLISTED ENDOCRINE PX DX NUCLEAR MEDICINE
78199	UNLIS HEMATOP RET/ENDO&LYMPHATIC DX NUC MED
78299	UNLISTED GASTROINTESTINAL PX DX NUCLEAR MEDICINE
78399	UNLISTED MUSCULOSKELETAL PX DX NUCLEAR MEDICINE
78499	UNLISTED CARDIOVASCULAR PX DX NUCLEAR MEDICINE
78599	UNLISTED RESPIRATORY PX DX NUCLEAR MEDICINE
78699	UNLISTED NERVOUS SYSTEM PX DX NUCLEAR MEDICINE
78799	UNLISTED GENITOURINARY PX DX NUCLEAR MEDICINE
78999	UNLISTED MISCELLANEOUS PX DX NUCLEAR MEDICINE
79999	RADIOPHARMACEUTICAL THERAPY UNLISTED PROCEDURE
80299	QUANTITATION OF THERAPEUTIC DRUG, NOT ELSEWHERE CLASSIFIED
81099	UNLISTED URINALYSIS PROCEDURE
81479	UNLISTED MOLELCULAR PATHOLOGY PROCEDURE
81599	UNLISTED MULTIANALYTE ASSAY ALGORITHMIC ANALYSIS
84999	UNLISTED CHEMISTRY PROCEDURE
85999	UNLISTED HEMATOLOGY & COAGULATION PROCEDURE
86486	SKIN TEST UNLISTED ANTIGEN EACH
86849	UNLISTED IMMUNOLOGY

86999	UNLISTED TRANSFUSION MEDICINE PROCEDURE
87797	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), NOT OTHERWISE SPECIFIED, DIRECT PROVE TECHNIQUE, EACH ORGANISM
87798	INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA), NOT OTHERWISE SPECIFIED, AMPLIFIED PROBE TECHNIQUE, EACH ORGANISM
87799	INFECTIOUS AGENT DETECTION BY NUCLIEC ACID (DNA OR RNA), NOT OTHERWISE SPECIFIED, QUANTIFIATION, EACH ORGANISM
87899	INFECTIOUS AGENT DETECTION BY IMMUNOASSAY WITH DIRECT OPTICAL (I.E. VISUAL OBSERVATION, NOT OTHERWISE SPECIFIED
87999	UNLISTED MICROBIOLOGY
88099	UNLISTED NECROPSY PROCEDURE
88199	UNLISTED CYTOPATHOLOGY PROCEDURE
88299	UNLISTED CYTOGENETIC STUDY
88399	UNLISTED SURGICAL PATHOLOGY PROCEDURE
88749	UNLISTED IN VIVO LABORTORY SERVICE
89240	UNLISTED MISCELLANEOUS PATHOLOGY
89398	UNLISTED REPRODUCTIVE MEDICINE LAB PROCEDURE
90399	UNLISTED IMMUNE GLOBULIN
90749	UNLISTED VACCINE/TOXOID
90899	UNLISTED PSYCHIATRIC SERVICE/PROCEDURE
90999	UNLISTED DIALYSIS PROCEDURE, INPT. OR OUTPT.
91299	UNLISTED DIAGNOSTIC GASTROENTEROLOGY PROCEDURE
92499	UNLISTED OPHTHALMOLOGICAL SERVICE/PROCEDURE
92700	UNLISTED OTORHINOLARYNGOLOGICAL SERVICE
93799	UNLISTED CARDIOVASCULAR SERVICE/PROCEDURE
93998	UNLISTED NONINVASIVE VASCULAR DIAGNOSTIC STUDY
94799	UNLISTED PULMONARY SERVICE/PROCEDURE
95199	UNLISTED ALLERGY/CLINICAL IMMUNOLOGIC SRVC/PX
95999	UNLIS NEUROLOGICAL/NEUROMUSCULAR DX PX
96379	UNLISTED THERAPEUTIC PROPH/DX IV/IA NJX/NFS
96549	UNLISTED CHEMOTHERAPY PROCEDURE
96999	UNLISTED SPECIAL DERMATOLOGICAL SERVICE/PROCED

97039	UNLIST MODALITY SPEC TYPE&TIME CONSTANT ATTEND
97139	UNLISTED THERAPEUTIC PROCEDURE SPECIFY
97799	UNLISTED PHYSICAL MEDICINE/REHAB SERVICE/PROC
99199	UNLISTED SPECIAL SERVICE PROCEDURE/REPORT
99429	UNLISTED PREVENTIVE MEDICINE SERVICE
99499	UNLISTED EVALUATION AND MANAGEMENT SERVICE
99600	UNLISTED HOME VISIT SERVICE/PROCEDURE
A0999	UNLISTED AMBULANCE SERVICE
A4335	INCONTINENCE SUPPLY; MISCELLANEOUS
A4421	OSTOMY SUPPLY; MISCELLANEOUS
A4649	SURGICAL SUPPLY; MISCELLANEOUS
A4913	MISCELLANEOUS DIALYSIS SUPPLIES NOS
A6549	GRADIENT COMPRESSION STOCKING/SLEEVE NOS
A9152	SINGLE VIT/MINERAL/TRACE ELEMENT ORAL-DOSE NOS
A9153	MX VIT W/WO MINERLS&TRACE ELEMS ORL PER DOSE NOS
A9280	ALERT OR ALARM DEVICE NOT OTHERWISE CLASSIFIED
A9699	RADIOPHARMACEUTICAL THERAPEUTIC NOC
A9900	DME SUP/ACCESS/SRV-COMPON/OTH HCPCS
A9999	MISCELLANEOUS DME SUPPLY OR ACCESSORY NOS
B9998	NOC FOR ENTERAL SUPPLIES
B9999	NOC FOR PARENTERAL SUPPLIES
C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS
E0676	INTERMITTENT LIMB COMPRESSION DEVICE NOS
E1229	WHEELCHAIR PEDIATRIC SIZE NOS
E1699	DIALYSIS EQUIPMENT NOT OTHERWISE SPECIFIED
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE NOC
H0047	ALCOHOL AND/OR OTHER DRUG ABUSE SERVICES NOS
K0462	TEMP REPL PT OWNED EQUIP BEING REPR ANY TYPE
K0899	PWR MOBILTY DVC NOT CODED DME PDAC/NOT MEET CRIT
L0999	ADD TO SPINAL ORTHOTIC NOT OTHERWISE SPECFIED
L1499	SPINAL ORTHOSIS NOT OTHERWISE SPECIFIED
L2999	LOWER EXTREMITY ORTHOSES NOT OTHERWISE SPECIFIED
L3649	ORTHOPED SHOE MODIFICATION ADDITION/TRANSFER NOS
L3999	UPPER LIMB ORTHOSIS NOT OTHERWISE SPECIFIED
L5999	LOWER EXTREMITY PROSTHESIS NOS

L7499	UPPER EXTREMITY PROSTHESIS NOS
L8499	UNLISTED PROC MISCELLANEOUS PROSTHETIC SERVICES
L8699	PROSTHETIC IMPLANT NOT OTHERWISE SPECIFIED
L9900	ORTHO&PROS SPL ACSS&/SRVC CMPNT OTH HCPCS L CODE
Q4050	CAST SUPPLIES UNLISTED TYPES&MATERIALS OF CASTS
Q4051	SPLINT SUPPLIES MISCELLANEOUS
Q4082	DRUG OR BIOLOGICAL NOC PART B DRUG CAP
Q5009	HOSPICE/HOME HEALTH CARE PROVIDED IN PLACE NOS
S5001	PRESCRIPTION DRUG BRAND NAME
S5199	PERSONAL CARE ITEM NOS EACH
S9542	HOME INJ TX NOC W/CARE COORDINATION PER DIEM
S9999	SALES TAX
T1505	ELECTRONIC MEDICATION COMPLIANCE MANAGE DEVC NOS
T1999	MISC TX ITEMS & SPL RETAIL PURCHASE NOC
T5999	SUPPLY NOT OTHERWISE SPECIFIED
V2599	CONTACT LENS OTHER TYPE
V2799	VISION ITEM OR SERVICE MISCELLANEOUS
V5274	ASSISTIVE LEARNING DEVICE NOS
V5299	HEARING SERVICE MISCELLANEOUS

With a few exceptions listed below, these codes will no longer be managed through the prior authorization process. They will be managed **By Report** at the time of claim submission. That is, records supporting the use of these codes must be submitted with the claim. These claims will pend to our AMA Edit Team who will review for:

- Experimental/Investigational status per relevant Clinical Policy Bulletins
- Medical necessity applying relevant criteria
- Assignment of a more appropriate specific code if one exists
- Approval to pay as submitted

Codes not included in the process change are:

- 41899 - General Anesthesia for dental procedures - Prior Authorization Required
- E1399 and K0108 - wheelchair components and services - Prior Authorization Required
- 90999 - unlisted dialysis procedure - Prior Authorization Required
- Unlisted J codes - Prior Authorization Required

If medical records are not submitted with your claim, the claim will be denied for lack of documentation. You may resubmit the claim with required supporting records.

1.18 – Date Spans

MC does accept claims billed in a date span, however, the way this should be billed differs depending on the type of code billed. The National Uniform Claim Committee provides instructions on how to bill on the 1500 claim form. These instructions include the following guidance:

- The number of days billed must correspond with the number of units in box 24G on the 1500 claim form.

The following examples note the appropriate way to bill for date spans:

- For codes that are billed in 15-minute increments, billing through a date span is not appropriate, whether the dates are consecutive or not. The number of units in box 24G do not correspond directly to the number of dates billed in the date span.
- The claim can be billed as a multi-line claim with a line for each date with its own unique units. Please click on the link to review:

EXAMPLES OF APPROPRIATE DATE SPAN BILLING

MC monitors the submission of date span claims. Date span claims that are not appropriately billed may be subject to denial.

Per AHCCCS, effective with dates of service beginning February 17, 2023, and forward, Provider Types (77) Behavioral Health Outpatient Clinic and (IC) Integrated Clinics submitting claims to MC must list a single claim line for each date of service equal to one (1) day of service, CPT/ HCPCS code and the total units for each line of service. MC will align our process with AHCCCS direction.

CHAPTER 2 – PROFESSIONAL CLAIM TYPES BY SPECIALTY

2.0 – Laboratory Services

Sonora Quest Laboratories, a subsidiary of Laboratory Sciences of Arizona ("SQ") is MC's in-network provider of laboratory services for all lines of business. Providers shall only refer members to SQ for laboratory services unless prior authorization is obtained for an out-of-network laboratory provider. Services rendered by an out-of-network laboratory provider will be denied if prior authorization is not obtained.

If your practice location does not presently have a relationship with Sonora Quest Laboratories, please contact their Sales Support Department at 602-685-5285. Sonora Quest Laboratories will work closely with your practice to assure a smooth transition takes place. Please feel free to contact Sonora Quest's website at **http://www.sonoraquest.com/** to access current laboratory locations.

Additional requirements for labs are as follows:

- ALL genetic testing requests must be authorized in advance. The prior authorization staff will direct you to the appropriate laboratory service provider for the test that you are requesting.
- Please DO NOT send any MC members or lab specimens drawn in the office to a hospital reference laboratory for services. All laboratory testing can be provided by Sonora Quest Laboratories.
- Since Sonora Quest is MC's preferred lab, we only allow the following lab services to be reimbursed in the physician office setting:

CPT Code	CPT Description
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, non-automated, without microscopy
81025	Urine pregnancy test, by visual color comparison methods

82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple cards for consecutive collection)
82962	Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use
83026	Hemoglobin; by copper sulfate method, non-automated
83036 QW	Hemoglobin; glycosylated (A1C)
83037 QW	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
83655	Lead
83861 QW	Microfluidic analysis utilizing an integrated collection and analysis device, tear osmolarity
85013	Blood count; spun microhematocrit
85014 QW	Blood count; hematocrit (Hct)
85018 QW	Blood count; hemoglobin (Hgb)
85610 QW	Prothrombin time
85651	Sedimentation rate, erythrocyte; non-automated
86308 QW	Heterophile antibodies; screening
86328	Immunoassay for infectious agent antibody(ies), qualitative or semiqualitative, single step method (e.g., reagent strip); severe] acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease {COVID-19])
86580	Skin test; tuberculosis, intradermal
87210 QW	Smear, primary source with interpretation; wet mount for infectious agents
87426 QW	SarsCov Coronavirus AG IA
87428 QW	SarsCov & Inf Vir A&B AG IA
87635 QW	SarsCov2 Covid19 Amp Prb
87636 QW	SarsCov2 & Inf A&B Amp Prb
87637 QW	SarsCov2 & Inf A&B&RSV Amp Prb
87804 QW	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
87811 QW	SarsCov2 Covid19 W/Optic
87880 QW	Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A
U0002	SARS-CoV-2/2019-nCoV (COVID-19 2019 novel coronavirus (2019-ncov) realtime rt-pcr diagnostic panel

0240U	Nfct DS Vir Resp RNA 3 Trgt
0241U	Nfct DS Vir Resp RNA 4 Trgt

Definitive Urine Drug Tests – HCPCS Codes G0480-G0483

Based on a recent **article** from the Office of the Inspector General (OIG), Drug testing is generally used to detect the presence or absence of drugs in patients undergoing treatment for pain management or substance use disorders. Payments for definitive drug testing services increase based on the number of drug classes tested. The Centers for Medicare & Medicaid Services (CMS) identified overpayments for the definitive drug testing service with the highest reimbursement amount (HCPCS code G0483, definitive drug testing for 22 or more drug classes) due to noncompliance with Medicare requirements. In addition, a prior OIG report on drug testing services identified that payments for G0483 were at risk for overpayments.

In accordance with CMS, MC conducts audits on these codes to validate medical necessity. CMS defines medical necessity as follows:

"Services must be under accepted standards of medical practice and considered to be specific and effective treatment for the patient's condition. The amount, frequency, and duration of the services planned and provided must be reasonable."

MC's intent is to review these codes for overutilization as well. This not only applies to MCA, but to all Medicaid Plans as well. Medical records must be substantiated to prove billing codes of G0480-G0483 are warranted. This will be conducted through medical necessity review via medical records.

2.1 – Influenza and Vaccine Guidelines

MC would like to provide you with the latest information regarding influenza vaccine for the current flu season.

You can help your patients reduce their risk for contracting seasonal flu and serious complications by using every office visit or encounter as an opportunity to recommend they take advantage of MC and MCA's coverage of the annual flu shot.

MC and MCA members have been informed there are several ways they can get their flu shot:

- Visit their PCP.
- Visit a participating pharmacy that offers the flu vaccine, i.e., CVS, Walgreens, Walmart, etc.
- Visit an urgent care facility.

- If the member resides in a Skilled Nursing Facility, the flu shot will be provided directly to the member. Please note that flu shots need to be billed with room and board in order to avoid encounter denials. Claims not billed in this manner will be denied.
- Or call their case manager.

Please always refer to your most recent CPT or HCPCS code guidelines for appropriate billing of claims.

MCCC, MCLTC, MC RBHA, MC DD, and MC DCS CHP Influenza Vaccine Resources

Arizona Vaccine News is available from the Arizona Department of Health Services (ADHS) for current influenza information.

IMPORTANT NOTE: If the flu vaccine is given as part of the Vaccine for Children's Program, an SL modifier must be appended to the vaccine code. In addition, administration codes should be billed with 90460-90461 or 90471-90474 codes, not G0008.

For additional information regarding the Vaccine for Children Program, please refer to **Section 3.4 – Vaccine for Children Program**.

MCA Influenza Vaccine Resources

For additional information concerning influenza vaccines, please feel free to refer to the CMS **Vaccine Pricing page on the CMS** website.

2.2 – Synagis Guidelines

Respiratory syncytial virus (RSV) season typically begins on November 1st of each year and continues through March of the following year. Synagis (palivizumab) injections to prevent RSV may be provided by any provider for MC and submitted with CPT Code **90378 -** *Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each.*

Synagis (palivizumab) injections do not require prior authorization.

2.3 – Anesthesia

Anesthesia claims are billed on a 1500 (02-12) form and must include the start and stop time for anesthesia administration, with the total time indicated in the units' field.

Anesthesia Services Provided in a Physician's Office

All services provided by a non-participating provider require prior authorization from MC. This includes anesthesia services provided in an office by a non-participating anesthesiologist. While

the office where services are rendered may be a participating provider, the non-participating anesthesiologist providing anesthesia services requires prior authorization.

Anesthesia Services Provided in an Inpatient or Outpatient Facility

Anesthesia services are included under the authorization for an inpatient facility or outpatient facility authorization. A separate authorization is not required. If a surgical procedure requiring authorization is not authorized, services will be denied for anesthesia as well.

Anesthesia Calculations

Anesthesia services (except epidurals) require the continuous physical presence of the anesthesiologist or certified registered nurse anesthetist (CRNA).

Anesthesiologists and CRNAs must enter the appropriate American Society of Anesthesiologists (ASA) code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of MINUTES in Field 24G of the CMS 1500 claim form.

The begin and end time of the anesthesia administration must be entered on the claim on the line immediately below Field 24D/ ASA code. The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim.

MC, in accordance with AHCCCS, follows the limits and guidelines as established by ASA for base and time unit. Every 15 minutes or any portion thereof is equal to one unit of time. MC will calculate units based on minutes billed for most anesthesia procedures. MC adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established fee for service base rate to obtain the allowed amount.

The current base rate is $32.12 per unit. The base rate may change on an annual basis, in accordance with the AHCCCS fee schedule, but has not changed since October 1, 2020. We will update the base rate in this manual as it changes.

2.4 – Radiology

eviCore healthcare administers prior authorization services for complex radiology services for MC. Services requiring authorization but performed without authorization may be denied for payment, and you may not seek reimbursement from members.

Prior authorization is required for the following complex radiology services:

- CT/CTA
- MRI/MRA
- PET

Please refer to MC's Participating Provider Authorization Requirement Search Tool (ProPat) available in Availity for the ability to review which services require authorization and which do not. You must have an **Availity** login to access this tool.

Services performed in conjunction with an inpatient stay, observation, or emergency room visit are not subject to authorization requirements.

To request an authorization from eviCore healthcare, please submit your request online, by phone or by fax to:

- Log onto the **eviCore healthcare Online Web Portal.**
- Call eviCore healthcare at 888-693-3211.
- Fax an **eviCore healthcare Request Form** (available online at the eviCore healthcare Online Web Portal) to 888-693-3210.

In order to avoid unnecessary denials, it's important to submit medical necessity documentation along with your request to support the need for these services.

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please call eviCore healthcare's toll-free number for expedited authorization reviews. Be sure to tell the representative the authorization is for medically urgent care.

eviCore healthcare recommends that ordering physicians secure authorizations and pass the authorization numbers to the rendering facilities at the time of scheduling. eviCore healthcare will communicate authorization decisions by fax to both the ordering physicians and requested facilities. Authorizations contain authorization numbers and one or more CPT codes specific to the services authorized. If the service requested is different than what is authorized, the rendering facility must contact eviCore healthcare for review and authorization prior to claim submission. If not done, this could result in claim denials.

2.5 - Obstetrical Billing

Referrals

As outlined in the Provider Manual, a woman may self-refer to an OB/GYN for obstetrical care and that provider serves as the member's PCP while pregnant. A member may also self-refer for gynecological services as well.

Referrals to Maternity Care Health Practitioners may occur in two ways:

- A pregnant member may self-refer to any contracted Maternity Care Practitioner.
- A PCP may refer pregnant members to a contracted Maternity Care Practitioner.

At a minimum, Maternity Care Practitioners must adhere to the following guidelines:

- Coordinate the member's maternity care needs until completion of the postpartum visits.
- Schedule a minimum of one postpartum visit at postpartum.
- When necessary, refer members to other practitioners in accordance with the MCP referral policies and procedures.
- Schedule return visits for members with uncomplicated pregnancies consistent with the American College of Obstetrics and Gynecology standards:
    - Through twenty-eight weeks of gestation – once every four weeks
    - Between twenty-nine- and thirty-six-weeks' gestation every two weeks
    - After the thirty sixth week – once a week

Prior Period Coverage (PPC)

MC is responsible for reimbursing providers for covered services rendered to recipients during the *Prior Period Coverage* (PPC) time frame. The PPC is the period between the recipients starting date of AHCCCS eligibility and the date of enrollment with a contractor. If the Total OB Package falls within the prior period coverage timeframe, then it is applicable to the Total OB Package reimbursement rules.

Payment of TOB Package

MC will reimburse Obstetrics services on a fee for services basis, unless specifically contracted in a different manner. Billing should be in accordance with Current Procedural Terminology (CPT®) rules.

The services normally provided in uncomplicated maternity case include antepartum care, delivery, and postpartum care. A TOB would normally be billed when a member sees only one OB provider group through the pregnancy and has the same insurance coverage.

A TOB initially starts after a pregnancy diagnosis has been established. Per the American Congress of Obstetricians and Gynecologists (ACOG), as an example, if a patient presents with signs or symptoms of pregnancy or has had a positive home pregnancy test and is there to confirm pregnancy, this visit may be reported with the appropriate level E/M CPT code. However, if the OB record is initiated at this visit, then the visit becomes part of the TOB package and is not billed separately. If the pregnancy has been confirmed by another physician, you would not bill a confirmation of pregnancy visit.

The confirmation of pregnancy visit is typically a minimal visit that may not involve face to face contact with the physician (for an established patient). The physician may draw blood and

prescribe prenatal vitamins during this initial visit and still report it as a separate E/M service if the OB record is not started.

CPT codes used for the TOB package include:

- **59400** – *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care*
- **59510** – *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care*
- **59610** – *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery*
- **59618** – *Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery*

Descriptions of Service

The following descriptions of service and inclusive services come from CPT:

- **Antepartum Care** - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation and weekly visits until delivery. Any other visits or services within this period should be coded separately.
- **Delivery Services** - includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. When reporting delivery only service (CPT codes 59410, 59515, 59614, or 59622) include delivery services and all inpatient and outpatient postpartum services.
- **Medical Problems** – medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the Medicine and Evaluation and Management Services section in CPT, in addition to codes for maternity care.

  Medical complications of pregnancy could include:
  - Cardiac problems
  - Diabetes
  - Hyperemesis
  - Hypertension
  - Neurological problems

- Premature rupture of membranes
- Pre-term labor
- Toxemia
- Other medical problems complicating labor and delivery

Surgical complications of pregnancy could include:

- Appendectomy
- Bartholin cyst
- Hernia
- Ovarian Cyst
- Other medical complications, i.e., drug abuse

- **Postpartum Care Only Services (59430)** - include office or other outpatient visits following vaginal or cesarean section delivery.

Multiple Births

The initial delivery of the first baby will be payable at the appropriate fee for service rate and should be billed with the appropriate CPT delivery code that applies.

Subsequent delivery of each additional baby should be billed with appropriate **delivery only** code with a 51-modifier appended to each. Those CPT codes are as follows:

- **59409** – *Vaginal delivery only (with or without episiotomy and/or forceps)*
- **59612** – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)*
- **59514** – *Cesarean delivery only*
- **59620** – *Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery*

The rate payable for each subsequent delivery will be 50% of the allowable amount for the above codes. The only exception to the above is if the provider's contract specifically addresses a different reimbursement methodology.

Billing for Multiple Fetal Non-Stress Tests (CPT Code 59025)

Fetal non-stress tests can be billed with a maximum of two units per visit. AHCCCS does not allow any more than 2 separate fetal non-stress tests per day per fetus. Appropriate billing when 2 separate fetal non stress tests are required is listed below:

- Single pregnancy – no more than 2 units per day
- Twins – no more than 4 units per day
- Triplets – no more than 6 units per day

CPT codes should be billed in the following manner for multiple births to alleviate services being denied as a duplicate (example provided is for twins):

1. Claim line one – **59025** – 1 or 2 (maximum) units
   Claim line two – **59025 – 76** (*Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional*) – 1 or 2 (maximum) units
   Or
2. Claim line one – **59025** – 1 or 2 (maximum) units
   Claim line two – **59025 – 77** (*Repeat Procedure by Another Physician or Other Qualified Health Care Professional*) – 1 or 2 (maximum) units

Total maximum units for the day could be:

- 2 units per line with a total of 4 units per day for twins
- 3 units per line with a total of 6 units per day for triplets
- Etc.

PLEASE NOTE: Claims billing must match medical records. While AHCCCS allows a maximum of 2 units per day, if a physician only performed 1 unit per day per fetus, it must be billed in accordance with services provided by physician.

Broken TOB Package

There may be times when a transfer of care may occur from one provider to another during a pregnancy. If a physician or physician group provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to a referral to another physician or physician group for delivery, this would be considered a broken TOB package. Those cases require special billing and follow CPT code guidelines as follows:

- For 1 – 3 antepartum care visits, use appropriate E&M CPT code, i.e., **99201 - 99215**.
- For 4 – 6 antepartum care visits, use CPT code **59425** – *Antepartum care only: 4-6 visits.*
- For 7 or more antepartum care visits, use CPT code **59426** – *Antepartum care only; 7 or more visits.*
- Providers in group practices may not unbundle the global delivery code when a recipient receives OB services from more than one provider in the same group and delivery is performed by a provider in the same group.

Other codes available in CPT that represent broken TOB package include:

Delivery Only CPT Codes that Include Postpartum Care

Delivery codes including postpartum care CPT codes are as follows:

- **59410** – *Vaginal delivery only (with or without episiotomy and/or forceps), including postpartum care.*
- **59515** – *Cesarean delivery only; including postpartum care.*
- **59614** – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care.*
- **59622** – *Cesarean delivery only, following attempted vaginal deliver after previous cesarean delivery; including postpartum care*

Delivery Only CPT Codes

The following CPT codes will be billed if provider is only billing for delivery services:

- **59409** – *Vaginal delivery only (with or without episiotomy and/or forceps).*
- **59514** – *Cesarean delivery only.*
- **59612** – *Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps).*
- **59620** – *Cesarean delivery only following attempted vaginal delivery after previous cesarean delivery.*

Postpartum Care Only CPT Code

A provider billing for postpartum care only should bill code **59430** – *Postpartum care only (separate procedure).*

If the provider only billed a portion of the global routine obstetric care, the service is reported with codes that describe that portion of the service as delivery only or postpartum care only, based on the delivery method.

Authorization is no longer required for the TOB package.

Please refer to Availity, under the ***Mercy Care PA Search Tool,*** for additional prior authorization guidelines for each plan.

Appropriate Claim Billing Examples

AHCCCS AMPM Policy 410 on Maternity Care Services notes that first and last prenatal care dates of service, as well as the number of obstetrical visits that the member has with the provider are recorded on all claim forms submitted to the Contractor regardless of the payment methodology uses.

Based on this, MC will require that you bill in the following manner:

Example 1: TOB Package Claims

Dates of Service		Place of Service	Procedures, Services or Supplies		$ Charges	Days or Units
From	To		CPT/HCPCS	Modifiers		
2/19/2013	2/19/2013	11	99213		$0.00	1
3/19/2013	3/19/2013	11	99213		$0.00	1
4/16/2013	4/16/2013	11	99213		$0.00	1
5/14/2013	5/14/2013	11	99213		$0.00	1
6/11/2013	6/11/2013	11	99213		$0.00	1
7/9/2013	7/9/2013	11	99213		$0.00	1
8/6/2013	8/6/2013	11	99213		$0.00	1
8/20/2013	8/20/2013	11	99213		$0.00	1
9/3/2013	9/3/2013	11	99213		$0.00	1
9/10/2013	9/10/2013	11	99213		$0.00	1
9/17/2013	9/17/2013	11	99213		$0.00	1
9/24/2013	9/24/2013	11	99213		$0.00	1
10/01/2013	10/01/2013	21	59400		$2,200.00	1
11/12/2013	11/12/2013	11	99213		$0.00	1

All pre- and post-natal care information is necessary for MC to report these required statistics to AHCCCS. No dollar amount is billed for the pre- and post-natal dates, as payment is included in the delivery. Only the delivery CPT code would have a billed amount.

Please Note: MC will pay obstetrical claims upon receipt of claim after delivery and will not postpone payment for inclusion of the postpartum visit. Postpartum services must be

provided to members within 60 days of delivery utilizing a separate "zero-dollar" claim for the postpartum visit.

Example 2: Broken OB Package Claims

Initial Provider – Services provided for greater than 7 visits for antepartum care.

Dates of Service		Place of Service	Procedures, Services or Supplies		$ Charges	Days or Units
From	To		CPT/HCPCS	Modifiers		
2/19/2013	2/19/2013	11	99213		$0.00	1
3/19/2013	3/19/2013	11	99213		$0.00	1
4/16/2013	4/16/2013	11	99213		$0.00	1
5/14/2013	5/14/2013	11	99213		$0.00	1
6/11/2013	6/11/2013	11	99213		$0.00	1
7/9/2013	7/9/2013	11	99213		$0.00	1
8/6/2013	8/6/2013	11	99213		$0.00	1
8/20/2013	8/20/2013	11	99213		$0.00	1
9/3/2013	9/3/2013	11	99213		$0.00	1
9/10/2013	9/10/2013	11	99213		$0.00	1
9/17/2013	9/17/2013	11	99213		$0.00	1
9/24/2013	9/24/2013	11	59426		$800.00	1

Second Provider – Patient was out of town and a different doctor not in the same practice delivered the baby and is providing postpartum care.

Dates of Service		Place of Service	Procedures, Services or Supplies		$ Charges	Days or Units
From	To		CPT/HCPCS	Modifiers		
10/1/2013	10/1/2013	21	59410		$1,500.00	1
11/12/2013	11/12/2013	11	99213		$0.00	1

All pre- and post-natal care information is necessary for MC to report these required statistics to AHCCCS. No dollar amount is billed for the pre- and post-natal dates, as payment is included in the specific CPT code. Only the CPT code for the type of OB package being billed would have a billed amount.

In every broken OB package type, both post-and pre-natal care information needs to be billed in the same manner as the above examples.

Please Note: MC will pay obstetrical claims upon receipt of claim after delivery and will not postpone payment for inclusion of the postpartum visit. Postpartum services must be provided to members within 60 days of delivery utilizing a separate "zero-dollar" claim for the postpartum visit.

Important Note: When billing via a paper claim, the total amount of the claim should be listed on the last page, along with the service that generates payment.

Maternal/Fetal – High Risk Pregnancy

A member may be referred to a maternal/fetal specialist at any time either due to a high-risk pregnancy or as a high-risk medical complication of pregnancy develops. **All services** provided by a maternal/fetal specialist are paid on a fee for service basis outside of the TOB.

2.6 – Physical, Occupational and Speech Therapy

Physical Therapy (PT)

PT is medically ordered treatments to restore, maintain or improve muscle tone, joint mobility, or physical function and to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired, per **A.R.S. §32-2001**.

MC covers medically necessary PT services for members in an inpatient or outpatient setting, when services are ordered by the member's PCP/attending physician as follows:

- Inpatient PT services are covered for all members who are receiving inpatient care at a hospital, nursing facility or custodial care facility.
- Outpatient
    - Outpatient PT services are covered for members under the age of 21 when medically necessary.
    - Outpatient PT services are covered for adult members, 21 years of age and older (Acute and ALTCS) as specified in A.A.C. R9-22-215 and A.A.C. R9-28-206 as follows:
        - 15 PT visits per benefit year for the purpose of **restoring** a skill or level of function and **maintaining** that skill or level of function once restored, and
        - 15 PT visits per benefit year for the purpose of **acquiring** a new skill or a new level of function and **maintaining** that level of function once acquired.
            - Medically necessary PT for above visit limitations may be provided in the same contract year but the limits still apply.
            - There are some procedure codes that may apply to visit limitations.
            - MC must ensure visits are approved as required in this policy.
            - For members under MCA, Medicare cost sharing and outpatient therapy limits apply.
            - A visit is PT services received in one day.
    - Outpatient settings include, but are not limited to:
        - Therapy clinics,
        - Outpatient hospitals units,
        - FQHCs, physicians' offices, and
        - Home health settings.
    - PT services shall be provided by a qualified Physical Therapist or by a qualified individual under the supervision of Physical Therapist within their scope of practice, and consistent with A.R.S. Title 32, Chapter 19 and ADHS administrative rules, 4 A.A.C. Chapter 24.
    - Outpatient PT is not covered as a maintenance regimen. Authorized treatment services include, but are not limited to:
        - The administration and interpretation of tests and measurements performed within the scope of practice of PT as an aid to the member's treatment,
        - The administration, evaluation and modification of treatment methodologies and instruction, and

- The provision of instruction or education, consultation, and other advisory services.

Occupational Therapy (OT)

OT is medically ordered treatments to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost, or reduced by illness of injury, or to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired. OT is intended to improve the member's ability to perform those tasked required for independent functioning, per **A.R.S. §32-3401**.

MC covers medically necessary OT services provided to all members who are receiving inpatient care at a hospital, nursing facility, and custodial care facility when services are ordered by the member's PCP/attending physician. Inpatient OT consists of evaluation and therapy.

Outpatient OT services are a MC covered benefit, when medically necessary as described below:

- Outpatient OT services are covered for ALTCS members and members under the age of 21, when medically necessary.
- Outpatient OT services are covered for Acute members, 21 years of age and older as follows:
  - 15 OT visits per benefit year for the purpose of **restoring** a skill or level of function and **maintaining** that skill or level of function once restored, and
  - 15 OT visits per benefit year for the purpose of **acquiring** a new skill or a new level of function and **maintaining** that skill or level of function once acquired.
    - Medically necessary OT for both of above may be provided in the same contract year but the 15 visit limits for each OT category above applies.
    - There are some procedure codes that may apply to both visits listed above. MC must ensure visits are approved as required in this policy.
    - For MC members who are also Medicare beneficiaries, Medicare cost sharing and the outpatient therapy limits apply.
- A visit represents OT services received in one day. Outpatient settings include, but are not limited to:
  - Therapy clinics,
  - Outpatient hospitals units,
  - FQHCs, physicians' offices, and
  - Home health settings.
- OT services must be provided by a qualified Occupational Therapist or by a qualified individual under the supervision of an Occupational Therapist within their scope of

practice, and consistent with **A.R.S. Title 32, Chapter 34** and ADHS administrative rules, **4 A.A.C. Chapter 43**.

- OT services may include, but are not limited to:
    - Cognitive training,
    - Exercise modalities,
    - Hand dexterity,
    - Hydrotherapy,
    - Joint protection,
    - Manual exercise,
    - Measuring, fabrication or training in use of prosthesis, arthrosis, assistive device, or splint,
    - Perceptual motor testing and training,
    - Reality orientation,
    - Restoration of activities of daily living,
    - Sensory reeducation, and
    - Work simplification and/or energy conservation.

Speech Therapy (ST)

ST is the medically ordered provision of diagnostic and treatment services that include evaluation, diagnostic and treatment services that include evaluation, program recommendations for treatment and/or training in receptive and expressive language, voice, articulation, fluency, rehabilitation, and medical issues dealing with swallowing.

- MC covers medically necessary ST services provided to all members who are receiving inpatient care at a hospital, nursing facility or custodial care facility when services are ordered by the member's PCP or attending physician. ST provided on an outpatient basis is covered only for members receiving EPSDT services, KidsCare and ALTCS members. Speech therapy for MC DD members is covered for all ages.
- ST shall be provided by a qualified Speech Language Pathologist (SLP) or by a qualified individual under the supervision of an SLP within their scope of practice, and consistent with **A.R.S. Title 36, Chapter 17** and ADHS administrative rules, **9 A.A.C. Chapter 16.**
- The SLP must be identified as the treating provider and bill for services under his or her individual NPI number (a group ID number may be utilized to direct payment).
- ST may include:
    - Articulation training,
    - Auditory training,
    - Cognitive training,
    - Esophageal speech training,

- Fluency training,
- Language treatment,
- Lip reading,
- Non-oral language training,
- Oral-motor development, and
- Swallowing training

Outpatient Rehabilitation Modifiers

MC has implemented CMS policy guidance relative to outpatient rehabilitation services to all Medicaid lines of business. This extends a uniform coding requirement consistent with CMS standards for Medicaid outpatient rehabilitation services.

According to the CMS claims processing manual, all claims for outpatient rehabilitation therapy services must be reported using a uniform coding system. The current HCPCS/CPT is used for the reporting of these services and must include specific modifier(s) to distinguish the discipline of the plan of care under which the service is delivered to track and administer benefit limits set in place by AHCCCS under **AMPM 310-X.**

The uniform coding requirement is specific to payment for physicians, non-physician practitioners (NPPs), physical therapist private practice (PTPP), occupational therapist private practice (OTPP), speech therapist private practice (SLPP), comprehensive outpatient rehabilitation facility (CORF), outpatient physical therapy (OPT), hospital, skilled nursing facility (SNF), and any others billing for physical therapy, speech-language pathology, or occupational therapy services that are provided and billed to MC programs.

The codes are as follows:

Modifier Codes

GN – Services delivered under an outpatient speech-language pathology plan of care
GO – Services delivered under an outpatient occupational therapy plan of care
GP – Services delivered under an outpatient physical therapy plan of care

To appropriately distinguish between habilitative and rehabilitative services and ensure accurate claims processing, providers must append the appropriate modifiers. These modifiers are required in addition to the CMS/AHCCCS therapy modifiers GN, GO, and GP.

96 – Habilitative Services – When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified

health care professional may add modifier 96 to the service or procedure code to indicate the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

97 – Rehabilitative Services – When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt or disabled.

The **CMS Therapy Code List and Disposition Table** for the current year provides more specifics on the items noted below.

Therapy Disposition Column Codes

Column Code 5 – These codes are "always therapy" services regardless of who performs them. These codes always require a therapy modifier – GP, GO, or GN – to indicate that they've furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively.

Column Code 7 – These HCPCS/CPT codes represent "somethings therapy" services. However, these codes are "always therapy" services when furnished by a therapist and in this situation require the use of a therapy modifier – GP, GO, or GN – in order to indicate the service is furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively.

When these "sometimes therapy" codes are not considered therapy servi8ces, the therapy thresholds and therapy modifiers do not apply. Codes marked "7" are not therapy services when:

- It is not appropriate to bill the service under a therapy plan of care, and
- They are billed by practitioners who are not therapists, e.g. physicians, clinical nurse specialists, nurse practitioners, physician assistants, and psychologists.

While this disposition designates that a particular HCPCS/CPT code will not of itself always indicate that a therapy service was rendered, these codes always represent therapy services

when rendered by therapists or by practitioners who are not therapists in situations where the service provided is integral to an outpatient rehabilitation therapy plan of care. For these situations, these codes must always have a therapy modifier. For example, when the service is rendered by either a Doctor of Medicine or a nurse practitioner (acting within the scope of his or her license when performing such service), with the goal of rehabilitation, a therapy modifier is required. When there is doubt about whether a service should be part of a therapy plan of care, the contractor shall make that determination.

Column Code 9 - These evaluation and re-evaluation codes require a specific therapy modifier – GP, GO, or GN – to indicate when the evaluative service is furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively.

In addition to Modifiers GN, GO, and GP the provider will also need to define the type of service, with either the 96 (Habilitative services) or 97 (Rehabilitative services) modifier.

2.7 – Home Health Claims

MC covers medically necessary home health services provided in the recipient's place of residence in lieu of hospitalization. MC also covers home health services for elderly and physically disabled and developmentally disabled MCLTC recipients under Home and Community Based Services.

Covered services include:

- Home health nursing visits
- Home health aide services
- Medically necessary supplies
- Therapy services within certain limits

Home health nursing and home health aide services must be provided on an intermittent basis and ordered by a physician.

All home health services require prior authorization from MC or the MCLTC's case manager.

All home health agencies must bill for services on a CMS 1500 claim form.

Home health nursing services

Home health nursing services must be billed with the following codes:

S9123 - *Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used)*

S9124 - *Nursing care, in the home; by licensed practical nurse, per hour*

Private duty nursing services (RN or LPN)

Private duty nursing services (RN or LPN) for ventilator dependent individuals at home who require more care than is defined as part-time or intermittent must be billed as follows:

Registered nurse (RN) services must be billed with the following code and modifier:

S9123 billed with **TG** modifier – *Nursing care, in the home; by registered nurse, per hour (complex/high level of care)*

Licensed Practical Nurse (LPN) services must be billed with the following code and modifier:

S9124 billed with **TG** modifier – *Nursing care, in the home; by licensed practical nurse, per hour (complex/high level of care)*

Respiratory therapy services

Respiratory therapists must bill with the following code:

S5180 - *Home health respiratory therapy, initial evaluation*

Respiratory therapists may not use the ventilator management codes 94002 – 94005 CPT codes. Physicians and hospitals will continue to use CPT codes 94002 - 94005.

MCA Claims

Claims submitted for MCA are paid based on the terms of the of the provider's contract for fee for service reimbursement.

For MCA, participating home health agencies must bill for services on a CMS 1500 claim form, the same as MC.

Non-participating home health agencies must bill in the same manner as they would Medicare.

2.8 - Well Visits

MC Medicaid Lines of Business

All MC's Medicaid lines of business cover adult well visits (well exams) such as, but not limited to, well woman exams, breast exams, and prostate exams. These are covered for members 21 years of age and older. Most well visits include a medical history, physical exam, health screenings, health counseling and medically necessary immunizations.

In addition, female members will have direct access to preventive and well care services from a gynecologist within MC's network, without a referral from a primary care provider.

MCA Initial Preventive Physical Examination (IPPE)

The Initial Preventive Physical Examination (IPPE) is also known as the "Welcome to Medicare Preventive Visit." The goals of the IPPE are health promotion and disease prevention and detection. Medicare pays for one IPPE per beneficiary per lifetime for beneficiaries within the first 12 months of the effective date of the beneficiary's first Medicare Part B coverage period. This service must be billed with CPT code:

> **G0402** - *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment*

For additional information regarding the IPPE, please click on the following link from CMS:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

MCA Annual Wellness Visit (AWV)

Per CMS guidelines for the Annual Wellness Visit (AWV): *When you provide a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service in addition to the AWV, Medicare may pay for the additional service. Report the Current Procedural Terminology (CPT) code with modifier -25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury or to improve the functioning of a malformed body member*.

Below are the appropriate CPT billing codes for the Annual Wellness Exams:

> **G0438** - *Annual Wellness Visit including a personalized prevention plan of service (initial visit)*
>
> **G0439** - *Annual wellness visit including a personalized prevention plan of service (subsequent visit)*

The following links will take you to the CMS MLN Network and documents that further explain all components of the AWV and the IPPE:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

2.9 – Hospice

MC Medicaid Lines of Business

Hospice services provide palliative and supportive care for all terminally ill members, as well as their families or caregivers. A physician must certify that the member is terminally ill. Hospice care is limited to those members who are in the final stages of a terminal illness (i.e., members who have a prognosis of death within six months).

The initial physician certification is effective for 90 days. If the member continues to need services, the physician must re-certify for a second 90-day period. Subsequent re-certifications for 60-day periods are required if the member continues to require hospice services.

A hospice uses a medically directed interdisciplinary care team of professionals and volunteers to meet the physical, psychological, social, spiritual, and other special needs which are experienced during the final stages of illness, during dying, and bereavement.

Hospice services include:

- Nursing services
- Respite care
- Bereavement services
- On-call availability for reassurance
- Information and referral for members and families
- Social services
- Pastoral/counseling services
- Dietary services
- Homemaker services
- Home health aide services
- Therapies
- Medical supplies, appliances, and DME
- Pharmaceuticals

Hospice services may be provided in the member's home (a nursing facility can be considered a member's home) or in an inpatient setting.

Home care may be provided on an intermittent, regularly scheduled, and/or an on-call, around the-clock basis according to member and family needs.

Non-institutional hospice services may be provided in the member's home if the member’s condition remains stable enough for the member to remain at home.

Billing and Authorization Requirements
Hospice services require authorization for all lines of business.

Hospice providers must bill for services on the UB-92 claim form using bill types 081X - 082X. The last digit must be 1 through 4 or 6 through 8.

Payment is made to a hospice provider for only one of four revenue codes. MC's reimbursement rates for the four levels of service are all-inclusive rates that include durable medical equipment, medication, and other health care services (physician) related to the recipient's terminal illness.

Recipients requiring medical services not related to the terminal illness may receive them without having payment for these services included in the all-inclusive rate. Acute medical care services in this instance are non-inpatient services provided to ALTCS eligible recipients who are not covered by Medicare. Acute medical care services must be coordinated between the primary care physician and the case manager.

The following revenue codes may be billed to MC. (NOTE: Medicare claims with A, B, C, or D in the third digit cannot be processed. They refer only to the Notice of Election for Medicare.)

Revenue Code 651 (Routine Home Care Day)

- A routine home care day is a day during which a recipient is at home (or in a nursing facility) and not receiving continuous care.
- Reimbursement is the lesser of the hourly rate multiplied by the hours billed or the per diem rate.
- When hospice care is furnished to a fee-for-service recipient in a nursing facility, the hospice should bill only for the routine home care rate.
- The nursing facility is reimbursed directly by MC for the room and board and other services furnished by the facility.

Revenue Code 652 (Continuous Home Care Day)

- A continuous home care day is a day during which a recipient receives services consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis as necessary to maintain terminally ill recipients at their places of residence. A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.
- Home health aide, homemaker services, or both may also be provided on a continuous basis.

- Continuous home care is not available to nursing facility residents.
- Reimbursement is the lesser of the billed charge or the MC hourly rate multiplied by the number of hours billed.

Revenue Code 655 (Inpatient Respite Care Day)

- An inpatient respite care day is a day during which a recipient receives care in an approved facility on a short-term basis. Institutional (inpatient hospice) services may be delivered at the provider's site or through subcontracted beds in an institutional setting such as a hospital or nursing facility when the recipient's condition is such that care can no longer be rendered in the recipient's home.
- The inpatient rate is paid from the date of admission up to, but not including the date of discharge.
- For the date of discharge, the appropriate home care rate is paid.
- If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.
- Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.

Revenue Code 656 (General Inpatient Care Day)

- A general inpatient care day is a day on which a recipient receives general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings.
- The inpatient rate is paid from the date of admission up to, but not including the date of discharge.
- For the date of discharge, the appropriate home care rate is paid.
- If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.

MCA

According to the Medicare Managed Care Manual, published by CMS, under **Chapter 4 – Benefits and Beneficiary Protections**, it states the following:

> ***"10.2.2 – Exceptions to Requirement for MA plans to Cover FFS Benefits***
> ***(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)***
> *The following circumstances are exceptions to the rule that MAOs must cover the costs of Original Medicare benefits:*
>
> ***Hospice:*** *Original Medicare (rather than the MAO) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan. For detailed*

information about services furnished to an enrollee who has elected hospice care, see section 10.4 below.

10.4 - Hospice Coverage
(Rev. 121, Issued: 04-22-16, Effective: 04-22-16, Implementation: 04-22-16)
As defined in 42 CFR § 422.320, an MA plans must inform each enrollee eligible for hospice care about its availability. This is true whether a Medicare hospice program is located within the plan's service area or if it is common practice to refer patients to hospice programs out the plan's service area.

An MA enrollee who elects hospice care but chooses not to dis-enroll from the plan is entitled to continue to receive through the plan any MA benefits other than those that are the responsibility of the hospice. Under such circumstances the MA plan is paid a reduced capitation rate for that enrollee by CMS and the MA plan is responsible for continued coverage of supplemental benefits. CMS pays (a) the hospice program for hospice care furnished to the enrollee and (b) the MA plan, providers, and suppliers for other Medicare-covered services furnished to the enrollee through the original Medicare program, subject to the usual rules of payment.

Table I summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

Types of Services	***Enrollee Coverage***	***Enrollee Cost-Sharing***	***Payments to Providers***
Hospice program	*Hospice program*	*Original Medicare cost-sharing*	*Original Medicare*
Non-hospice[1], Parts A & B	*MA plan or Original Medicare*	*MA plan cost-sharing if enrollee follows MA plan rules[3]*	*Original Medicare[2]*
		Original Medicare cost-sharing if enrollee does not follow MA plan rules[3]	*Original Medicare*
Non-hospice[1], Part D Supplemental	*MA plan (if applicable) MA plan*	*MA plan cost-sharing MA plan cost-sharing*	*MAO MAO*

Notes:
1) The term 'hospice care' refers to original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term 'non-hospice care' refers either to

services not covered by original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

2) If the enrollee chooses original Medicare for covered, non-hospice-care, original Medicare services, and follows MA plan requirements, then, the enrollee pays plan cost-sharing and original Medicare pays the provider. The MA plan must pay the provider the difference between original Medicare cost-sharing and plan cost-sharing, if applicable.

3) An HMO enrollee who chose to receive services out of network has not followed plan rules and therefore is responsible to pay FFS cost sharing; a PPO enrollee who receives services out of network has followed plan rules and is only responsible for plan cost sharing. The enrollee need not communicate to the plan in advance his/her choice of where services are obtained.

Please see the following resources for additional information:

- *The Social Security Act, Section 1853(h)(2)(B); and*
- *The Medicare Claims Processing Manual, Chapter 11 - Processing Hospice Claims, Section 30.4"*

The only claims payable during the hospice election period by MCA would be additional benefits covered under MCA that would not normally be covered under traditional Medicare-covered services. Please refer to the MCA website under **MCA Additional Benefits** for a listing of these additional benefits.

Per CMS guidelines, MCA is not responsible for a hospice member's claims while receiving a reduced CMS capitation payment, which may include dates after a member has revoked their hospice election. For more information, please refer to the Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance.

While a hospice election is in effect, all Medicare Part A and B services furnished from the election's effective date to revocation or expiration of the enrollee's hospice election should be submitted directly to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, until the first day of the month following the month in which hospice was revoked.

CMS provides notification of hospice election through eligibility files sent to MCA. In certain cases, MCA may be notified of a retro-election of hospice coverage by CMS, which may require recoupment of claims originally paid by MCA that should have been paid by a fee-for-service contractor of CMS. Recoupments will only be made within 365 days (1 year) from the date the

claim is received by MCA or eligibility posting deadline, whichever is later. The claim should then be submitted to the appropriate CMS fee-for-service contractor for consideration.

2.10 – Transportation Claims

MC follows regulatory guidelines for billing transportation claims. Please refer to **AHCCCS Fee For Service Manual - Chapter 14 – Transportation** or the **Medicare Claims Processing Manual – Chapter 15 - Ambulance** for additional detail.

MC

- **Emergency Transportation**
  - All members are covered for emergency transportation without prior authorization.

- **Non-Emergency Transportation**
  - MC members are eligible to receive medically necessary non-emergency transportation when there is no other means of transportation available. Transportation services include bus tickets, taxis, stretcher vans or wheelchair vans and non-emergency ambulances.
  - Providers may arrange medically necessary non-emergent transportation for MC members by calling Member Services at 602-263-3000 or 800-624-3879, Express Service Code 630.

MCA

- **Emergency Transportation**
  - All members are covered for emergency transportation without prior authorization.
  - MCA enrollees are not eligible for non-routine, non-medically necessary transportation, as it is not a Medicare covered benefit. MCA enrollees with either MCPLTC or MCP Acute are eligible for non-emergency transportation under their MCPLTC coverage. This benefit will be paid under MCPLTC/MCP Acute as the primary payor.

Non-Emergency Transportation Program Integrity Reviews

MC conducts program integrity reviews of transportation providers as well as other outpatient providers that provide transportation. Non-emergency transportation (NEMT) is an area in which there is potential risk to providers and to the health plans. There has been concern over potential fraud, waste, and abuse via non-emergency transportation billing. AHCCCS has specific guidelines noted for NEMT in their Provider Manual, AMPM policies and Covered Behavioral Health Services Guide which we encourage all providers to review.

Chapter 14 of the AHCCCS FFS Provider Manual states the following: *When free transportation services are unavailable and an eligible person is unable to arrange or pay for transportation, AHCCCS covers medically necessary non-emergency medical transportation to and from an AHCCCS covered medical or behavioral health service for most members. Non-emergency medical transportation is not covered for Federal Emergency Services Program recipients.* ***Transportation is limited to the cost of transporting the recipient to the nearest AHCCCS registered provider capable of meeting the recipient's medical needs and transportation must only be provided to transport the recipient to and from the required, AHCCCS covered medical or behavioral health service.***

Please note that AHCCCS expects that the services are for covered medical and behavioral health services. Services should be limited to the cost of transporting the member to the nearest AHCCCS registered provider capable of meeting the member's needs. AHCCCS notes the following for behavioral health services*:*

Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered behavioral health services, allowing the person to achieve their service plan goals.

Please note that while this allows the person to receive transportation services to achieve their service plan goals, the services should be for medical necessary covered services and not simply to locations in which the member can benefit for their service plan goals. This could be argued to be anything or any location. We are charged with being good stewards of federal and state funds and we should be cognizant of utilizing these services in the most conservative manner possible while still allowing the members to benefit from the needed covered services.

For NEMT, there are two different billing scenarios:

- Loaded transportation (the member is with the staff)
- Provider travel (the provider is traveling to where the member is to provide a service)

AHCCCS FFS Manual Chapter 14 states the following regarding loaded mileage:

Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a recipient on board the vehicle and being transported to receive medically necessary AHCCCS covered medical or behavioral health services.

For all providers, please note that **loaded transportation** services should be billed with both the appropriate base rate (A0100, A0120) and the associated mileage (S0209, S0215). Claims/encounters should not be submitted without both codes for loaded transportation services. Split claims for NEMT services will be denied. Mileage and base rate do not begin until the member is in the vehicle with the driver. The transportation to pick-up the member is not billable in terms of mileage or time.

For **provider travel**, the member is not in the vehicle with the staff. The staff is traveling to where the member is to provide a service. This is billed utilizing code A0160 only. Per AHCCCS please note that this code is not billable for the first 25 miles. The first 25 miles are unencountered. The only mileage that can be billed is mileage over the 25-mile threshold. This is true for each segment of the trip. This code is **not billable** to for travel time/mileage when going to pick up the member for loaded transportation.

Each NEMT service should note the following items as noted in Chapter 14 of the FFS Provider Manual:

- Complete transport service provider's name, ID, address and phone number
- Printed name and signature of the driver who provided the service
- Complete date of service
- Vehicle identification:
    - State licensed
    - License plate number
    - Make and color of the vehicle
- Vehicle type (car, van, wheelchair van, stretcher, etc.)
- Member information
    - Member's full name
    - AHCCCS ID
    - Date of birth
    - Mailing address
- Complete address of pick-up destination
- Time of pick up
- Odometer reading at pick up
- Complete address of drop off destination
- Time of drop off
- Odometer reading at drop off
- Type of trip – one way or round trip
- Reason for the trip

    - Note: when NEMT services are initially arranged, the transportation provider must obtain sufficient information to determine whether the service is occurring to an AHCCCS covered service.
- Diagnosis
- Escort name and relationship to recipient being transported
- Member signature (or fingerprint) verifying services were rendered
- Driver's signature

AHCCCS does provide further clarification on the recipient signature. The following requirements should be noted:

- If the member is unable to sign or utilize a fingerprint, the parent/guardian, caretaker/escort, or family member can sign for the member. The relationship to the member must be noted.
    - If the member that is unable to sign is traveling alone, the trip report may be signed by the provider at the medical or behavioral health service appointment.
- The driver can never sign for the member.

Please ensure that documentation for NEMT includes all items as noted above. Documentation via a spreadsheet or screenshots of maps does not capture all the required elements.

In terms of the base rate billed under A0100 or A0120 – while AHCCCS allows 5 units of this service to be billed per day per member, MC strongly recommends that only 2 units of this service be billed per day – once at the initial pickup and the second unit when the loading occurs to take the member home. While there may be intermittent stops during the trip, there is not sufficient reason to bill those additional units as the intent is not to start the transportation over, but rather to simply reload the member to continue the trip.

Pick-up and drop-off addresses are required to be submitted with each claim.

2.11 – Dental Claims

Effective January 1, 2026, Liberty Dental Plan administers dental benefits for MC Medicaid lines of business. Liberty Dental Plan has administrative oversight for the following responsibilities:

- Contracting
- Credentialing
- Patient Management
- Prior Authorization
- Claims
- Customer Service Calls from Providers

- Provider Appeals

MC will administer the following for our members:

- Grievances or Appeals
- Customer Service Calls from Members

Claims can be sent to Liberty Dental Plan at the following claims address:

Liberty Dental Plan
Attention: Claims
P.O. Box 401086
Las Vegas, NV 89140

For electronic claims submissions, Liberty Dental Plan works directly with the following Clearinghouses:

- DentalXchange (800-576-6412)
- Vyne Dental (463-218-6519)

You can contact your software vendor to make certain that they have Liberty Dental Plan listed as the payor and claim mailing address on your electronic claims. Your software vendor will be able to provide you with any information you may need to ensure that submitted claims are forwarded to Liberty Dental Plan. Liberty Dental Plan's Payor ID is CX083.

If you have additional questions regarding your claims for Liberty Dental Plan, you may contact them directly at 888-352-7924. They will be happy to assist you.

You may also utilize their Interactive Voice Response (IVR) system 24 hours a day, 7 days a week that provides up-to-date information regarding member eligibility, claim status, and much more. Benefits associated with this program and more detailed information regarding Liberty Dental Plan can be found in their Provider Reference Guide on-line at: **https://www.libertydentalplan.com/Resources/Documents/AZ-Provider-Reference-Guide.pdf**.

2.12 – Oral Surgery Claims

Oral surgery claims are considered medical in nature and need to be submitted to MC or MCA for claims processing. The claim should be submitted on a CMS 1500 (02/12) Form.

2.13 - Behavioral Health Claims

General Information

Please refer to MC's Provider Manual for further detail regarding Behavioral Health requirements. The Provider Manual can be found on our **Provider Manual** web page.

Available Resources

MC would like to provide you with additional detail that may not be found in the Provider Manual, above. These resources can assist you to accurately submit your behavioral health claims for payment.

AHCCCS Coding Resources

You may also refer to the **AHCCCS Coding Resources** web page for additional information regarding the AHCCCS Behavioral Health Services Matrix, Covered Behavioral Health Services Guide and Same Day Disallow Table.

Medication Management

PCPs may provide medication management (prescription of behavioral health medications, monitoring visits, associated laboratory tests) for MC members with attention deficit hyperactivity disorder (ADHD), anxiety, or depression. PCPs that provide treatment and medication management for these diagnoses must follow **Clinical Guidelines** adopted by MC for those conditions. The guidelines are kept current and are available on the MC website. MC's behavioral health coordinators and behavioral health medical director are available for consultation regarding the guidelines.

- MC covers prescriptions of these four behavioral health conditions when on the **Preferred Drug List**. Prior authorization is required for medications not on the preferred drug list.
- Prescriptions can be filled at any contracted MC pharmacy.

Any member who has a behavioral health condition other than the four disorders listed above, will be covered through MC for medication management and treatment by a behavioral health provider.

The following ICD-10 codes cover the diagnoses that may be treated by a PCP through treatment and medication management:

ICD-10 Diagnosis

Code	**Description**
F06.30	Mood disorder due to known physiological condition, unspecified
F06.31	Mood disorder due to known physiological condition with depressive features

F06.32	Mood disorder due to known physiological condition with major depressive-like episode
F06.34	Mood disorder due to known physiological condition with mixed features
F06.4	Anxiety disorder due to known physiological condition
F17.200	Nicotine dependence, unspecified, uncomplicated
F17.201	Nicotine dependence, unspecified, in remission
F17.203	Nicotine dependence, unspecified, with withdrawal
F17.208	Nicotine dependence, unspecified, with other nicotine-induced disorders
F17.209	Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
F17.220	Nicotine dependence, chewing tobacco, uncomplicated
F17.221	Nicotine dependence, chewing tobacco, in remission
F17.223	Nicotine dependence, chewing tobacco, with withdrawal
F17.228	Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
F17.229	Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
F17.290	Nicotine dependence, other tobacco product, uncomplicated
F17.291	Nicotine dependence, other tobacco product, in remission
F17.293	Nicotine dependence, other tobacco product, with withdrawal
F17.298	Nicotine dependence, other tobacco product, with other nicotine-induced disorders
F17.299	Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.9	Major depressive disorder, single episode, unspecified
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent, severe without psychotic features
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission

F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified
F34.1	Dysthymic disorder
F40.00	Agoraphobia, unspecified
F40.01	Agoraphobia with panic disorder
F40.02	Agoraphobia without panic disorder
F40.10	Social phobia, unspecified
F40.11	Social phobia, generalized
F40.210	Arachnophobia
F40.218	Other animal type phobia
F40.220	Fear of thunderstorms
F40.228	Other natural environment type phobia
F40.230	Fear of blood
F40.231	Fear of injections and transfusions
F40.232	Fear of other medical care
F40.233	Fear of injury
F40.240	Claustrophobia
F40.241	Acrophobia
F40.242	Fear of bridges
F40.243	Fear of flying
F40.248	Other situational type phobia
F40.290	Androphobia
F40.291	Gynephobia
F40.298	Other specified phobia
F40.8	Other phobic anxiety disorders
F40.9	Phobic anxiety disorder, unspecified
F41.0	Panic disorder [episodic paroxysmal anxiety]
F41.1	Generalized anxiety disorder
F41.3	Other mixed anxiety disorders
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F43.0	Acute stress reaction
F48.8	Other specified nonpsychotic mental disorders
F70	Mild intellectual disabilities
F71	Moderate intellectual disabilities
F72	Severe intellectual abilities
F73	Profound intellectual disabilities

F79	Unspecified intellectual disabilities
F84.0	Autistic Disorder
F90.0	Attention-deficit hyperactivity disorder, predominantly inattentive type
F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
F90.2	Attention-deficit hyperactivity disorder, combined type
F90.8	Attention-deficit hyperactivity disorder, other type
F90.9	Attention-deficit hyperactivity disorder, unspecified type
F98.0	Enuresis not due to a substance or know physiological condition
F98.1	Encopresis not due to a substance or known physiological condition

Coordination of Benefits

- If a member has MCA as their primary payor, we will coordinate benefits automatically with MC. MC is always the payor of last resort.
- If a member has MCA as their primary payor and the service is not covered by MCA, but covered under the member's MC Medicaid line of business, we will by-pass coordination of benefits and pay under their MC line of business.
- If a member has traditional Medicare or another Medicare Advantage plan and the service is covered by that plan, the claim will need to be sent to them primarily for payment. Once you receive the Medicare Explanation of Benefits (EOMB):
    - If submitting by paper, submit the claim and EOMB to MC to coordinate benefits.
    - If you are billing electronically, you may submit the primary payor's payment information in the appropriate reporting fields.

Appropriate Billing for T1016 – *Case Management*

HCPCS Code **T1016 - *Case management, each 15 minutes,*** is a supportive service to provide oversight and/or enhance and assist a member with identified treatment goals and monitor treatment effectiveness.

Activities may include:

- Assistance in maintaining, monitoring, and modifying covered services as outlined in the member's service plan to address an identified clinical need.
- Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team for the purpose of helping in accessing an identified clinical service with the goal of addressing a clinical need to enhance or maintain the member's clinical functioning.
- Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.
- Communication and coordination of care with the person's family, behavioral

and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies.
- Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g., personal assistant, nursing services and family counseling).
- Outreach and follow-up of crisis contacts and missed appointments.
- Participation in staffings, case conferences or other meetings with or without the person or their family participating; and
- Other activities as needed that address and or support the member with identified treatment needs.

Case management does not include:
- Administrative functions such as authorization of services and utilization review;
- Outreach and communication that is does not clinical in nature and directly related to the member's identified treatment needs, clinical presentation, and access to services.

Service Standards/Provider Qualifications

Case management services must be provided by individuals who are qualified behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals as defined in **9 A.A.C. 10**.

If case management services are not provided by behavioral health professionals, these services must be provided under their direction or supervision.

The following code modifiers may be billed with HCPC Code T1016:

- **T1016 HO**
  Case Management by Behavioral Health Professional - Office: Case management services (see general definition above for case management services) provided at the provider's work site.
  Provider Qualifications: Behavioral health professional
  Billing Unit: 15 minutes

- **T1016 HO**

Case Management by Behavioral Health Professional - Out-of-Office: Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.
Provider Qualifications: Behavioral health professional
Billing Unit: 15 minutes

- **T1016 HN**
  Case Management - Office: Case management services (see general definition above for case management services) provided at the provider's work site.
  Provider Qualifications: Behavioral health technician or Behavioral health paraprofessional
  Billing Unit: 15 minutes

- **T1016 HN**
  Case Management - Out-of-Office: Case management services (see general definition above for case management services) provided at a person's place of residence or other out-of-office setting.

Case management can be billed as either a face-to-face service or it can also be billed for non-face-to-face activities.

AHCCCS Billing Limitations

For case management services the following billing limitations apply:

- Services must meet the 8-minute rule requirements as noted in the AHCCCS Covered Behavioral Health Services Guide.
- Case management services provided by a DLS licensed inpatient, residential or in a therapeutic/medical day program setting are included in the rate for those settings and cannot be billed separately. However, providers other than the inpatient, residential facility or day program can bill case management services provided to the person residing in and/or transitioning out of the inpatient or residential settings or who is receiving services in a day program.
- A single provider may not bill case management for any time associated with a therapeutic interaction, nor simultaneously with any other services.
- Multiple provider agencies may bill for this service during the same period when more than one provider is simultaneously providing a case management service (e.g., a staffing). In addition, more than one individual within the same agency may bill for this service (e.g., individuals involved in transitioning a person from a residential level of care to a higher (subacute) or lower (outpatient) level of care, staff from each setting may bill case management when attending a staffing. When billing case management in

this situation, each staff billing for the service must clearly document their participation in the staffing and unique contribution to the discussion as related to the member's treatment goal.

- Billing for case management is limited to individual providers who are directly involved with service provision to the person (e.g., when a clinical team comprised of multiple providers, physicians, nurses etc. meet to discuss current case plans).
- Transportation provided to an AHCCCS Behavioral Health Services enrolled member is not included in the rate and should be billed separately using the appropriate transportation procedure codes.

MC Billing Requirements

Multiple case management services provided in one day billed under the same AHCCCS Provider ID must be rolled up into one claim line to avoid duplicate claim denials. Please also ensure that all services meet the 8-minute rule requirements as noted in the AHCCCS Covered Behavioral Health Services Guide.

T1016 - Case Management Review and Billing Concerns

It's important to note that MC may periodically audit provider billing practices by reviewing documentation to ascertain claims are being appropriately billed in accordance with MC and AHCCCS guidelines. Documentation must support appropriate billing for this code. If the documentation does not support the billing, additional administrative action may be taken, including the recoupment of the claim and potential reporting to AHCCCS.

MC has identified several concerns that may help you avoid inappropriate billing including:

- Multiple case management services provided in one day billed under the same AHCCCS Provider ID must be rolled up into one claim line.
- Administrative functions are not to be billed under case management or any other code.
- Appointment reminders or services that do not include actual clinical intervention should not be billed as case management or any other code.
- Services provided for care coordination or other purposes that do not involve actual clinical intervention should still be documented as contact notes but are not billable.
- Staffings should only be billed by individuals directly involved in the member's care and should only be billed for actual clinical discussion/intervention. Everyone must either write their own note.
- Having one individual dictate the note and having others sign it with the inclusion of a line such as "I participated in this staffing" is not sufficient.
- Case management cannot be billed simultaneously with any other services.

- Emails can be used in limited circumstances, but the email must be included in the record and should not be the main method of communication with the member.
- Voice messages can be billed in limited circumstances. Asking for a return call or appointment reminders are not billable. There should be sufficient documentation to justify the need to bill for the voice message. Listening to voice messages cannot be billed.
- T1016 should not be used as a catch-all to bill for services not otherwise billable under other covered service codes.
- Quality of the service is what drives billing, not quantity.
- Simply because the service meets the time guidelines to bill does not mean it should be billed. The main key is not the time but the intent of the service. Is the intent of the service the delivery of a clinical service/assessment or an administrative function?

Appropriate documentation to support the billing of this service is required.

Appropriate and Inappropriate Scenarios That Support the Billing of HCPCS Code T1016

Please remember that accurate documentation must be made to justify billing for T1016. The following are different scenarios of documentation submitted by providers. Please note that the 8-minute rule must be utilized to determine if services are billable, even if rolled up due to multiple eligible services being billed on the same date of service.

A patient is a no show for an appointment. An outreach call is made after the no show to assess safety.

If the case manager's intent is to outreach because the member missed an appointment and the case manager is asking about any increase in symptoms, immediate needs, status of medication refills, options for next appointment, scheduling the next appointment with confirmation from the member, transportation needs and any other needs between the phone call and next appointment, this detail would need to be in the documentation.

If the case manager calls to reschedule the appointment and asks the member if everything is OK, that does not substantiate billing T1016.

An SMI patient missed their injection today and the care team takes time to assess if an amendment and pick up order is warranted.

Clinical intervention intent would be to talk to the member about missing the injection, assessment of symptoms and need for higher level of care, adherence to COT, reason for medications related to wellness, barriers in missing the injection and the plan to get the member in for his/her injection that day. Care coordination with the team related to

amendment of a pick-up order would need to be discussed with clinical team/doctor, etc. This detail needs to be documented to bill for T1016.

If sufficient clinical intervention is not provided, it would be inappropriate to bill for T1016.

Group facilitator calls the transportation company to set up transport for patient to and from group.

This is an administrative function and does not warrant billing for T1016 – case management.

Care coordinator calls the guardian to check on status and complete the CASII.

Is the care manager only asking and recording the CASII score/response from the guardian or is there a clinical intervention/discussion in completing the CASSII? What is the purpose of getting the CASII - clinical evaluation of the scores and responses of the guardian and plan of action? Detail would need to be provided.

Substance use patient has a positive UA. Therapist, Care Coordinator, Nurse, and medical provider staff the case to discuss if patient should be detoxed.

What is the clinical discussion occurring with the group? Positive UA for what? What is the risk of the substance use, considerations of treatment referral and engagement plan with the member? Why did the member relapse? What are the treatment topics being reviewed and discussed to determine the clinical recommendation of detox vs another intervention? This needs to be detailed in the notes to qualify for T1016 billing.

It's important to remember that time is not the final determining factor in billing T1016. Questions that need to be answered and documented are whether the service is medically necessary and why? The documentation needs to clearly document the need. The key to appropriate documentation is that the content of the note justifies the care coordination (intent of the activity, discussion and outcome as related to the treatment plan for the member).

In addition to the above, more information can be found in AHCCCS **AMPM Policy 570 – Care Coordination Requirements**.

Applied Behavior Analysis

Behavior Analysis Services are a MC covered benefit for individuals with Autism Spectrum Disorder (ASD) and/or other diagnoses as justified by medical necessity.

Members must receive ABA services from a provider in MC's provider network. Medically necessary services, including ABA, are determined by the member's Child and Family Team (CFT) or Adult Recovery Team (ART).

Behavior Analysis Services are designed to accomplish one or more of the following:

- increase functional skills,
- increase adaptive skills (including social skills),
- teach new behaviors,
- increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health.

Behavior Analysis Services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional (BHP) as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Please refer to the ***Behavioral Health Services Billing Matrix*** on the **Medical Coding Resources** AHCCCS web page for more information regarding required coding information, including covered settings or other billing/coding information.

Behavioral Analysis providers are required to submit prior authorization for Adaptive Behavior **Treatments** (CPT Codes 97153-97158). Adaptive Behavior **Assessments** (CPT Codes 97151 and 97152) will not require authorization. Service(s) rendered without authorization may be denied for payment. For Behavioral Analysis services a specific prior authorization form has been developed for initial and re-authorization of services. To access the form and a list of required clinical documentation, visit our website under **Forms** web page named Prior Authorization for ABA Services. Prior authorization, if determined medically necessary, is approved for a maximum for 6 months, re-authorization will be required for continued service delivery.

The ABA service codes must be billed with the appropriate modifier to identify the experience level of the staff rendering the service.
Modifier tiers:

- BHT/RBT - Less Than Bachelor's Degree - Modifier HM
- Trainee, Master, BCaBA – Bachelor's Degree Level - Modifier HN
- BCBA - Master's Degree Level - Modifier HO
- BCBA-D - Doctoral Level - Modifier HP

2.14 - Family Planning Claims

Family planning services are funded and contracted through Aetna Medicaid Family Planning for MC. To pay family planning services through the Aetna Medicaid Family Planning fund, the following rules will apply:

- Any service billed with the following primary ICD-10 diagnoses will be paid as family planning:
  - Z30.011 – Encounter for initial prescription of contraceptive pills
  - Z30.012 – Encounter for prescription of emergency contraception
  - Z30.013 – Encounter for initial prescription of injectable contraception
  - Z30.014 – Encounter for initial prescription of uterine contraception
  - Z30.018 – Encounter for prescription of other contraceptives
  - Z30.19 – Encounter for initial prescription of contraceptives, unspecified
  - Z30.02 – Counseling and instruction in natural family planning to avoid pregnancy.
  - Z30.09 – Encounter for other general counseling and advice on contraception
  - Z30.40 – Encounter for surveillance of contraceptives, unspecified
  - Z30.41 – Encounter for surveillance of contraceptive pills
  - Z30.42 – Encounter for surveillance of injectable contraceptive
  - Z30.430 – Encounter for insertion of intrauterine contraceptive device
  - Z30.432 – Encounter for removal of intrauterine contraceptive device
  - Z30.433 – Encounter for removal and reinsertion of intrauterine contraceptive device
  - Z30.49 – Encounter for surveillance of other contraceptives
  - Z30.8 – Encounter for other contraceptive management
  - Z30.9 – Encounter for contraceptive management, unspecified
  - Z31.42 – Aftercare following sterilization reversal
  - Z31.62 – Encounter for fertility preservation counseling
  - Z31.84 – Encounter for fertility preservation procedure
- Any service billed with a modifier of FP will be paid as family planning (if the modifier is valid for the code).
- The following codes will always be paid as family planning regardless of the diagnosis or presence of the FP modifier:

CODE	DESCRIPTION
00851	ANES; TUBAL LIGATION/TRANSECTION
11976	REMOVAL WITHOUT REINSERTION, IMPLANT
55250	VASECTOMY, UNILATERAL OR BILATERAL (SEPARATE PROCEDURE), INCLUDING POSTOPERATIVE SEMEN EXAMINATION(S)

57170	DIAPHRAGM FITTING.WITH INSTRUCTIONS
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
58565	HYSTEROSCOPY BI TUBE OCCLUSION W/PERM IMPLNTS
58600	DIVISION OF FALLOPIAN TUBES
58605	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S), ABDOMINAL OR VAGINAL APPROACH, POSTPARTUM, UNILATERAL OR BILATERAL, DURING SAME HOSPITALIZATION (SEPARATE PROCEDURE)
58611	LIGATION OR TRANSECTION OF FALLOPIAN TUBE(S) WHEN DONE AT THE TIME OF CESAREAN DELIVERY OR INTRA-ABDOMINAL SURGERY (NOT A SEPARATE PROCEDURE) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
58615	OCCLUSION OF FALLOPIAN TUBE, DEVICE
58661	LAPAROSCOPY, SURGICAL; WITH REMOVAL OF ADNEXAL STRUCTURES
58670	LAPAROSCOPY, TUBAL CAUTERY
58671	LAPAROSCOPY, TUBAL BLOCK
59840	INDUCED ABORTION, BY DILATION AND CURETTAGE
59841	INDUCED ABORTION, BY DILATION AND EVACULATION
59850	INDUCED ABORTION BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS
59851	INDUCED ABORTION BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS WITH DILATION AND CURETTAGE AND OR EVACUATION
59852	INDUCED ABORTION BY 1 OR MORE INTRA-AMNIOTIC INJECTIONS WITH HYSTEROTOMY
59855	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES
59856	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES WITH DILATION AND CURETTAGE AND/OR EVACUATION
59857	INDUCED ABORTION, BY 1 OR MORE VAGINAL SUPPOSITORIES WITH HYSTEROTOMY
A4261	CONTRACEPTIVE SUPPLY
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE
A4267	CONTRACEPTIVE SUPPLY
A4268	CONTRACEPTIVE SUPPLY
A4269	CONTRACEPTIVE SUPPLY
J1050	DEPO-PROVERA INJ 1MG
J7297	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG, 3 YEAR DURATION
J7298	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, 52 MG, 5 YEAR DURATION

J7300	INTRAUTERINE COPPER CONTRACEPTIVE
J7301	LEVONORGESTREL-RELEASING INTRAUTERINE CONTRACEPTIVE SYSTEM, (SKYLA), 13.5 MG
J7304	CONTRACEPTIVE SUPPLY, HORMONE CONTAINING PATCH, EACH
J7306	LEVONORGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANTS AND SUPPLIES
J7307	ETONOGESTREL (CONTRACEPTIVE) IMPLANT SYSTEM, INCLUDING IMPLANT AND SUPPLIES
	ALL OTHER CONTRACEPTIVE DRUGS, SUPPLIES, AND ITEMS IDENTIFIED WITH AN NDC CODE

- Claims for medical services will only be accepted on **Form 1500 (02/12)**.
- Inpatient hospitalizations, outpatient surgery and emergency department facility claims should be filed on **CMS UB-04 Form**.
- Family Planning services may be billed with other services on the same claim. When billed on the same claim though, a provider will receive two remits, one for family planning services and one for non-family planning services, as these services are paid out of separate funds.
- Family Planning claims may be submitted electronically.

Providers must submit the following information:

- AHCCCS Provider ID number.
- Family planning service diagnosis (all claims **must** have a family planning service diagnosis).
- Explanation of Benefits from other insurance (including Medicare).
- Correctly signed and dated sterilization consent forms.
- The 30-day waiting period can be waived for emergent or medically indicated reasons.
- Operative reports for surgical procedures.
- Use HCPCS “J” codes, and provide the drug administered, NDC code and the dosage for injected substances.
- Anesthesia claims require an ASA code for surgery with the appropriate time reflected in minutes.
- For Family Planning Services Extension Program members, x-ray and lab charges will be paid as family planning if they are related to family planning. There must be a Family Planning Service diagnosis.
- A separate claim must be submitted for each date of service.

If you have authorization or claims questions related to family planning, please call:

Aetna Medicaid Administrators LLC
602-798-2745: Phoenix
888-836-8147: Outside Phoenix

Members may choose to obtain family planning services and supplies from an appropriate provider regardless of whether or not the family planning service providers are network providers. Members do not need prior authorization in order to obtain family planning services and supplies from an out-of-network provider.

2.15 – Podiatry

Medically necessary foot and ankle care is covered when provided by a podiatrist or podiatric surgeon, when ordered by the primary care provider, attending physician or practitioner, for MC eligible members. The member's medical record must document the order for the podiatrist service. The podiatrist or podiatric surgeon must be an AHCCCS registered provider.

When billing for a podiatrist's services, the CMS 1500 field 17 must have Qualifier DK and the ordering provider's name. Field 17b must have the ordering provider's NPI. Podiatrist claims will be denied if these fields are blank, or the ordering provider is not an AHCCCS registered provider.

In accordance with A.R.S. 32-801, podiatric physicians and surgeons may perform amputations of the partial foot and toe but are excluded from performing an amputation of the leg or entire foot and are excluded from administering an anesthetic other than local.

Foot and Ankle Care Limitations

Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to EPSDT members). A "contract year" is defined as October 1-September 30.

Coverage of mycotic nail treatments will not exceed one bilateral mycotic nail treatment (up to ten nails) per 60 days (this does not apply to EPSDT members).

Neither general diagnosis such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency or incapacitation injuries or illnesses such as rheumatoid arthritis, CVA (stroke) or fractured hip are diagnosis under which routine foot care is covered.

Bunionectomy is covered only when the bunion is present with overlying skin ulceration, or neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

Foot and Ankle Care Prior Authorization Requirements

Prior Authorization is not required for evaluation and management services. Elective surgical services are subject to Prior Authorization requirements. Please refer to our ProPat listing to determine if Prior Authorization is necessary.

2.16 – HEDIS Measures

HEDIS (Healthcare Effectiveness Data and Information Set) is a health care performance measurement tool used by more than 90 percent of America's health plans to measure performance on important dimensions of health care and services. MCA uses HEDIS results to make improvements in our quality of care and service.

HEDIS measures address a broad range of important health issues. Among them are the following:

- Adult BMI Assessment (ABA)
- Care for Older Adults (COA)
- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)
- Medication Reconciliation Post-Discharge (MRP)
- Transitions of Care (TRC)

Click on the items below for additional information on these HEDIS measures and the HEDIS medical record review process:

- **NCQA HEDIS® and Quality Compass®**
- **HEDIS Frequently Asked Questions**

In addition to the above, MC's Network Management Department has conducted recent webinars regarding the following:

- **Comprehensive Diabetes Care**
- **Gaps in Care Report**
- **Transitions of Care**

- Colorectal Cancer Screenings

Please click on the links to view these presentations in their entirety. These presentations are also available on our **Provider Training and Education** webpage under Network Management Webinars.

2.17 – Social Determinants of Health

As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of Social Determinants. Information about any Social Determinants should be included in the member's chart. Any Social Determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for MC members, to comply with state and federal coding requirements. **We strongly encourage the use of these ICD-10 codes, to give a complete picture of the member to meet their needs.**

Social Determinants of Health diagnosis codes **should never** be billed as the primary diagnosis code. These codes are **always** secondary. MC will deny claims where a Social Determinant of Health ICD-10 code is billed as a primary diagnosis code until a corrected claim is re-submitted.

For a list of ICD-10 codes relevant to Social Determinants of Health, please see **2021 Social Determinants of Health ICD-10 Diagnosis Codes**. The list of Social Determinants of Health codes may be added to or updated periodically. Providers should remain current in their use of these codes.

For more information regarding Social Determinants of Health, please reference the **AHCCCS Fee For Service Manual, Chapter 4, General Billing Rules**, on page 15, under **Social Determinants.**

These same billing rules apply to MCA as well.

2.18 – Chiropractic Claims

Medicaid Coverage

MC will cover up to 20 medically necessary chiropractic visits for adults each year. Services must be ordered by a primary care provider and within the scope of chiropractic practice as defined by state law. Additional chiropractic services may be authorized in the same year if determined to be medically necessary.

Traditional Medicare Coverage

Under Traditional Medicare, coverage is limited to manual manipulation for the treatment of subluxation. "Subluxation" is a term used by Chiropractors to describe a spinal vertebra that is

out of position in comparison to the other vertebrae. All other services furnished or ordered by chiropractors are not covered.

Traditional Medicare-Covered: Chiropractic manipulations for subluxation*

- 98940 Chiropractic manipulative treatment; spinal (1 to 2 regions)
- 98941 Spinal (3 to 4 regions)
- 98942 Spinal (5 regions)
- Modifier: AT
    - This modifier should be used when reporting service 98940, 98941, 98942. This modifier shouldn't be used when providing maintenance therapy.
- Only subluxation is covered. Medicare does not cover any other routine chiropractic services.

For more information regarding Medicare coverage, please click on the link to the following CMS web pages:

- **Medicare Benefit Policy Manual**
- **Medicare Coverage Database**

MCA Coverage

In addition to the Traditional Medicare chiropractic coverage available to MCA members, MCA also provides a Supplemental Chiropractic Benefit which allows 12 supplemental chiropractic routine visits every year with no copay.

These services include:

- Routine chiropractic services
    - Routine chiropractic is a supplemental benefit offered by MCA that covers chiropractic services that aren't covered under Original Medicare. Services may include therapies, manipulations, osteopathic adjustments, spinal decompression, PT, EMS, TEMS, Acupuncture, among others.
- Radiology including ultrasound
- DME

2.19 – Telehealth

MC covers medically necessary, non-experimental, and cost-effective services provided via telehealth. There are no geographic restrictions for telehealth; services delivered via telehealth are covered in both rural and metropolitan regions.

Telehealth may include healthcare services delivered via asynchronous (store and forward – reimbursement for this type of consultation is limited), remote patient monitoring, tele-dentistry, or telemedicine (interactive audio and video). See the AHCCCS Medical Policy Manual Policy 320-I for more information on reimbursable telehealth services.

Modes of Service Delivery

Service delivery via telehealth can be done via teledentistry, remote patient monitoring, telemedicine, or asynchronous (store and forward).

- Telehealth means services delivered via:
  - Asynchronous (store and forward);
  - Remote Patient Monitoring;
  - Teledentistry; or
  - Telemedicine (real-time interactive audio and video).
- Asynchronous or "Store and Forward" means the transmission of recorded health history (e.g., pre-recorded videos, digital data, or digital images, such as x-rays and photos) through a secure electronic communications system between a practitioner, usually a specialist, and a member or other practitioner, to evaluate the case or to render consultative and/or therapeutic services outside of a synchronous (real-time) interaction. As compared to a real-time member care, asynchronous care allows practitioners to assess, evaluate, consult, or treat conditions using secure digital transmission services, data storage services, and software solutions.
- Remote Patient Monitoring is the personal health and medical data collection from a member in one location via electronic communication technologies, which is transmitted to a provider in a different location for use in providing improved chronic disease management, care, and related support. Such monitoring may be either synchronous (real-time) or asynchronous (store and forward).
- Teledentistry is the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video, or data communications by an AHCCCS registered dental provider to a dentist at a distant site for triage, dental treatment planning, and referral.
- Telemedicine is the practice of synchronous (real-time) health care delivery, diagnosis, consultation, and treatment and the transfer of medical data through interactive audio and video communications that occur in the physical presence of the patient.
- Distant site means the site at which the provider delivering the service is located at the time the service is provided via telehealth.
- Originating site means the location of the AHCCCS member at the time the service is being furnished via telehealth or where the asynchronous service originates. This is considered the place of service.

Telehealth Conditions and Limitations

At the time-of-service delivery via real time telehealth an individual who is familiar with the member's condition may be present with the member. This is called a telepresenter.
Telepresenter services are not billable.

All services provided via telehealth must be medically necessary, non-experimental, and cost-effective for the diagnosis or treatment of a member's medical or behavioral health condition.

Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation is covered to transport a Title XIX or Title XXI member to and from the originating site to receive an AHCCCS covered medically necessary consultation or treatment.

Office Setting

Prolonged preventive services, beyond the typical service of the primary procedure, which require direct patient contact and occur in either the office or another outpatient setting are covered under telehealth for the MCA line of business. The following codes are examples:

- G0513 Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (listed separately in addition to code for preventive service).
- G0514 Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (listed separately in addition to code for preventive service).

Telehealth Billing Information

Claim Form

Claim Form Services shall be billed on a CMS 1500 claim form.

Providers

Telehealth, including Tele-dentistry services, may be provided by AHCCCS registered providers, within their scope of practice.

Place of Service (POS) **NOTE: To be used when billing on the CMS 1500 Claim form at the Capped FFS Rate.

The Place of Service (POS) listed on the CMS 1500 claim form shall be the originating site (where the AHCCCS member is located or where the asynchronous service originates).

- i.e., A member is located at a Rural Health Clinic (originating site) and the individual provider (who will submit the claim) is in their office (distant site). The POS listed on the claim (submitted by the individual provider) will be POS 72 (Rural Health Clinic).

NOTE: There is no POS field on the UB-04 Claim Form.

Codes

For a complete code set of services, along with their eligible place of service and modifiers, which can be billed as telehealth please visit the AHCCCS Medical Coding Resources web page at:

https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

For a full list of available POS and appropriate modifiers, refer to the AHCCCS Medical Coding Resources webpage at:

https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html

Medicare Dual Claims

For Medicare Dual members, claims may be submitted with the POS listed as 02 (Telemedicine) to comply with Medicare guidelines. The POS 02 (Telemedicine) will designate the service being provided as a telehealth service.

- i.e., A member is located at Rural Health Clinic (originating site) and the individual provider (who will submit the claim) is in their office (distant site). The POS listed on the claim (submitted by the individual provider) will not be POS 72 (Rural Health Clinic) but will instead be listed as POS 02.

NOTE: Medicare's telehealth coverage, conditions and limitations may vary from Medicaid's. However, for members with Medicare as the primary payer a claim must be submitted to Medicare first. The EOB would then be submitted to AHCCCS along with the claim. For additional information about the submission of claims for Medicare Dual members, including crossover claims, please refer to Chapter 9, Medicare/Other Insurance Liability, of the Fee-for-Service Provider Billing Manual.

Additional Information

For additional information on telehealth services, please refer to the AHCCCS Medical Policy Manual, AMPM 320-I, Telehealth Services.

The following codes have been approved to be billed in our system with an effective date of 7/1/2021. All scope of practice, coding, documentation, and policy requirements must be met for all codes submitted to AHCCCCS.

- 99446 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review.
- 99447 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review.
- 99448 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review.
- 99449 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medica consultative discussion and review.
- 99451 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.
- 99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.

2.20 – Continuous Glucose Monitoring

Continuous Glucose Monitors (CGM) are covered based on Medicare and AHCCCS criteria. Please ensure that you review all guidelines prior to billing for CGMs. AHCCCS has established prior authorization criteria for coverage of CGMs.

2.21 – CMS Opioid Treatment Program (OTP)

As of January 1, 2020, MC pays Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder (OUD) treatment services in an episode of care provided to people with MCA Part B (Medical Insurance).

Under the OTP benefit, Medicare covers:

- U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispending and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments

CMS released guidelines effective 1/1/21 for billing OTP providers. While CMS requires billing for the freestanding OTP services on a UB-04 form, MCA would like to continue to have providers bill services on a CMS-1500 form as the facility.

OTP services include:

- G2067-G2080
- G2215-G2216

Other important billing information:

- Outpatient hospitals are allowed to bill via UB-04 as it is required
- There is a new Condition Code for a provider-based OTP: 89
    - Hospital-based providers bill OTP services on TOB 013X and 085X effective January 2021
    - Use Revenue Codes 090x-091x, 0949 on TOB 013x, 085x, or 087x, when billing for OTP services
- For the OTP freestanding/facility billed for those codes listed, Place of Service 58 should be billed

Please review the **Opioid Treatment Programs (OTPs) Medicare Billing and Payment Fact Sheet** for additional information.

2.22 – Augmentative and Alternative Communication Device Systems (AAC)

For DD members, durable medical equipment and supplies will include augmentative and alternative communication device systems as of 10/1/2020.

For your convenience, we have developed an **Augmentative and Alternative Communication Device Systems (AAC) Provider Guideline**. Please click on the link to view in further detail.

This provider guide is intended for health care professionals such as physicians, speech language pathologists (SLP), occupational therapists (OT), and physical therapists (PT) who assist members considering augmentative and alternative communication (AAC) as a system of techniques and tools to address the needs of members with significant and complex communication disorders characterized by impairments in speech-language production and/or comprehension, including spoken and written modes of communication.

CHAPTER 3 – EARLY PERIODIC SCREENING AND DEVELOPMENTAL TESTING (EPSDT)

3.0 – Early Periodic Screening and Developmental Testing (EPSDT) General Overview

Providers have several responsibilities regarding Early Periodic Screening and Developmental Testing (EPSDT). These responsibilities are outlined in detail in our provider manuals. Outlined below are general claims billing requirements for EPSDT services.

3.1 – Well Child Visits

Children may receive additional inter-periodic screening at the discretion of the provider. MC does not limit the number of well-child visits those members under age 21 receive. Claims should be billed with the following ICD-10-CM Diagnosis Codes (effective 10/1/15 and after) based on age appropriateness:

Codes to Identify Well-Child Visits – ages 0 months through 20 years of age)

Well-Visit Ages New Patients	CPT Codes	ICD-10 Codes		Well-Visit Ages Established Patients	CPT Codes	ICD-10 Codes
Infant (Younger than 1 Year)	99381	Z00.110 Z00.111 Z00.121 Z00129		**Infant (Younger than 1 Year)**	99391	Z00.110 Z00.111 Z00.121 Z00.129
1-4 Years	99382	Z00.121 Z00.129		**1-4 Years**	99392	Z00.121 Z00.129
5-11 Years	99383	Z00.121 Z00.129		**5-11 Years**	99393	Z00.121 Z00.129
12-17 Years	99384	Z00.121 Z00,129		12-17 Years	99394	Z00.121 Z00.129
18 Years or Older	99385	Z00.00 Z00.01		18 Years or Older	99395	Z00.00 Z00.01

Well Child Visits for sports and other activities should be based on the most recent EPSDT Well Child Visit, as the annual Well Child Visits are comprehensive and should include all the services required for sports or other activities. AHCCCS does not cover sports or other physicals solely for that purpose. If it can be combined with a regularly scheduled EPSDT visit, it is covered, though no additional payment would be allowable for completing the school or other organization paperwork that would allow the child to participate in the activity.

Please ensure that you review AMPM Policy 430 and AMA CPT guidance if billing for "sick visits" performed at the same time as Well Child visits.

3.2 – Developmental Screening Tools

The following developmental screening tools are available for members at their EPSDT visit:

- **Ages and Stages Questionnaires™ Third Edition (ASQ)** is a tool which is used to identify developmental delays in the first 5 years of a child's life. The sooner a delay or disability is identified, the sooner a child can relate to services and support that make a real difference.
- **Ages and Stages Questionnaires®: Social-Emotional (ASQ:SE)** is a tool which is used to identify developmental delays for social-emotional screening.
- The **Modified Checklist for Autism in Toddlers (M-CHAT)** may be used only as a screening tool by a primary care provider, for members 16-30 months of age, to screen for autism when medically indicated.
- **The Parents' Evaluation of Developmental Status (PEDS)** may be used for developmental screening of EPSDT-aged members.

Providers may bill for this service if the following criteria is met:

- General Developmental screening for members aged 9, 18 and 30 months.
- Autism Specific developmental screening for members aged 18 and 24 months.
- Prior to providing the service, the provider is required to complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to CAQH. A copy of the screening tool must also be submitted to CAQH, regardless of the credentialing process. CAQH is not required for payment, but it is required for our EPSDT provider audits.
- The appropriate CPT code and modifier – 96110-EP - is billed. Copies of the completed tools must be retained in the medical record.

Per the EPSDT Policy Coding Resource document (updated 11/20/23):

An AHCCCS approved Developmental Screening tool shall have been completed. Accepted screening tools are described in the CMS core measure Developmental Screening in the First Three Years of Life - **https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_467_MIPSCQM.pdf**.

In addition, only for the 18-month EPSDT visit may the 96110 code be used twice as the clinical circumstances warrant more than one tool is used during this visit.

The use of AHCCCS approved Developmental Screening tools may be billed separately using CPT-4 code 96110 (Developmental Screening, with interpretation and report, per standardized instrumentation).
Providers shall bill for global developmental screenings by using Z13.42 - Encounter for Screening for Global Developmental Delays (milestones).

Providers shall not utilize Z13.42 to bill for domain-specific developmental delays (e.g., ASD).

3.3 – PCP Application of Fluoride Varnish

According to the **AHCCCS Medical Policy Manual (AMPM) under Policy 431 - EPSDT Oral Health Care,** a change was made that advises the Physician, Physician's Assistant or Nurse Practitioner must perform an oral health screening as part of the EPSDT physical examination. Please refer to this document if you have further questions about this change.

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least 6 months of age, with at least 1 tooth eruption. Additional applications occurring every 6 months during an EPSDT visit, up until the recipient's 2nd birthday, will also be reimbursed.

AHCCCS recommended training for fluoride varnish application is located at the **Smiles For Life** website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should submit a copy of their certificate to CAQH. This certificate will be used in the credentialing process to verify completion of training necessary for reimbursement.

Please use the following CPT code for billing this service:

99188 – *Application of topical fluoride varnish by a physician or other qualified health care professional*.

3.4 - Vaccines for Children Program

EPSDT covers all child and adolescent immunizations. Immunizations must be provided according to the **Advisory Committee on Immunization Practices (ACIP)** guidelines and be up to date. Providers are required to coordinate with the Arizona Department of Health Services' (ADHS) Vaccine for Children Program (VFC) to obtain vaccines for MCP members who are 18 years of age and under.

Additional information can be attained by calling **Vaccine for Children** at 602-364-3642 or by accessing their website.

Arizona law requires the reporting of all immunizations administered to children under 19 years old. Immunizations must be reported at least monthly to ADHS. Reported immunizations are held in a central database, the Arizona State Immunization Information System (ASIIS) that can be accessed online to obtain complete, accurate records.

Federal vaccines can no longer be used to immunize privately insured children. Although a newborn may be eligible for Medicaid, hospitals cannot make an absolute determination that a newborn is not also eligible for private insurance at the time that this immunization would be administered. Because of this, the hospitals face the potential of administering VFC vaccines to newborns against the federal requirements. Since many hospitals have dis-enrolled from the VFC program due to this new policy, newborns who are delivered at the facilities may not receive the birth dose of the Hepatitis B vaccine.

MC requests that all primary care providers and pediatricians caring for newborns review each member's immunization records fully upon the initial visit, and subsequent follow-up visits, regardless of where the child was delivered. It is our intention to ensure that the newborns receive all required vaccines, and that those who have not received the birth dose of the Hepatitis B vaccine in the hospital be "caught up" by their primary care provider.

Claims Coding

Providers must add the modifier SL (State Supplied Vaccine) to the following CPT Codes:

Code	Description
90460	*Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administration*
90461	*Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)*
90471	*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)*
90472	*Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*
90473	*Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)*

90474	*Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)*
90480	*Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, single dose*
G0312	*Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5 to 15 mins time.*
G0313	*Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 mins time.*
G0314	*Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 mins time*
G0315	*Immunization counseling by a physician or other qualified health care professional for COVID-19 for ages under 21, 5-15 minutes time*

This differs from previous instructions where the SL modifier was only added to the vaccine CPT code itself.

- If the vaccine is provided through the VFC program, the SL modifier must be added to both the vaccine code and the vaccine administration code.
- Do not add the SL modifier to vaccine and administration codes use to report services provided to members who are over 18 years of age or for vaccines that are not covered under the VFC program administered to children.

If the provider individually administers more than one vaccine, the provider can bill for the administration of each vaccine, provided the additional vaccines are administered through a separate injection. The provider will not be paid for additional toxoids in the same syringe.

Providers cannot divide vaccines commonly administered in a single injection to report multiple administrations. When medically necessary and appropriate to administer a second injection, a second administration fee may be paid.

AHCCCS has opened the add-on code 90461 and will pay a maximum of one unit for that code. No additional payment is made for additional toxoids in the same syringe for that code.

Under VFC, the CPT code identifying the vaccine or toxoid given should be identified with the appropriate CPT code to identify the vaccine, the SL modifier, and the charge listed as $0.00.

The CPT code identifying the administration should be identified with the appropriate CPT code to identify the administration code, the SL modifier, and the charge appropriate for the administration.

SY Modifier

Key points regarding the **SY Modifier** – *Persons who are in close contact with member of high-risk population (use only with codes for immunizations)* are listed below.

- AHCCCS published a **notice** on their website on August 19, 2020 stating that effective September 1, 2020, a 10% FFS rate increase would be applied to vaccine codes 90630-90756 and Q2034 in addition to vaccine administration codes 90460-90474. The notice advised that for CPT codes related to the administration of the influenza vaccine, modifier SY needs to be used when billing that code to receive the 10% rate increase.
- The codes listed in the AHCCCS notice covered under VFC are CPT 90630, 90672, 90674, 90685, 90686, 90687, 90688, 90689, 90694 and 90756. Vaccine administration codes billed in conjunction with these vaccines require an SL modifier only. AHCCCS has built in the 10% rate increase to the codes.
- Codes listed that are **not** covered under VFC are CPT 90653, 90655, 90656, 90657, 90658, 90660, 90662, 90673, 90682 and HCPCS Q2034. If used for a VFC aged member, vaccine administration codes billed in conjunction with these vaccines require an SY modifier.
- Adults receiving any of the services identified by the vaccination codes listed in the AHCCCS notice should be billed with an SY modifier on the vaccination administration codes to receive the 10% increase.
- Further clarification was provided by AHCCCS under the **COVID-19 FAQ** section for Flu Shots, where it was updated on October 1, 2020 to state that vaccine admin codes should not be billed with two different modifiers. They should be billed with either the SY (for adults, or for children for vaccines not covered by VFC) or the SL modifier (for children for vaccines covered by VFC).
- The SY modifier should not be appended to the vaccine code. It is to be used on the vaccination administration codes only (CPT 90460-90474). Providers should not append both the SL and the SY modifier to a vaccine administration code.

3.5 – Eyeglass Coverage

MC covers eyeglasses and eye glass replacements for children and youth. Vision services for MC members include regular eye exams and vision screenings, prescription eyeglasses, and repairs or replacements of broken or lost eyeglasses.

There are no restrictions for replacement eyeglasses when medically necessary for vision correction. This coverage includes, but is not limited to, loss, breakage or change in prescription.

Caregivers do not need to wait until the next regularly scheduled vision screening to replace or repair eyeglasses. If the child/youth in their care breaks or loses their prescribed eyeglasses, an appointment needs to be scheduled for a vision screening with the child/youth's healthcare provider.

Federal law [42 USC 1396d(a)] requires Medicaid to cover all services when medically necessary and cost effective for MC members. This means that MC will cover these health services if the treatment or service is necessary to "correct or ameliorate" defects or physical and behavioral illnesses or conditions.

Providers and dispensers are cautioned about "upselling" equipment for members. Members are not required to agree to any upgrades. To the extent that any upgrade is not AHCCCS covered and is to be a member responsibility, the provider must ensure the member agrees to accept financial responsibility and signs a document, in advance, accepting payment responsibility. The member agreement of financial responsibility document must also provide a description and approximate cost. General requirements for member billing are discussed in AAC R9-22-701. If any discussion with the family results in financial exposure, it shall not take place until prior communication with, and approval by, MC occurs.

CHAPTER 4 – INPATIENT CLAIMS

4.0 – MC APR-DRG Pricing Information Summary for Medicaid Lines of Business

In accordance with AHCCCS, effective October 1, 2014, MC determines Medicaid reimbursement for most acute care hospital inpatient services for most Arizona hospitals and out-of-state hospitals using a Diagnosis Related Group (DRG) payment methodology. Specifically, All Patient Refined Diagnosis Related Groups (APR-DRGs) created by 3M Health Information Systems is used to categorize each inpatient stay. Each inpatient hospital claim is assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category.

MC follows AHCCCS guidelines when it comes to pricing APR-DRG's. For additional detail regarding this, please refer to:

AHCCCS APR-DRG Payment System Design Payment Policies

All details and rules regarding how APR/DRG are priced can be found in this document.

Additional information may also be found in the AHCCCS Fee for Service Manual – Chapter 11 – Hospital Services.

4.1 – MCA DRG Pricing

MCA claims are processed in accordance with traditional Medicare pricing – MS-DRG. MS-DRGs are billed for inpatient discharges and payments are adjusted under the IPPS based on appropriate weighting factors assigned to each DRG. Under the IPPS, MCA pays for inpatient hospital services on a rate per discharge basis that varies according to the DRG to which a beneficiary's stay is assigned. The formula used to calculate payment for a specific case multiplies an individual hospital's payment rate per case by the weight of the DRG to which the case is assigned. Each DRG weight represents the average resources required to care for cases in that DRG, relative to the average resources used to treat cases in all DRGs.

For more information on how MS-DRGs are calculated, please visit the CMS web page:

MS-DRG Classifications and Software

CHAPTER 5 – FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) PROSPECTIVE PAYMENT SYSTEM (PPS) PROCESSING

5.0 – FQHC PPS Overview

AHCCCS, along with MC pays FQHCs an all-inclusive per visit PPS rate on a per claim basis, which replaces the current methodology of reimbursing claims through a fee for service methodology. This will affect MCA as well.

FQHCs and FQHC Look-Alikes must register under the provider type of C2 and obtain a unique NPI number not already associated with another active AHCCCS provider ID for each clinic covered by the CMS FQHC, FQHC-LA or RHC designation. If necessary, a new NPI can be obtained at: **https://nppes.cms.hhs.gov/NPPES**. It is important to note that claim submissions must be billed with the rendering provider's NPI in box 19 of the 1500 (02-12) claim form. Failure to bill with that NPI number will result in the claim being denied.

Per AHCCCS, an FQHC/RHC Visit is defined as a face-to-face encounter with a licensed AHCCCS-registered practitioner during which an AHCCCS-covered ambulatory service is provided when that service is not incident to another service.

According to AHCCCS, a group therapy modifier (HQ) is will not be considered as an FQHC visit. For an encounter to be "face-to-face", it must also be "one-on-one".

Multiple encounters with more than one practitioner within the same discipline, i.e., dental, physical, behavioral health, or with the same practitioner and which take place on the same day and at a single location, constitute a single visit unless the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. In this circumstance, the subsequent encounter is considered a separate visit. A service which is provided incident to another service, whether on the same day or at the same location, is part of the visit and is not reimbursed separately.

5.1 – FQHC PPS – MC Billing

All FQHC, FQHC-LA, and RHC visits must be billed using the Form 1500 (02-12) or the 2012 ADA Form. For purposes of reimbursing visits, MC has adopted HCPCS code **T1015** – *Clinic visit/encounter, all-inclusive* for reporting physical health, behavioral health, and dental visits. A claim for a FQHC, FQHC-LA or RHC visit must include all appropriate procedure codes describing the services rendered in addition to HCPCS visit code T1015.

A visit will be identified by, and reimbursement for the visit will be associated with, HCPCS code T1015; all other services reported on the claim will be bundled into the visit and valued at $0.00. T1015 is reimbursable at the established AHCCCS PPS rate for each FQHC and should be billed using that rate. We follow all regulatory requirements for FQHC billing.

5.2 – FQHC PPS - MCA Billing

All FQHC and RHC visits must be billed using the UB-04 Form. A visit will be identified by, and reimbursement for the visit will be associated with the following HCPCS codes; all other services reported on the claim will be bundled into the visit and valued at $0.00. Current reimbursement rates for the following codes are as follows:

- Established patients - $89.00 per visit
- New patients - $105.00 per visit

For purposes of reimbursing visits beginning 4/1/2015, MCA will be using Medicare specific codes as follows:

- **G0466** – *Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit*
- **G0467** - *Federally qualified health center (FQHC) visit, established patient; a medically necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit*
- **G0468** – *Federally qualified health center (FQHC) visit, IPPE or AWV; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV*
- **G0469** – *Federally qualified health center (FQHC) visit, mental health, new patient; a medically-necessary, face-to-face mental health encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit*
- **G0470** – *Federally qualified health center (FQHC) visit, mental health, established patient; a medically-necessary, face-to-face mental health encounter (one-on-one)*

between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a mental health visit.

Certain services are not considered FQHC services either because they are 1) not included in the FQHC/RHC benefit; or 2) are not a Medicare benefit. These services include:

- **Medicare Excluded Services** – This includes physical checkups, dental care, hearing tests, eye exams, etc. A full listing of Medicare excluded services can be found in the Medicare Benefit Policy Manual – Chapter 16 – General Exclusions from Coverage under **Section 10 – General Exclusions from Coverage**.

Please Note: MCA offers additional benefits that are not normally covered by traditional Medicare. Please refer to our Mercy Care Advantage Provider Manual under Chapter 7 – MCA Covered Services and Supplemental Benefits for detail regarding these services. While these are not part of the FQHC/RHC services, they should be billed and will be processed separately from FQHC.

- **Technical Component of an FQHC/RHC** – This includes diagnostic tests such as the technical component of x-rays, EKGs, and other tests.
- **Laboratory Services** – This does not include venipunctures.
- **Durable Medical Equipment** – This includes crutches, hospital beds and wheelchairs used in the patient's place of residence, whether rented or purchased.
- **Ambulance Services**
- **Prosthetic Devices**
- **Body Braces**
- **Practitioner Services at Certain Other Medicare Facility**
- **Tele-Health Distant Site Services**
- **Hospice Services**

The above services are not part of the FQHC/RHC services, and as such they should be billed and will be processed separately from the FQHC payment.

5.3 – FQHC PPS - Dual Eligible Claims Billing

Since CMS billing requirements are different from AHCCCS billing requirements, we will require the initial claim sent to MCA be billed according to the instructions above in the MCA Billing section. Once you have received the remit, please rebill the service following billing instructions in the MC Billing Section and submit with the MCA remit you previously received. Claims must be billed in this fashion for us to properly encounter claims to our regulators.

5.4 – Services Provided by a Behavioral Health Technician

Allow FQHC reimbursement at the PPS visit rate for allowable services provided by a BHT only when those services qualify as *incident to* the services of an FQHC practitioner consistent with federal requirements[1]. This does not include case management.

Services "incident to" a visit means:

- Services and supplies that are an integral, though incidental, part of the physician's or practitioner's professional service (examples: medical supplies; venipuncture; assistance by auxiliary personnel such as a nurse or medical assistant); or
- Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (Examples: x-ray; medication; laboratory test).

Behavioral Health Technician (BHT) services, excluding case management, may qualify as an FQHC/RHC visit when those services qualify as services incident to the services of an FQHC/RHC practitioner consistent with 42 CFR 405.2462.

> (Group therapy does not qualify as an FQHC service, since it is not a face-to-face encounter. For a visit to qualify as a face-to-face encounter the visit must be one-on-one, disqualifying group therapy from being a PPS-eligible service.)

For BH services that are not incident to a professional service, PPS payment under the T1015 is not allowable. If a provider wants to provide BH services without a qualifying a qualifying service, they must register as an outpatient behavioral health clinic (provider type 77) and bill under the clinic ID.

The professional service must be a under the category of Behavioral Health Medical Professional[2] (BHMP) and may not include services provided under the credentials of a Behavioral Health Professional[3] (BHP) (i.e., counseling, assessment).

Please note that even though a Behavioral Health Professional may be required to sign off on a Behavioral Health Technician's documents, this does not count as a professional service or an incident to service.

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[1] Effective for dates of service on and after 04/01/2015 AHCCCS pays the all-inclusive per visit PPS rate on a per claim basis for providers registered as Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), replacing the previous method of reimbursing claims reported under individual FQHC/RHC employed practitioners by the capped fee-for-service fee schedule and annually reconciling to the PPS rate.

[2] BHMP credentials include MD, DO, MD

[3] BHP credentials include LISAC, LMSW, LAC

T1015 may be billed up to 3 times per day per member – once for behavioral health professional services, once for physical health professional services and once for dental professional services.

The **AHCCCS FFS Provider Manual** is attached for reference. Please click on the link to view in detail.

5.5 – FQHC PPS - Billing Resources

Additional information regarding FQHC PPS billing is available at the AHCCCS website as follows:

Fee for Service Provider Manual – Chapter 10 Addendum FQHC/RHC

Additional information regarding FQHC PPS billing is available at the CMS website as follows:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/index.html

CHAPTER 6 – SKILLED NURSING FACILITY CLAIMS

6.0 – Skilled Nursing Facilities General Information

In this section we are providing an overview of Skilled Nursing Facilities related to MC's authorization requirements and claims payment rules. For additional information regarding Skilled Nursing Facilities, please refer to our **Mercy Care Provider Manual Chapter 300 – Mercy Care Long Term Care (MCLTC) – Plan Specific Terms** which also contains valuable information.

6.1 – Roles and Responsibilities

Skilled Nursing Facilities (SNF) and MC have defined roles and responsibilities necessary to provide quality services. The roles and responsibilities outlined below are intended to assist facilities in the delivery of quality care to MC and MCA members and to clarify processes that will facilitate prompt and accurate reimbursement for delivered covered services.

SNF Roles and Responsibilities

- **Obtain Authorization from MC for the following services:**
  - Sub-Acute Services (Skilled) - MC Concurrent Review Nurse (CRN)
  - Custodial Services (MCLTC) - MCLTC Case Manager
  - Specialty Levels of Care (wandering dementia, ventilator, high respiratory, behavioral health units) MCLTC Case Manager
  - Bed Holds (MCLTC) – MCLTC Case Manager
- **Communicate with MCLTC Case Manager**
  All MCLTC members are assigned to a MCLTC Case Manager. The SNF must communicate all changes in medical condition, level of care, hospitalizations, deaths, discharges, and presentation of 30-day notices to the Case Manager.
- **Submit Claims**
  - Submit claims meeting timeliness standards
  - Submit claims on correct billing forms
  - Manage accounts receivables by regularly checking **Availity.** SNFs must register and receive a password to access this Availity. Please review the Availity information contained in our Provider Manuals.
  - Do not submit spreadsheets to Claims or Provider Relations, unless requested to do so by MC.
  - All resubmissions of claims must meet timeliness standards and be clearly marked as a resubmission, with blue or black ink, as indicated in the Provider Manual.
  - Follow appropriate appeal/resubmission steps as outlined in each plan's Provider Manual about any claim that cannot be resolved to maintain timely filing rights.

- **Coordinate Discharge**
  - Sub-Acute Stays (Skilled) – Coordinate with the MC Medical Management SNF CRN and the MCLTC Case Manager if the member is a MCLTC member.
  - Custodial Stays (MCLTC) – Coordinate with MCLTC Case Manager.

MC Roles and Responsibilities

- **Respond to Authorization Requests in a Timely Manner**
  The Prior Authorization Department will respond to authorization requests within 24 hours of the request.
- **MCLTC Case Manager**
  - Each MCLTC member has an assigned case manager.
  - Case managers serve as a point of contact for member issues.
- **Claims Payment**
  - Claims will be paid timely.
  - Interest will be paid on MCLTC claims that are not paid within the timelines set forth by contract.
  - Adhere to state and federal guidelines when responding to claims disputes and follow appeals process.

6.2 – Skilled Nursing Facility Authorizations Requirements

MC requires prior authorization for selected acute outpatient services and planned hospital admissions.

Concurrent Review Nurses must authorize all skilled stays for MC and MCA skilled stays. The Concurrent Review Nurses also authorize custodial stays for all MC Members.

MCLTC case managers authorize custodial stays for all MCLTC members.

When requesting an authorization for a skilled stay for inpatient SNF admission, sufficient information must be provided, or MC will not be able to generate the prior authorization. To expedite the prior authorization process, please be prepared to provide the following information when calling:

- Facility face sheet
- Admit date
- Admit diagnosis
- Services to be rendered

When making a request for a continued authorization, please complete the request on the **Skilled Stay Continued Authorization Request Form which** is available on the MC website. Missing or inaccurate information may delay important processing of the review and ultimately, the payment of the claim. The request will be reviewed for clinical information to certify the continuation of the stay (intensity of need versus intensity of services being rendered).

The Continued Authorization Request Form must contain the following:

- Date of admission
- Diagnosis
- Reason for the admission
- Services the member receiving
- Plan of care
- Member baseline functional level (usually available by the second week PT/OT has completed the initial evaluation)
- Functional progress that has been made since last request in the space provided
- Estimated length of stay
- Discharge plan
- Status of MCPLTC application
- Status change

MC – Acute Stay

Medical management issues an authorization for the MC Acute members' stay and the level of care for all skilled and all custodial stays.

AHCCCS policy states that AHCCCS members who have not been determined eligible for ALTCS are covered for up to 90 days of nursing facility coverage per contract year (October 1 – September 30). The 90 days of AHCCCS acute care coverage for SNF services begins on the day of admission, even if the member is insured by a third-party insurance carrier, including Medicare.

SNFs should work with the member and their family to begin the ALTCS application procedure as quickly as possible.

- **Sub-Acute (Skilled) Stay**
    - The SNF calls the MC SNF Authorization Line at 602-263-3000 for initial authorization for SNF placement.
    - The SNF must have clinical information available for the authorization nurse or designee to determine if admission meets sub-acute service.

- The SNF nurse or designee will issue an authorization number to the SNF with an approved length of stay and level of care.
- For continued stay requests, the SNF must fax to the SNF review line or call the SNF Authorization Line with clinical information to support continued stay.
- The SNF can use their form or MCP's **Skilled Stay Continued Authorization Request** Form to submit requests. This must be done at least 3 days prior to end date of authorization.
- MC CRN or designee will render a decision within 24 hours of receipt of clinical information.
- The purpose of concurrent review is to reach an agreement between MC and the SNF at the time the member is in the SNF.
- If the SNF disagrees with the level of care or length of stay after the member has been discharged, the SNF must appeal.
- If MC Acute secondary applies to Medicare Fee for Service (FFS) or another Medicare Advantage Plan or other primary insurance the following applies:
  - No authorization is required for co-pay, co-insurance, or deductible
  - Claims need to be billed separately

- **Custodial Stay**
  - Medical Management issues the authorization and notifies the SNF.
  - MC Acute secondary to Medicare
    - Authorization is entered if we are notified.
    - Medical Management follows members for possible MCLTC transition (for tracking purposes only).

MCLTC/Non-Medicare

- **Sub-Acute (Skilled) Stay**
  - For new admissions from the hospital, Medical Management will notify SNF of sub-acute (skilled) stay and give level of care and authorization number.
  - For members currently in the nursing home who have had a change of treatment and now qualify for sub-acute level, the nursing home will call the assigned MCP CRN and provide substantiating information.
  - MCP's SNF CRN will communicate with the MCLTC Case Manager when the member is no longer in a sub-acute (skilled) stay.
- **Custodial Stay and Specialty Units (Ventilator, Respiratory, Wandering Dementia Units, Behavioral Health Units)**
  - MCLTC Case Manager determines level of care based on supporting documentation.
  - MCLTC Case Manger creates an authorization and notifies SNF.

- There is no secondary payor for custodial care. Other commercial carriers will not cover a custodial stay. MC pays 100% of contracted rate minus member's Share of Cost (SOC).

MCLTC/Medicare

- **Sub-Acute (Skilled) Stay**
  - No authorization is required for co-pay, co-insurance, or deductible.
  - Claims need to be billed separately.
- **Custodial Stay and Specialty Units (Ventilator, Respiratory, Wandering Dementia Units, Behavioral Health Units)**
  - MCLTC Case Manager determines level of care based on supporting documentation.
  - MCLTC Case Manager creates an authorization and notifies SNF.
  - There is no secondary for payor for custodial care. Other commercial carriers will not cover a custodial stay. MC pays 100% of the contracted rate less member's Share of Cost (SOC).

MCA

- **Sub-Acute (Skilled) Care**
  - The SNF calls the MC SNF Prior Authorization Line at 602-263-3000 for initial authorization for SNF placement.
  - The SNF must have clinical information available for the authorization nurse or designee to determine if admission meets sub-acute service.
  - The Concurrent Review Nurse or designee will issue an authorization number to the SNF at that time, with an approved length of stay.
  - SNF must give MCA the RUGS code after the MDS assessment is reviewed.
    - RUGS code must be given within 14 days of admission to skilled stay or at the point of discharge if the stay is less than 14 days.
    - Claims payment cannot be made if there are no RUGS code reported.
    - If the RUGS code changes within the stay of the member, the SNF must fax the SNF review line, 602-414-7252, with the updated RUGS code.
    - If a claim is billed with RUGS code(s) different than initially provided, the claim will deny.
  - For continued stay requests, the SNF must fax to the SNF review line or call the SNF prior authorization line with clinical information to support continued stay.
    - The SNF may use their internal form or the MCA **Skilled Stay Continued Authorization Request** form to submit their request. This must be submitted at least 3 days prior to end date of authorization. MCA CRN or designee will render a decision within 24 hours of receipt of clinical information.

- After a determination has been made by MCA that the enrollee no longer meets the criteria and must be discharged, the SNF is responsible for serving the Notice of Medicare Non-Coverage (NOMNC) to the enrollee at least 2 days in advance of the services ending and retain the NOMNC in their records.
- If an enrollee decides to appeal the discharge, the Quality Improvement Organization (QIO) will contact the plan asking for medical records supporting the discharge decision and MCA is required to provide those records by the end of the day of request.
- If the QIO overturns the appeal, the QIO will notify MCA of the discharge date for the enrollee and MCA is responsible for payment through that date. If QIO concurs with MCA, the enrollee is financially responsible if he/she chooses to remain in the facility beyond the discharge date.
- MC is responsible for co-insurance, co-pay, or deductible.
    - No authorization is required
    - SNF must bill with appropriate Medicaid revenue code(s)

6.3 – Skilled Nursing Facility Bed Hold Authorizations and Claims Billing

Payment for bed-hold authorization will require approval by a MCLTC Case Manager. It is important to note that bed holds must be billed on a separate claim form from their SNF stay, using a UB-04. An example of this would be a member is in a SNF from 1/1/15 – 1/31/15, however, on 1/15/15 – 1/20/15, they were hospitalized. We would need three claims submitted as follows:

1/1/15 – 1/14/15 – Normal SNF Billing on a UB-04
1/15/15 – 1/20/15 – Bed Hold Days Billing on a UB-04
1/21/15 – 1/31/15 – Normal SNF Billing on a UB-04

Since these are covered under separate authorizations, they require separate claims.

The facility must provide the reason for the bed hold and the anticipated length of leave. There are two types of leave that can be authorized for a bed hold for MCLTC members; short term hospitalization leaves and therapeutic leave. Members under the age of 21 may use any combination of bed hold days and therapeutic leave days per contract year with a limit of 21 days per contract year (October 1 – September 30).

- **Short Term Hospitalization Leave**
  A bed hold may be authorized when short-term hospitalization is medically necessary. The total number of days available for each member over the age of 21 is limited to 12 days per contract year (October 1 – September 30).

- **Therapeutic Leave**
  This service may be authorized due to a therapeutic home visit to enhance psychosocial interaction or on a trial basis as part of discharge planning. The total number of therapeutic leave days available for each member over the age of 21 is limited to 9 days per contract year (October 1 – September 30).

6.4 - Durable Medical Equipment

All durable medical equipment (DME) is included in the SNF per diem rate except for customized equipment and specialty beds.

- Customized Equipment - Customized DME may be provided to members by a contracted MC DME provider if the items are ordered by the member's primary care provider and authorized by MC.
- Specialty Mattresses - A specialty mattress such as a low air loss or high air loss mattress must be medically necessary and requires prior authorization. SNFs must obtain prior authorization through the MC Prior Authorization Department.
- Specialty Beds – Hill-Rom is the maker of Clinitron Beds (many models). Hill-Rom no longer bills Managed Care/Insurance Payors.
  - When a doctor orders an Air Fluidized Bed, any DME provider that supplies Air Fluidized Beds (Any Brand even Hill-Rom Brands) can fill that request if Prior Authorization is received from MC.
    - Most DME providers bill MC directly.
    - If a DME provider does not bill MC and is supplying the bed to a Skilled Nursing Facility (SNF), then there is a way the SNF can bill the MC for the cost of the bed and then directly reimburse the DME vendor by invoice.
- Routine equipment is included in the per diem paid to the SNF and should be provided by the SNF. This includes bariatric durable medical equipment.

Some of the more common DME items used are listed below. This list is not all-inclusive and serves as general reference only. Any DME items not listed require Prior Authorization.

DME in a Nursing Facility

Equipment	MCA Non-Custodial	MCA Custodial	Acute/ALTCS/ DDD Non-Custodial	Acute/ALTCS/ DDD Custodial
Air Fluidized Bed (i.e., Clinitron) and Powered Air Flotation Bed	Included in per diem or RUG rate	Not covered in SNF	See above instructions regarding Clinitron beds. Authorization required.	See above instructions regarding Clinitron beds. Authorization required.
Bariatric Bed, Wheelchair, etc.	Included in per diem or RUG rate	Not covered in SNF	Included in Bariatric per diem rate. Other per diem rates: Separately payable to DME company with authorization	Included in Bariatric per diem rate. Other per diem rates: Separately payable to DME company with authorization
Bedside Commode	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate	Included in per diem rate
Cane/Crutches	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate	Included in per diem rate
Cushions	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
Feeding Pumps	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
Foot Cradles	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
Geri-Chairs (Non-Customized)	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate	Included in per diem rate

Equipment	MCA Non-Custodial	MCA Custodial	Acute/ALTCS/ DDD Non-Custodial	Acute/ALTCS/ DDD Custodial
Glucose Monitors (i.e., Accu-Chek)	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate	Included in per diem rate
Heating/Cooling Pads	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate	Included in per diem rate
Hospital Beds (Electric & Manual)	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
IV Pole	Included in per diem or RUG rate	Covered under Part B when used in conjunction with Enterals	Included in per diem rate.	Included in per diem rate
Lifts	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate.	Included in per diem rate.
Misc. Supplies – emesis basins, bed pans, catheters, surgical dressings, etc.	Included in per diem or RUG rate	Part B: Enterals, gravity kits, syringe kits, pump kits, tubes, pumps, dressings, parenteral nutrition, trach supplies, ostomy supplies, catheters	Included in per diem rate	Included in per diem rate
Nebulizer	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate

Equipment	MCA Non-Custodial	MCA Custodial	Acute/ALTCS/ DDD Non-Custodial	Acute/ALTCS/ DDD Custodial
Powered Pressure-Reducing Air Mattress (Alternating), Other mattresses, mattress overlays and/or pads	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
Suction Machine	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
Walker	Included in per diem or RUG rate	Not covered In SNF	Included in per diem rate	Included in per diem rate
Wheelchairs (All Non-Customized)	Included in per diem or RUG rate	Not covered in SNF	Included in per diem rate	Included in per diem rate
Wheelchairs (Customized)	Included in per diem or RUG rate	Not covered in SNF	Separately payable to DME company with authorization	Separately payable to DME company with authorization
Wound Vac.	Included in per diem or RUG rate	Not covered in SNF	Separately payable to DME company with authorization	Separately payable to DME company with authorization

*For MCA – If a facility is licensed for skilled care, then the services for DME are not covered even if the member is in a custodial stay.

6.5 – Therapy Authorizations and Claims Payment

When MC, MCLTC or MCA is the primary payor, the SNF must use contracted therapy providers. Therapies do not require prior authorization while in a SNF. For a listing of contracted therapy providers, please visit the MC Provider Directory located on our website under **Find A Provider**.

MC Acute Stay

All covered therapy services are included in the per diem rate. The SNF must arrange or provide covered therapy services for MC Acute members residing in its facility.

MCLTC Stay

Covered therapy services are included in the per diem rate. The SNF should arrange or provide covered therapy services for MCLTC members residing in its facility.

MCLTC members may receive covered therapy services more than once per day.

MCA

- When a SNF is paid under PDPM, therapies are included in the RUGS reimbursement.
- For SNFs outside of Maricopa County on per diem contracts, therapy is included as part of the per diem rate.

Medicare Exception: The only exception to this is when traditional Medicare is the primary payor but there is no Medicare Part A Coverage. Those claims will need to be split on two claims between inpatient services and the ancillary therapy services. This is because Medicare pays for Part B ancillary services when there is no Part A coverage. You should bill Medicare for the Medicare Part B covered services. Once you receive Medicare's Explanation of Benefits, submit the claim with the Medicare EOB separate from the Medicare non-covered inpatient stay.

6.6 – Insertion of PICC Lines

MC pays for PICC line insertion. The physician/nurse practitioner who administers the PICC line must be AHCCCS registered. The Skilled Nursing Facility should not bill directly for this service.

6.7 - Share of Cost

Share of Cost (SOC) is the dollar amount a member must contribute toward the cost of their care and most typically applies to MCLTC members residing in Skilled Nursing Facilities (SNF); however, it may also apply to DD members. The amount of the SOC is determined by AHCCCS.

- For MCLTC - Members are required to contribute toward the cost of their care through Share of Cost (SOC). When a recipient's eligibility for MCLTC is approved, a notice is generated to the member which identifies the amount of SOC the recipient owes, regardless of payment received from other payers or insurance. SOC change notices are sent to nursing facilities for any change that might occur to the SOC amount due. The identified SOC provided by AHCCCS is deducted from the payment owed for the claim. If a patient transfers from one facility to another in a month's time and the total SOC

could not be applied to the first facility, the remainder will be carried over to the second facility's claim.

- For DD - Members are required to contribute toward the cost of their care based on their income and type of placement. Some members, either because of their limited income or the methodology used to determine the SOC, have a SOC in the amount of $0.00. Generally, only institutionalized members have a SOC. For members receiving Nursing Facility (NF) services, collection of the member SOC shall remain the responsibility of the Division.

Additional information regarding SOC includes:

- SOC begins on the first day of the month following placement of the member but may start later depending on AHCCCS processes. SOC is the first money used towards the per diem. SOC is not prorated for partial months.
- One hundred percent (100%) of the SOC for the month of discharge is refunded by the SNF to the member upon discharge if the member is discharged to the community.
- If the member is discharged to another SNF, the SOC amount will be applied to the per diem rate for the days the member was in the first facility. If any SOC money remains, this money should be applied to the second SNF.
- If the member or the member's designated payee fails to pay the member's SOC within the facility's established time requirements, the facility should proceed with its usual collection methods (i.e., reminder telephone call), and notify the case manager.
- If payment is 30 days overdue, the facility shall contact the MCLTC case manager and will also contact the member and/or representative and send a collection letter.

6.8 – Prior Period Coverage

Prior Period Coverage refers to the period from the effective date of AHCCCS eligibility to the day before the member is enrolled with the program contractor. MC is retroactively liable for payment of covered services received by the member during Prior Period Coverage. In addition:

- AHCCCS is solely responsible for determining if a member is eligible for Prior Period Coverage and in assigning the Prior Period Coverage eligibility dates.
- MC is not responsible for payment of non-covered services during the Prior Period Coverage period.
- SNFs should refer to the AHCCCS Medical Policy Manual, Chapter 300, Policy 310 of the Medical Policy for AHCCCS Covered Services.

6.9 – General Billing and Claim Submission Guidelines

MCLTC/MC Acute

- MC shall compensate the SNF according to their contract for the provision of Covered Services to eligible members. Reimbursement and service descriptions are also found in the contract with MC.
- Both initial and any or all subsequent visits to a member in a nursing facility made by a Physician Assistant (PA) or Nurse Practitioner (NP) are covered services when the following criteria are met: the PA or NP is not an employee of the facility and the source of payment for the nursing facility stay is Medicaid.
    - MC manages this by leveraging AHCCCS reference data that includes validating the provider's category of service, location and service, member's enrollment, and provider's enrollment.
- Claims for skilled or custodial stays should be billed on a UB-04 claim form.
- Levels of Care are determined as follows:
    - The appropriate level of care will be determined by the MC Concurrent Review Nurse utilizing MC criteria.
    - All Covered Therapy Services are included in the per diem rate. The SNF shall arrange or provide Covered Therapy Services for members while residing in its facility.
    - Pharmacy is not included in the per diem rate. The SNF shall use a contracted pharmacy to obtain medications.
    - Daily documentation in the medical chart of continued need for sub-acute level of care is required.
    - The SNF must notify MC Staff within 24 hours when a member no longer requires sub-acute level of care services.

- Levels of Care are defined as follows:
    - **Level I – Custodial** - Member must be pending ALTCS eligibility. Additionally, the member must be awaiting surgery, on tube feeding or oxygen dependent (or identified as new occurrence of need). Level I may include up to one hour per day of therapy (PT/OT/ST).
    - **Level II - Sub-Acute** - This includes all components of Level I plus any combination of the following must be provided; simple wound care, administration of IV fluids or antibiotics, small volume nebulizer (at 5 or greater) or any therapy up to 2 hours per day (PT/OT/ST). Please note that Level II or greater may go to a Level III.
    - **Level III - Intensive Sub-Acute** - This includes all components of Level I and II, plus any combination of the following must be provided: complex wound care/decubitus, total parenteral nutrition or tracheotomy care or any therapy up to 3 hours per day (PT/OT/ST). An RN charge nurse is required to be on the station where the Level III members are located 24 hours a day.

- **Level IV - Vent Care/Dialysis** - This includes all components of Level I, II and III, plus ventilator with tracheotomy care or dialysis on site.

Billing for a Skilled Stay (Acute)

Billing for a Skilled Stay incorporates the following criteria:

- Must require skilled nursing (6 days/week) and/or skilled rehabilitation (5 days/week).
- Must be ordered by a physician.

Revenue Codes 0191-0194 will be used for skilled care stays and billed in accordance with the authorization received:

- 0191 – Level I
- 0192 – Level II
- 0193 – Level III
- 0194 – Level IV

Billing for a Custodial Care Stay

A Custodial Care Stay incorporates the following criteria:

- Non-medical assistance -- either at home or in a nursing or assisted-living facility -- with the activities of daily life (such as bathing, eating, dressing, using the toilet) for someone who's unable to fully perform those activities without help.

Revenue Codes 0191-0194 will also be used for custodial care stays and billed in accordance with the authorization received:

- 0191 – Level I
- 0192 – Level II
- 0193 – Level III
- 0194 – Level IV
- 0199 - Respite or LOA's (manually priced)
- 0183-0185 - Bed Holds (no changes)

Condition Code 63 in the authorization issued by Case Management will identify the level of care as custodial:

Old Description	Old Service Codes	New Service Codes & Description
LOC 1	081	0191 LOC 1 Custodial CC 63
LOC 2	082	0192 LOC 2 Custodial CC 63
LOC 3	083	0193 LOC 3 Custodial CC 63
High Respiratory Services	071/080	0194 LOC 4 Custodial CC 63

Condition Code 62 in the authorization issued by Case Management will identify the level of care as behavioral health or a more complex member:

Old Description	Old Service Codes	New Service Codes & Description
Wandering Dementia	073	0191 LOC 1 Complex CC Wandering Dementia
BH Troublesome	077	0191 LOC 1 Complex CC 62 BH III - T Troublesome
BH Stepdown	076	0192 LOC 2 Complex CC 62 BH II - Stepdown
BH Standard	075	0193 LOC 3 Complex CC 62 BH I
BH High Acuity	074	0194 LOC 4 Complex CC 62 BH High Acuity

Value code A8 in the authorization issued by Case Management will identify the level of care as bariatric:

Old Description	Old Service Codes	New Service Codes & Description
Bariatric	070	0191 LOC 1 Bariatric VC A8
Bariatric Level II	072	0192 LOC 2 Bariatric VC A8

Condition Code 71 in the authorization issued by Case Management will identify the level of care as staff assisted dialysis:

Old Description	Old Service Codes	New Service Codes & Description
Staff Assist Dialysis	079	0191 LOC 1 Staff Assisted Dialysis CC71

Authorization Crosswalk

Always check with your Case Manager if you have any questions regarding the level of care authorized.

Previous Description	Prevous Revenue Codes	After Date of Service 1/1/17, Coding and Description
LOC 1	0081	0191 LOC 1 Custodial CC 63
Wandering Dementia	0073	0191 LOC 1 Complex CC 62 Wandering Dementia
BH Troublesome	0077	0191 LOC 1 Complex CC 62 BH III - Troublesome
Bariatric Level 1	0070	0191 LOC 1 Bariatric VC A8
Staff Assist Dialysis	0079	0191 LOC 1 Staff Assisted Dialysis CC 71
LOC 2	0082	0192 LOC 2 Custodial CC 63
BH Stepdown	0076	0192 LOC 2 Complex CC 62 BH II - Stepdown
Bariatric Level 2	0072	0192 LOC 2 Bariatric VC A8 (Permission needed to use)

Sub-Acute Level 3	0193	0193 LOC 3 Sub-Acute
LOC 3	0083	0193 LOC 3 Custodial CC 63
BH Standard	0075	0193 Loc 3 Complex CC 62 BH I
Vent	0194	0194 LOC 4 Vent
High Respiratory Services	0071/0080	0194 LOC 4 Custodial CC 63 High Respiratory
BH High Acuity	0074	0194 LOC 4 Complex CC 62 BH High Acuity
SNF Respite	0199	0199 Respite

Helpful Information

- Revenue Codes 0191-0194 are to be used for all levels of care.
- Condition/value codes will be included in all new authorization descriptions as well as the revenue code.
- Condition/value codes are **NOT** mandatory on the claims billed. This will require manual intervention on our part to process the claim. If the authorization indicates a condition/value code and it is not billed by the SNF, MC will use the authorization to price the claim manually or through an IT process.
- **IF** SNFs bill the condition/value code on the claim, the claim will process faster without manual intervention, which means faster payment to the provider.

MCA

- MCA submission of claims is based on the terms of the MCA contract for RUGS reimbursement.
- The secondary claims for MC Acute services will automatically cross over. You only need to bill the services once.
- Claims for RUGS reimbursement should be billed on a UB-04 claim form.

CHAPTER 7 – INTEGRATED CLINICS

An Integrated Clinic is a provider licensed by the Arizona Department of Health Services as an Outpatient Treatment Center which provides both behavioral health services and physical health services.

For the contracting year October 1, 2016, through September 30, 2017 (Contract Year Ending (CYE) 2017), providers which are registered with AHCCCS as Integrated Clinics1 (IC) during CYE 2017 may qualify for a Value Based Payment (VBP) Differential Adjusted Rate for selected services for those dates of service in CYE 2017 that coincide with the provider's registration as an Integrated Clinic. The VBP Differential Adjusted Fee Schedule, which represents a positive adjustment to the AHCCCS Fee-For-Service rates, distinguishes providers who have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. This fee schedule is currently limited to dates of service in CYE 2017. MC has implemented this required change by AHCCCS.

VBP Differential Adjusted Rates will be paid for select physical health services and will provide an increase of 10% over the AHCCCS Fee-For-Service rates for the same services. MC, as well as MC RBHA is also required to provide a 10% increase over their contracted rates as well. Physical health services which qualify for the increase include Evaluation and Management (E&M) codes, vaccine administration codes, and a global obstetric code, which are all allowable as of April 1, 2016, for providers registered with AHCCCS as Integrated Clinics. The specific list of codes which are as follows:

59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections; 1vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections; each additional vaccine (single or combination vaccine/toxoid)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid)
99201	New patient office or other outpatient visit, typically 10 minutes
99202	New patient office or other outpatient visit, typically 20 minutes
99203	New patient office or other outpatient visit, typically 30 minutes
99204	New patient office or other outpatient visit, typically 45 minutes

99205	New patient office or other outpatient visit, typically 60 minutes
99211	Office or other outpatient visit for the evaluation and management of an established patient, typically 5 minutes
99212	Office or other outpatient visit for the evaluation and management of an established patient, typically 10 minutes
99213	Office or other outpatient visit for the evaluation and management of an established patient, typically 15 minutes
99214	Office or other outpatient visit for the evaluation and management of an established patient, visit typically 25 minutes
99215	Office or other outpatient visit for the evaluation and management of an established patient, visit typically 40 minutes
99243	Patient office consultation, typically 40 minutes
99244	Patient office consultation, typically 60 minutes
99245	Patient office consultation, typically 80 minutes
99381	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedure, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedure, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedure, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedure, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedure, new patient; 18 through 39 years)

99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedures, established patient, infant (age less than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedures, established patient, early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedures, established patient, late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedures, established patient, adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnosis procedures, established patient, age 18 through 39 years
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure; approximately 45 minutes

To qualify for the above, providers must register as an integrated clinic with AHCCCS. When billing claims for payment, providers must submit their integrated clinic NPI in box 24J (or appropriate box for electronic submissions) for the claims to pay at the appropriate rate.

CHAPTER 8 – TRANSPLANT CLAIMS

This section offers general guidance to providers regarding the billing of transplant claims for MC. For additional detail, please refer to the following AHCCCS information:

- **AHCCCS Fee-For-Service Provider Manual – Chapter 24**
- **AHCCCS Medical Policy Manual – Chapter 300 – 310DD – Covered Transplants and Related Immunosuppressant Medications**

MC covers medically necessary transplants for members. To be covered, a transplant must be medically necessary, not experimental, and not for the purposes of research. Transplant services must be reimbursable on both a federal and state level.

Although transplant coverage is limited for individuals aged 21 and older (adults), MC covers all medically necessary, non-experimental transplants for individuals under the age of 21 under the EPSDT Program.

Transplant services are excluded for individuals who are only eligible for emergency services under the Federal Emergency Services Program.

Transplant services are covered only when performed in specific settings:

- Solid organ transplantation services must be provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers delineated in 42 CFR Part 482.
- Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation. The facility must also satisfy the Medicare conditions of participation and any additional federal requirements for transplant facilities.

The negotiated specialty contract is held between the provider and AHCCCS and specifies the inpatient, outpatient, and ancillary services that are included and the payment amount to be received for the services provided.

PCPs or Specialists will refer a member to the Transplant Center. The Transplant Center will contact MC to request prior authorization via the following fax number:

MC Fax: 855-671-5914

MC's Transplant Coordinator will review all prior authorization requests for all transplant service billing components for members enrolled with MC.

MC will issue a written decision approving or denying the authorization request within fourteen (14) days from receipt of a complete request for non-emergent services. In the case of emergent requests, the written decision will be provided within three (3) days of the request. Authorizations are input into QNXT by component.

The provider (facility that meets above specified settings) will submit a packet of all individual claims for all transplant related services as a transplant service billing component, along with the Transplant Invoice Coversheet directly to MC at the following address:

Mercy Care
Attention: Claims Transplant Coordinator
Cost Containment Unit
4750 S. 44th Place, Suite 150
Phoenix, AZ 85040

The payment amount is based on the specialty contract held by AHCCCS and will be made directly to the facility. The facility is then responsible for paying individual providers for their services. Other claims attached to the component will be entered into QNXT but will pay $0.00.

The provider is responsible for billing MC within six (6) months of the end date of each of the transplant service billing components. Timeliness of the claim submission for each billing component of the transplant will be based on the submission date for the complete set of claims related to the component. Claims initially received beyond the six (6) month time frame will be denied. If a claim is originally received within the six (6) month time frame, MC has up to twelve (12) months from the end date of the billing component to resubmit the claim and achieve clean claim status or to adjust a previously processed claim. If a claim does not achieve clean claim status or is not adjudicated correctly within twelve (12) months of the end date of the billing component, MC is not liable for payment.

All medically necessary services provided to the transplant recipient that are related to the transplant should be billed using the appropriate diagnosis codes, CPT codes, HCPCS procedure codes, and revenue codes to meet clean claim status.

MCA Transplant Claims

This section offers general guidance to providers regarding the billing of transplant claims for MCA. For additional detail, please refer to:

Medicare's Claims Processing Manual, Chapter 3 – Inpatient Hospital Billing, Section 90 – Billing Transplant Services

PCPs or Specialists will refer a member to the Transplant Center. The Transplant Center will contact MCA to request prior authorization via the following fax number:

MCA Fax: 855-671-5914

MCA Transplant Coordinator will review all prior authorization requests for members enrolled with MCA.

MCA will issue a written decision approving or denying the authorization request within fourteen (14) days from receipt of a complete request for non-emergent services. In the case of emergent requests, the written decision will be provided within three (3) days of the request. Authorizations are input into our claims processing system.

MCA should be billed directly, and the claims will be paid at either the CMS rates for non-contracted providers or per their contracted rate.

All medically necessary services provided to the transplant recipient that are related to the transplant should be billed using the appropriate diagnosis codes, CPT codes, HCPCS codes, and revenue codes to meet clean claim status.

CHAPTER 9 – NON-PARTICIPATING PROVIDER REGISTRATION

Per the AHCCCS website, any person or company may participate as an AHCCCS provider if the person or company is qualified to render a covered service and complies with AHCCCS policies and procedures for provider participation.

All providers of AHCCCS-covered services (either Fee-For-Service or managed care) must **meet the following requirements**:

- Register with the AHCCCS Administration which requires signing the Provider Agreement that includes Federal requirements under 42 CFR Part 431.107.
- Meet AHCCCS requirements for professional licensure, certification, or registration.
- Complete all applicable registration forms.
- Institutions (companies/facilities) are required to pay an ***enrollment fee***, effective January 1, 2012
- Specific provider types will require an OIG site visit prior to enrollment, and are subject to unannounced post enrollment site visits (**Required Fee and-or Site Visit by Provider Type**).

In accordance with the Deficit Reduction Act of 2005, Section 6085, contractors, including MC, is required to reimburse non-contracted emergency services providers at no more than the AHCCCS Fee-For-Service rate. This applies to in state as well as out of state providers. In accordance with Arizona Revised Statute 36-2903 and 36-2904, in the absence of a written negotiated rate, MC is required to reimburse non-contracted non-emergent in state providers at the AHCCCS fee schedule and methodology, or pursuant to 36-2905.01, at ninety-five percent of the AHCCCS Fee-For-Service rates for urban hospital days. All payments are subject to other limitations that apply, such as provider registration, prior authorization, medical necessity, and covered service.

Non-participating providers have the option of registering their group with AHCCCS, versus an individual physician. If the non-participating provider wants individual checks to go to each provider within a group, they don't have to register a group payment provider. However, if they choose to have one check made to the group entity, then they will need to register the group NPI in addition to the individual physician NPI.

If the group or individual we pay is a "Doing Business As", they must be registered with AHCCCS and their W-9 record provided must match the Tax Identification Number (TIN) registration with the IRS, as the owner of the TIN.

Please feel free to visit the **AHCCCS Provider Registration** web page which includes the following information:

- Provider Reenrollment
- AHCCCS Provider Registration Enrollment Fee
- AHCCCS Provider Registration Packets
- AHCCCS Enrollment Application Fee

MC cannot process a claim if a provider is not registered through AHCCCS for MC. Providers do not need an AHCCCS ID for MVS. Below are other important guidelines to keep in mind.

- Urgent/emergent services are payable as long as the provider is AHCCCS registered. Please follow the Out of State/One-Time Waiver of Registration Requirements.
- Non-emergent/non-urgent services are only payable if the provider is AHCCCS registered, and the provider has attained prior authorization from MC.
- All services provided by a non-par provider are not payable without a valid prior authorization from MC.
- A non-participating provider who is part of a contracted group must be credentialed and contracted to see MC members.
- Out of state providers, while subject to interest payment rules, are not subject to prompt payment discounts.
- Medicare certification is required to make MCA payments, along with a valid active NPI. Prior authorization rules apply.