

SECTION I BILLING AND CLAIMS

CLAIMS PAYMENT METHODS

Phoenix Health Plan offers 2 forms of payment for services provided; paper check and electronic funds transfer (direct deposit).

Electronic Funds Transfer (EFT)

EFT allows payments to be deposited electronically directly into a designated bank account. Some of the benefits of EFT are:

- Receipt of payment directly into your account within an average of 3-5 business days once payment is released.
- No need to manually deposit your checks.
- Capability to view remits on-line through our secure website.
- Allows for no delay between receipt of dollars and the ability to post payment.

Please visit our website in order to download and complete the EFT form or contact Network Management for a form to be faxed to your practice.

➤ <http://www.phoenixhealthplan.com/pdf/EFT%20Request%20Web%20Form.pdf>

CLAIMS STATUS

Providers that are registered through our website for secured access can check status of their submitted claims. Once claims have been data entered, claims will reflect as showing pending, paid or denied.

To register for secured access, go to www.phoenixhealthplan.com/forms.aspx in order to download and complete the Website Registration form or contact Network Management for a form to be faxed to your practice.

CLAIM SUBMISSION INFORMATION

Each provider must report all covered services to PHP either by encounter submission and/or the appropriate claim form for payment.

EDI (Payer ID 03440 Route ID 7)

Phoenix Health Plan (PHP) encourages providers to consider electronic claims submission (EDI) for your practice. There are many advantages to submitting claims electronically (decreased submission costs, faster processing and reimbursement, allows for documentation of timely filing, etc).

- For medical claims, please contact Emdeon at 1-800-369-8805 or go to www.emdeon.com for more information.
- For Dental claims, please contact Tesia at 1-800-724-7240 or go to www.tesia.com for more information.

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Timely Filing

For all AHCCCS covered services provided to members, regardless of reimbursement method, PHP must receive a completed claim form within 180 days from oldest date of service or discharge date on the claim.

Claims Address

All claims must be mailed to the billing address as listed below. Any claims mailed directly to the PHP office will cause a delay in payment.

<p>Phoenix Health Plan Claims P.O. Box 81000 Phoenix, AZ 85069</p>

AHCCCS Provider Identification Number

Registering with AHCCCS is a prerequisite for all providers who wish to provide services to the AHCCCS population. If you have never applied for nor received an AHCCCS provider I.D. number, either as an individual or facility, you must file the necessary registration materials with the AHCCCS provider registration department prior to submission of claims. PHP is unable to reimburse providers for any services provided to any member, who have not registered with AHCCCS.

If your facility has a Type II (legal/organizational entity) NPI number, you register the NPI number through AHCCCS following the registration process.

The AHCCCS Identification Number is a six-digit identification number issued by AHCCCS when a provider goes through the formal registration process.

National Provider Identifier (NPI)

Providers are required to use your NPI on every claim submitted. PHP will deny paper claims and reject electronic claims submitted without the appropriate NPI numbers.

Providers that bill with a facility/legal entity name, in box 33, are required to obtain a Type II (Organizational) NPI number for the legal entity. Once obtained, the Type II NPI number will need to register with AHCCCS.

The rendering providers NPI is allowed in box 33a only if he/she is a sole provider. Facilities with more than one provider require a type 2 NPI.

Tax Identification Number

Each provider must report the tax I.D. number under which they wish to be paid. It is imperative that PHP be notified of any tax I.D. number or name changes. Failure to provide the health plan with tax I.D. or name changes may result in denial of claims or backup withholding per Internal Revenue Service guidelines.

As a reminder, all claims should be submitted with the W-9 legal entity name in Box 33 and not the DBA

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(doing business as) name. PHP does not accept business names unless you are registered with the IRS to use that name.

Practice/Facility Name and Address

Please notify PHP and AHCCCS of all address changes. If AHCCCS is not notified of an address change, AHCCCS will terminate the provider's AHCCCS number, thus preventing claims being paid by the health plan. Please note that Post Office Boxes are not considered a valid service address.

PHP registers each provider under the provider name and the legal business name as registered with the IRS. To receive reimbursement, claim submissions must match the legal name of the business and the payment address on file. All changes to the payment name and address must be submitted in writing to network management.

CMS 1500 Submissions

For providers who submit for reimbursement on a CMS 1500 form, the facility's NPI number must appear in box 33a along with the provider's facility name as registered with the IRS in box 33 along with the rendering provider's NPI in box 24j. If you do not have a facility NPI, the rendering physicians NPI number must appear in box 33a.,

ADA Submissions

For dental providers who submit for reimbursement on an ADA J400 2008 form, the billing dentist or Dental Entity's NPI number must appear in box 49. For the treating dentist, the NPI number must appear in box 54.

UB-04 Submissions

For providers/facilities who submit for reimbursement on a UB-04 form, the facility's NPI number must appear in box 56. For those that enter the attending, operating and/or other physicians, the NPI number must be placed in boxes 76-79.

Scanning Recommendations & Tips

Optical character recognition (OCR) is utilized when processing claims. It is extremely important that the name matches our records in order for the system to correctly identify the pay-to information. Failure to have the correct name on your claim may delay payment.

- Printing claims on a laser printer will create the best possible character quality
- If a dot matrix printer must be used, please change the ribbon regularly
- Courier 12 pitch non proportional font is best for clean scanning
- Recommend that all characters are printed in uppercase for optimal scanning
- Always attempt to ensure that clean character formation occurs when printing paper claims (*i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number*)
- Please ensure that the claim form is lined up properly within the printer prior to printing

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- Please make every effort to *not* place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc. (*characters on the claim form outside of the lined boxes have a tendency to “throw off” the registration of the characters within a box*)
- Use an original claim form as opposed to a copied claim form as much as possible
- Use a standard claim form as opposed to a form of your own creation. (*individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly*)
- The billing, servicing and/or rendering provider’s NPI must be included in the locations listed below for accurate matching within the scanning and claim system.

CMS 1500 (08/05) CLAIM FORM

Diagnosis Codes

- In compliance with AHCCCS guidelines, diagnosis codes that require a 4th or 5th digit will be denied if not submitted with appropriate specificity. The health plan never changes or alters a diagnosis code.

The required fields to be completed on a CMS 1500 (08/05) Claim Form are as follows:

<u>LOCATION</u>	<u>DESCRIPTION</u>
1a	Insurer’s I.D. Number
2	Patient's Name (Last, First, Middle Initial)
3	Patient's Birth Date/Sex
5	Patient's Address
9	Other Insurer’s Name (Last, First, Middle Initial)
9a	Other Insurer’s Policy or Group Number
9b	Other Insurer's Date of Birth/Sex
9c	Employer's Name or School Name
9d	Insurance Plan Name or Program Name
10	Patient's Condition Related to: a, b, c
12	Patient's or Authorized Person's Signature
13	Insurer's or Authorized Person's Signature
14	Date of Current Illness; Injury; Pregnancy
17	Name of Referring Physician or Other Source
17a	Other ID Number
17b	NPI Number (only required if box 17 is populated)
21	Diagnosis or Nature of Illness or Injury 1, 2, 3, 4
23	Prior Authorization Number
24A	Date(s) of Service

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24B	Place of Service
24D	Procedures, Service or Supplies
24F	Charges (usual and customary amount(s))
24G	Units
24J	Rendering Provider NPI Number <u>(field required)</u>
25	Federal Tax ID Number or Social Security Number
28	Total Charge
31	Signature of Physician or Supplier and Provider Identification Number
32	Name and Address of Facility Where Services were rendered
33	Provider's Facility Name, Supplier's Billing Name (as registered with the IRS), Address, Zip Code and Phone Number.
33a	Facility NPI Number <u>(field required)</u>

UB-04 CLAIM FORM

In order to facilitate processing, the provider is required to return the UB-04 Claim Form to PHP as follows:

- Claim forms are to be separated from each other.
- All data elements must be entered for the applicable fields, including but not limited to the discharge hour and patient status. Only AHCCCS approved Revenue codes will be reimbursable by PHP.

Timely Filing

For all AHCCCS covered services provided to members, PHP must receive a completed claim form within 180 days from the date of discharge.

Diagnosis Codes

- In compliance with AHCCCS guidelines, diagnosis codes that require a 4th or 5th digit will be denied if not submitted with appropriate specificity. The health plan never changes or alters a diagnosis code.

The required fields to be completed on a UB-04 Claim Form are as follows:

<u>LOCATION</u>	<u>DESCRIPTION</u>
1	Provider Name, Address, and Phone Number
3b	Medical Record Number
4	Bill Type
5	Federal Tax Number

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6	Statement Covers Period
9	Patient Name
9	Patient Address
10	Patient Date of Birth
11	Patient Sex
12	Admission Date
13	Admission Hour
14	Type of Admission
15	Source of Admission (Inpatient only)
16	Discharge Hour (Inpatient only)
17	Patient Status (Inpatient only)
19-28	Condition Codes
42	Revenue Code
43	Revenue Code Description
44	HCPCS/Rates
45	Service Date
46	Service Units
47	Total Charges by Revenue Code
50	Payer
51	Health Plan ID Number
52	Release of Information
56	NPI Number (field required)
58	Insurer's Name
59	Patient's Relationship to Insured
60	Patient I.D. Number
61	Group Name
62	Insurance Group Number
63	Treatment Authorization Codes
65	Employer Name
66	Other Diagnosis Codes
69	Admitting Diagnosis Codes
74	Principal Procedure Code and Dates
74a-e	Other Procedure Codes

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76	Attending Physician Name (required for bill types 11x, 12x, 21x, and 22x) and NPI Number (required if name field is populated)	
77	Operating Physician Name and NPI Number (NPI Number only required if name field is populated)	
78-79	Other Physician Names and NPI Number (NPI Number only required if name field is populated)	

HOSPITAL OUTPATIENT BILLING

Hospital Outpatient Facility

- The UB-04 claim form is used to bill all services by revenue codes.
- Claims are submitted with an itemized bill unless Medicare is primary.
- Revenue codes must be approved for use by AHCCCS in order for the health plan to reimburse. Check the AHCCCS fee for service manual for valid revenue codes.

For dates of service on and after 7/1/2005, AHCCCS reimburses in-state, non-IHS hospitals for outpatient services billed on a UB claim form (Refer to Exhibit 1) using the AHCCCS Outpatient Hospital Fee Schedule. The Outpatient Hospital Fee Schedule provides rates at the procedure code level. Surgery/Emergency Department (ED) services are bundled similar to Medicare for payment purposes (Refer to Exhibit 2). For more information on outpatient hospital billing requirements, refer to the AHCCCS FFS Provider Manual, Chapters 6 and 11.

Professional Fees (ER Physicians)

Emergency room physicians' professional fees must be submitted on a CMS 1500 form using the current CPT codes.

IMMUNIZATION VACCINE FOR CHILDREN (VFC) PROGRAM & OTHER INJECTABLES

- Under the federal vaccines for children program (VFC), the vaccines for recipients 18 and younger are made available to the provider free of charge. Therefore, providers do not bill for the vaccine itself. The vaccine code is billed with the appropriate immunization CPT code accompanied with the "SL" (state supplied) modifier on the claim form and the provider is paid a fixed reimbursement for administrations of the vaccine. Per AHCCCS, providers must not use the immunization administration CPT codes 90465 to 90474 when billing under the VFC program. The VFC program may update covered immunizations and delete others during the year. PHP will cover immunizations that are approved based on this program.

Other Injections

- Vitamin B-12 injections (J3420) are payable for diagnosis codes 266.x, 281.0 and 579.8 **only**.
- J3490 (unclassified drug code) requires a description & dosage and should only be used if there is no other appropriate code. Requires prior authorization.

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MODIFIERS

Appropriate modifiers should be used when submitting claims to PHP. Claims that are submitted with an inappropriate or missing modifier will be denied.

PEDS TOOL

The PEDS screening can be conducted at each EPSDT well child visit for those that were born on or after 01/01/06 who were in the NICU following birth. Providers must have completed the PEDS training in order to bill for this service.

- Use of code 96110 with EP modifier used when submitting claims.

THIRD PARTY LIABILITY

AHCCCS is the payor of last resort. When a patient has any insurance other than PHP, the primary insurance company must be billed first.

Coordination of Benefits

- Prior authorization requirements apply to all members regardless of whether or not PHP is primary or secondary.
- All members are required to see contracted providers. If the member has primary coverage other than PHP and the physician is not a contracted provider, services must be prior authorized in order to be paid.
- If a member has other insurance coverage, including but not limited to Part A or Part B Medicare, the physician identifies and seek payment from the primary insurer prior to submitting claims to PHP.

Each provider shall include a complete copy of the primary insurance carrier's EOB when submitting claim/encounter for the services rendered. All services must be submitted regardless of the remaining liability. A claim for any balance due must be received by PHP within sixty (60) days from date of remit from the primary carrier or 180 days from date of service, whichever is greater.

The benefit calculation is as follows:

- The allowed amount shall be based upon the lesser of PHP's or third-party carrier's fee schedule, less the paid amount by the third-party carrier(s); any remaining balance shall be paid by PHP as coordination of benefits.
- When billing for services denied by the primary carrier, the EOB must include a written description of the denial code. EOB's received without this information will be denied for a complete EOB.
- If the primary insurance denies a service for more information, PHP will not reimburse that service until a denial based on coverage is received.

Worker's Compensation

Any illness or injury covered under the Worker's Compensation or Occupational Disease Laws should be billed directly to the employer's insurance carrier in accordance with all state and federal laws.

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Motor Vehicle Accident/Trauma

If a member requires services as a result of an accident (i.e., auto, motorcycle, etc.), please notify the TPL Department and provide the following information: (shouldn't we provide a phone number for TPL here?) Ask Keith if he wants a phone number here????

- Date of accident
- County where injuries were sustained
- Date(s) of hospitalizations and outpatient services
- Social Security Number
- Name of any other insurance company
- Address and telephone number of member

PHP's Liability for Medicare Beneficiaries

	Cost Sharing for Members with Fee-For-Service Medicare		Cost Sharing for Members with Medicare HMO
	In Network	In or Out of Network	
PHP's Responsibility:	Co-insurance and deductibles based upon the PHP Fee Schedule for Medicare services provided by a Medicare provider on a FFS basis.	Co-insurance and deductibles based upon the PHP Fee Schedule for Medicare services not covered by AHCCCS and provided by a Medicare provider on a FFS basis.	Medicare co-payments, deductibles or premiums assessed by Medicare HMO for dual eligible.
QMB – Duals Persons who are eligible for Medicaid, who meet QMB income and resource requirements, and who have Medicare Part A and Part B. AHCCCS pays the Part B premium.	YES	YES	NO
Non – QMBs Persons who are eligible for Medicaid, who do not meet the QMB income and resource requirements, and who have Medicare Part A. AHCCCS pays the Part B premium in certain instances.	YES	YES	NO
MN/MI with Medicare	YES	NO	NO

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CLAIMS RESUBMISSION POLICY

Providers may resubmit claims that have been adjudicated within twelve (12) months of the date of service. PHP will re-adjudicate claims re-submitted by providers only if an initial claim had been filed within the original prescribed submission deadline of 180 days from the date of service.

To avoid duplicate claims, resubmissions of claims should be at least 60 days following the original claims submission. This will allow adequate time for PHP to adjudicate the claim and have the check issued, mailed and posted by your staff.

PHP encourages providers to contact Claims Customer Service at 602-824-3743 or 1-800-747-7997 for assistance with questions or concerns surrounding claim status, payment, partial payment, non-payment or payment reconsideration.

A practitioner or provider also has the right to formally Appeal the claim by requesting a claim dispute. All claim disputes are submitted through the PHP Appeals Department and are investigated using applicable statutory, regulatory, contractual and policy provisions.

Please refer to Section L for more information on Provider Claims Disputes and for a copy of the Claim Dispute Form.

DUPLICATE OR ERRONEOUS PAYMENTS

Providers should notify, in writing, any payment incorrectly collected from PHP for services for which another carrier or entity has or should have primary responsibility. In the event of any overpayment, erroneous payment, duplicate payments or other payment of an amount in excess of which the provider is entitled, PHP may, in addition to any other remedy, recover the same by offsetting the amount overpaid against current and future reimbursements due to the provider.

EXPLANATION OF REMITTANCE ADVICE (RA)

The RA displays key payment information. The remittance advice is subject to change at PHP's discretion. PHP works with Emdeon to deliver your remittance advice and check. Remits can also be viewed and printed from our website through the secured access.

If you have any questions or concerns about you remittance advice or how it is delivered, please contact network management or claims customer service.

The following key fields are included on the Remittance Advice Report:

- **Provider NPI:** Rendering Provider's NPI Number and Name
- **Member:** Member Name
- **Medicaid:** PHP Member ID Number
- **Claim Date:** Date of Admission/Service
- **Form No.:** Claim Number
- **Bill Type:** Inpatient/Outpatient for UB04 or
 - Void Status for DUPLICATE, ORIGINAL, REPLACEMENT, or VOID
 - This will be "BLANK" for CMS 1500 (08/05) claim remittances

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- Prov Acct: Patient's Account Number or, if Member is NOT on the Plan, their name will appear
- From Date: Begin Service Date
- Proc Code: Code Value (CPT Code)
- Quant: Days or Units
- Billed Amount: The charges being submitted
- Allowed: Allowed Fee (includes both FFS and Capitation amount)
- Discount: Difference between Billed & Allowed
- CoPay/Coins: Co-payment or coinsurance. The Member is responsible for this amount.
- Deductible: The Member is responsible for this amount.
- Not Covered: Amount Pending/Denied.
- Net Amount: Plan Liability (capitated services will show as zero dollars)
- Expl Code: Reasons Paid/Pending/Denied
- Vendor Subtotal: Check Total
- Remit Total: Refunds, Voids, Payouts, Recoveries, and Voided Checks

MEDICAL REVIEW OF CLAIMS

Certain types of claims are subject to medical review prior to completion of processing.

The following types of claims may go through medical review. This list is not all-inclusive, and may be subject to change.

- Authorization number or description does not match billed services
- Emergency transportation (Air specialty transportation only)
- Infusion
- Multiple surgeries billing over \$10,000
- Pain management code with an authorization billed in conjunction with an anesthesia code
- Claim billing with Modifier 21, 22, 62, 73 or 66
- By report codes over \$300 Is this still the threshold???
- Out-of-area hospital services
- Outlier Claims
- Skilled Nursing Facility services (if member has Medicare Part B only)
- Dialysis claims with EPO over 37.5
- ER claims paid amounts over \$10,000
- PPC claims
- IP claims billing Psych rev codes/diagnoses
- Observation over 24 hours

Service codes typically subject to coding/bundling edits

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CLAIMS SCRUBBER

OARS (Overpayment and Recovery System) provides claims review by applying appropriate coding criteria as outlined by the American Medical Association's CPT-4 manual, NCCI standards and, where applicable, AHCCCS specific coding frequency.

OARS was developed utilizing information used by physicians, health care experts and accepted industry standard references. It is updated on an annual basis and enhanced to remain current with technology and accepted medical practice. AHCCCS updates are incorporated as communicated.

REIMBURSEMENT

PHP reimburses by two payment mechanisms, fee-for-service and capitation.

PCP Capitation Exclusions

Capitated PCPs are paid fee-for-service for all services until their panel has 100 members.

- Lab Codes: S3620, 36410, 36415, 81025, 86403, 86490, 86580, 87880
- Assistant surgeries: AHCCCS guidelines are followed with regard to those procedures that qualify (use 80/81/82 modifiers)
- Electrocardiograms: 93000-93014
- Flexible Sigmoidoscopies: 45330-45331
- Flu Shots: 90655, 90656, 90657, 90658
- Holter Monitors: 93224-93236
- Immunizations: Administration fee only for children 18 years and younger through VFC Program, must include *SL modifier*.
- Injectable Medications: J Codes (prior authorization is required for certain drugs. See the most current prior authorization guideline)
- Newborn Inpatient services (1st 3 days of life): 99431, 99433, 99435, 99436, 93440
- Norplant removal: 11976
- Small Volume Nebulizer: 94640
- Radiology services: 70360, 71010 – 71022, 71030, 73000 – 73020, 73070 – 73080, 73090 – 73110, 73500 – 73520, 73550 – 73565, 73590 – 73610, 73620 – 73660
- Specific family planning supply items (i.e. Copper IUDs): J7300
- TB Skin & Intradermal Test: 86580
- Tetanus: 90703, 90718
- Treadmill Tests: 93015-93018

Certain services require prior authorization. Please refer to the most current prior authorization guideline.

Covering Physicians

Physicians covering for a PCP are paid at the same rate of the PCP asking for coverage.

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Example: If Dr. Smith is a capitated PCP and he asks Dr. Jones, a fee-for-service provider, to cover for him while on vacation, no additional amount will be paid to Dr. Jones because Dr. Smith is receiving the capitation dollars. Dr. Smith and Dr. Jones must handle any payment arrangement between themselves.

Health Practitioners (CNM's, CRNA's, NP's, PA's, etc.)

Employed certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), nurse practitioners (NP) & physician assistants (PA) are reimbursed at a percentage of the regular physician's fee schedule as outlined in the provider contract. Please notify network management when a new health practitioner joins your practice. Services performed by a contracted health practitioner must be billed with the health practitioner's name in box 31 on the claim form.

OB Services

When submitting prenatal care and delivery claims, the following guidelines and coding procedures will apply:

- PHP reimburses based on a total OB_(TOB) package. Services submitted prior to the delivery date will be denied with instructions to re-bill at the time of delivery. The exception to this rule is for those members who transfer care to a high-risk OB doctor, transfer care to another OB provider or the patient leaves the network.
- CPT Codes that fall outside of the TOB package can be billed at time of service. Please refer to page I-14 for a list of services covered under TOB unless otherwise indicated.
- In addition to the appropriate delivery code, all office visits must be reported to PHP. Services should be billed using CPT Code 99213 with the dates listed from the first visit to the last visit before delivery. The unit field should reflect the total number of visits being reported from the first date of service until the date of delivery. Failure to show the date span for prenatal care and total number of visits in the unit field will result in denial of claim.
- OB claims require a minimum number of visits (according to AHCCCS guidelines) prior to delivery in order to qualify and be paid for a TOB package rate.
- Pregnant women up to 21 years and younger are required to have an EPSDT visit. Report this service on a separate line with the appropriate CPT Code. This should be reported with the total OB package with the date of service rendered and \$0.00 amount billed.

Vaginal Delivery Procedure Codes

59400 = Total OB (includes antepartum and postpartum care)

59409 = Delivery only

59410 = Delivery plus postpartum care

Please note if CPT 59400 is billed but does not meet qualifying criteria (i.e. there are not sufficient visits, no TOB auth on file, drop in delivery, etc.) PHP shall adjust the delivery to 59409; pay the delivery and request that the visits be billed out separately.

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Cesarean Delivery Procedure Codes

59510 = Total OB (includes antepartum and postpartum care)

59514 = Delivery only

59515 = Delivery plus postpartum care

Please note if 59510 is billed but does not meet qualifying criteria (i.e. there are not sufficient visits, no TOB auth on file, drop in delivery, etc.) PHP shall adjust the delivery to 59514; pay the delivery and request that the visits be billed out separately.

Total OB Authorization

- Total OB authorization includes all prenatal visits and postpartum care (including Prior Period Coverage dates). All charges/services for a TOB package must be submitted after the delivery date.
- No prior authorization or operative report is required for contracted physicians providing assistant surgeon services on cesareans. Assistant surgeon services are not covered for vaginal deliveries, ONLY for cesareans.

Terminated Pregnancies

If a claim indicates pregnancy terminated, patient transferred care, or patient moved out of state, the TOB authorization will cover all charges incurred up to that point and will be paid fee-for-service. The reason for discontinuation of care should be indicated on the claim form.

- If a provider, different from the provider with the total OB authorization, performs the delivery only, the provider with the total OB authorization shall be reimbursed for all prenatal visits on a fee-for-service basis. The prenatal visits should be submitted indicating each individual date of service and separate charges for each visit. Should a provider change practice affiliations, PHP must be notified regarding the disposition of members. The authorization may follow the physician but final billings must be initiated by each practice and each facility must indicate the dates of service and charges that apply. The physician's practice that provides the delivery will be eligible for Total OB reimbursement if the authorization is on file and the minimum number of visits has been provided.

Total OB Package

The following is a list of services that are included in the total OB package unless otherwise indicated. The only service that requires a separate authorization is amino infusion.

Service	Reimbursement	
	Separate	Included in Package
Physical Exam & Initial and subsequent history		X
Weight and blood pressure		X
Breast Stimulation Studies		X
Genetic Counseling (not testing)		X
Artificial rupture of membranes		X

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Service	Reimbursement	
	Separate	Included in Package
EPSDT Visits		X
Fetal Scalp Monitoring		X
Induction of Labor		X
All Prenatal Visits including Outpatient, Inpatient and Emergency Visits.		X
Delivery Services		X
One Postpartum Visit including pap smear		X
Laboratory Services and handling fees performed by Subcontractor or Contractor's Contracted Laboratory		X
Family Planning		X
Maternity Counseling		X
Nutritional Evaluation		X
Non-Stress Test (NST) 59025	X	
OB Ultrasound – limited to two Level 1 or II ultrasounds per obstetrical period	X	
RhoGAM injections	X	
Amniocentesis (59000)	X	
Inpatient Services		X
Wet Preps and Wet Mounts		X
External Cephalic Versions		X
Amniofusion	X	
Post Partum tubal ligation	X	
Prostaglandin Gel Insertion		X

Standard surgical guidelines are utilized including application of global rates and follow up days.

Anesthesia Labor and Delivery

Providers should use the following ASA codes:

- 01960 (Anesthesia for vaginal delivery only)
- 01961 (Cesarean delivery only)
- 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery)
- 01968 (Cesarean delivery following neuraxial labor analgesia/anesthesia)
- 01969 (Cesarean hysterectomy following)

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- OB anesthesia does not require documentation.
- PHP will pay the base units plus a maximum of 8 time units for labor and delivery anesthesia except for 01969 and 01967.
- 01969 has a maximum time unit of 10; 01967 has a maximum time unit of 12.
- Providers should not bill 01996 with anesthesia for delivery

Additional Surgical Procedures during Delivery

Any additional surgical procedures performed during the delivery admission must also be reported along with appropriate diagnosis.

CLAIMS SUBMITTED FOR FAMILY PLANNING SERVICES

No authorization is required for family planning services, but the diagnosis **must** indicate family planning.

Services not covered by AHCCCS for family planning include:

- Services for the diagnosis or treatment of infertility.
- Abortion counseling
- Abortions, unless one of the two following conditions is met:
 - All eligible recipients, when termination of the pregnancy is essential to protect the life of the mother.
 - Categorically eligible recipients, when the pregnancy is a result of rape or incest.

Tubal Ligations and Vasectomies

Prior authorization is required for tubal ligations and vasectomies. AHCCCS requires a completed federal consent form for all voluntary sterilization procedures. The Consent for Sterilization form can be found at www.hhs.gov/forms/HHS-687.pdf. Claims submitted for sterilization services provided during the recipient's retro-eligibility period or prior period coverage (PPC) are subject to medical review.

Federal consent requirements for voluntary sterilization require the following:

- The recipient must be at least 21 years of age at the time the consent is signed.
- Thirty days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery.
- The recipient may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the recipient gave informed consent for the sterilization.
- In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.
- The person securing the informed consent and the physician performing the sterilization procedure must sign and date the consent form.
- The surgeon involved with the sterilization procedure must submit a copy of the signed Federal

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Consent Form.

HCPCS code J7300 should be used for IUD device, CPT code 58300 for insertion and 58301 for removal.

Total hysterectomies do not require prior authorization or a federal consent form if performed on an emergency basis.

CLAIMS SUBMITTED FOR SOBRA FAMILY PLANNING SERVICES (Rate Code 55XX)

AHCCCS covers specified family planning (rate code 55XX) and related services provided to SOBRA eligible women whose eligibility terminated following delivery. The SOBRA family planning services (FPS) extension program provides comprehensive family planning services for a maximum of 24 months to women whose SOBRA eligibility has terminated, who are not eligible for any other AHCCCS services, and who voluntarily choose to delay or prevent pregnancy. If a member has family planning coverage only, the following services are covered: (FP modifier should be used).

Covered benefits are:

- Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories.
- Voluntary sterilization (male and female)
- Natural family planning education or referral to qualified health professional.

For a detailed list of covered services, please refer to *Section G* for additional information.

SURGERY CLAIMS

Anesthesia

Anesthesia claims must be billed with the total minutes in the unit field. Anesthesiologists do not require an authorization.

The following are **NOT** reimbursable:

CPT

00938	94656	99100	95813
01997	94770	99116	99135
62311	99135	99140	

Modifiers

P1	P3	P5
P2	P4	P6

- Consultation or other evaluation and management codes on the same day as an anesthesia administration **are not payable**.
- If the consult or evaluation/management is the day before the anesthesia, then they are payable with an authorization.

SECTION I BILLING AND CLAIMS

- Daily pain management following surgery is not a covered expense. These claims require medical review. Appropriate documentation (anesthesia and/or progress note) must be submitted with the claim.

Bilateral Procedures

- Indicate by billing with modifier 50.
- Effective January 1, 2008, for DOS billed:
 - Procedures are to be billed with a modifier 50 and a unit of one (1). This is a requirement of AHCCCS.
 - Example: 69436-50, dollar amount with 1 unit (150% of fee schedule)
- Prior to January 1, 2008, for DOS billed:
 - Do not combine the charges and enter a unit value of 2 on a single line. Charges must be entered on two lines.
 - Example: Line one = 69436 (no modifier), dollar amount with 1 unit. (100% of fee schedule)
9*Line two = 69436-50, dollar amount with 1 unit. (50% of fee schedule)

Multiple Surgery Guidelines

- Multiple procedures are paid at 100% of the applicable fee schedule for the first procedure,
- 50% of the applicable fee schedule for the next five procedures.
- OP reports are required for all multiple procedures.

Supplies

PHP follows Medicare guidelines for payment of surgical trays.

There are two (2) codes for which special supplies may be payable when the procedure/service is provided in the physician's office. They are:

<u>Code</u>	<u>Supply Code</u>
68761	A4263
95028	G0025

CLAIMS SUBMITTED BY INPATIENT FACILITIES

Tier	Identification Criteria	Allowed Splits
Maternity	A primary diagnosis defined as maternity 640.XX - 643.XX, 644.2X - 676.XX, V22.XX-V24.XX or V27.XX	None
NICU	Revenue Code = 174 and the provider has a Level II or III NICU	Nursery
ICU	Revenue code equal to 200 - 204, 207 - 212, or 219	Surgery Psychiatric Routine
Surgery	Surgery is identified by a revenue code of 36X. to qualify in this tier. There must be a valid surgical procedure code that is not on the	ICU

SECTION I BILLING AND CLAIMS

	excluded procedure list.	
Psych.	Psychiatric Revenue Codes 114, 124, 134, 144 or 154 and Psychiatric Diagnosis = 290.XX – 316.XX. qualifies as a psychiatric claim.	ICU
Nursery	Revenue Code of 17X. for providers who do not have a Level II or III Perinatal Center. If the NICU revenue code is billed the claim will deny	NICU
Routine	Revenue Codes of 100 – 101, 110 – 113, 116 – 123, 126 – 133, 136 – 143, 146 – 153, 156 – 159, 16X, 206, 213 or 214	ICU

- Maximum of 2 separate tier levels may be split per stay. See above table for acceptable splits.
- PHP does not reimburse revenue code 220.
- Inpatient claims billed for tier reimbursement must have ancillary charges to qualify for reimbursement.
- Discharge hour is required for inpatient claims except for interim bill type 112, 113, 122 and 123
- If a member is admitted, has surgery, and later becomes enrolled with PHP, the reimbursement will be based on a routine tier. The member must be eligible with PHP on the day of the surgical procedure to qualify for a surgical tier reimbursement.
- All UB-04 bills must have an itemized statement attached unless Medicare is primary.

Same Day Admit/Transfer

PHP reimburses the transferring hospital using the AHCCCS outpatient hospital fee schedule.

The receiving hospital will be paid the full per diem payment for the date of transfer, provided the hospital bills for at least one accommodation day.

Same Day Admit/Discharge

PHP reimburses same day admit/discharge claims using the AHCCCS outpatient hospital fee schedule.

If the hospital bills the claim as an inpatient admission and the AHCCCS system would qualify the claim at the Maternity or Nursery tier, reimbursement will be the lesser of:

- All covered charges (ancillary and non-accommodation), using the AHCCCS outpatient hospital fee schedule, or
- The per diem for the Maternity or Nursery’s classified tier.

Same Day Admit/Patient Expires

PHP will reimburse the facility the appropriate per diem payment for the date of death, provided the hospital bills for the accommodation day.

SECTION I BILLING AND CLAIMS

Documentation

- An OP report is required, if applicable as well as a labor and delivery report if applicable, ER record if admit was through the ER, admission H&P and admission face sheet for claims that will pay more than \$ 50,000, unless Medicare is primary.
- Claims received without complete medical records are denied with a claim note on the remittance advice of the exact information missing.
- PHP realizes that a discharge summary may not be produced by the physician in the case of very short stays, such as a normal newborn. However, that should be the only documentation that is not included.

OUTLIER CLAIMS

All requests for outlier consideration require a condition code of 61. If the calculations show that the claim does not qualify as an outlier, the claim will be paid at the regular tier rates. If the claim qualifies as an outlier, payment will be at the statewide inpatient cost to charge ratio, excluding any charges deemed not covered by medical review.

The following must be attached to the claim before it can be reviewed for outlier status:

- Itemized and detailed list of all charges
- Doctors orders or physician orders
- History and Physical
- Consult and progress notes
- Discharge summary
- Lab, X-ray, and EKG results
- Medication Administration Records (MAR) including IV fluids and meds
- ER flow sheets and orders and ER Physician notes (if applicable)
- Anesthesia Record and flowsheet (if surgery was performed)
- OP report or dictated procedure report (if surgery was performed)
- Cath Lab records and flowsheet (if applicable)
- Code arrest flowsheet (if patient coded)
- Emergency Medication Admin Record (if patient coded)
- Dialysis Physician orders and Dialysis flowsheet (if dialysis performed)

Claims received without complete medical records are denied with a claim note on the remittance advice of the exact information missing.

Providers have 180 days from the date of discharge to submit a claim for payment. In cases where payment is denied for additional information, providers will have an additional 180 days to resubmit with the necessary information for payment.

OUTPATIENT HOSPITAL FACILITIES

SECTION I BILLING AND CLAIMS

- Outpatient facility services must be billed on a UB-04 Claim Form.
- Bill type should be 13x (*Hospitals classified as Critical Access with AHCCCS may submit claims with bill type 85X*) – address rural rev codes
- All UB-04's are required to have an itemization attached (except EDI submitted claims)
- AHCCCS does not recognize all revenue codes. Refer to the AHCCCS fee for service manual for eligible revenue codes.
- Charges for hospital outpatient services that result in a direct admission to the hospital must be included on the inpatient UB-04 claim.
- If a member is treated in the ER, observation room or other outpatient department and is admitted directly to the hospital, the outpatient charges must be billed on the inpatient claim.
- If the member is discharged from the ER, observation room, or other outpatient department and then is subsequently admitted, the hospital should submit separate claims. The claim for the outpatient services is priced at the AHCCCS outpatient hospital fee schedule (OPPS) rate while the inpatient claim would be reimbursed at the appropriate tier(s).
- In-state, non-IHS hospitals are reimbursed for outpatient services billed on a UB claim form (Refer to Exhibit 1) using the AHCCCS outpatient hospital fee schedule. The outpatient hospital fee schedule provides rates at the procedure code level, and surgery/emergency department (ED) services will be bundled similar to Medicare for payment purposes (Refer to Exhibit 2). For more information on outpatient hospital billing requirements, refer to the AHCCCS FFS provider manual, Chapters 6 and 11.
- Hospitals must include the admit hour and discharge hour on both the outpatient and inpatient claim in order to distinguish inpatient and outpatient UB92 claims for the same member on the same date of service
- Observation services may be provided on an outpatient basis for up to 24 hours if determined reasonable and necessary to decide whether the member should be admitted for inpatient care. A request for authorization extension should be requested for observation stays extending beyond 24 hours. Observation services will be reimbursed based on the authorization..
- Observation services, without labor, billed on the UB claim form must be billed with a 762 revenue code (Treatment/Observation Room - Observation Room) and the appropriate observation HCPCS procedure code.
- Observation services, with labor, billed on the UB claim form must be billed with a 721 revenue code (Labor Room Delivery – Labor) and the appropriate HCPCS procedure code.
- Air transportation charges are not accepted on a UB-04 form.
- Professional fees must be billed on a CMS 1500 claim form.

ANCILLARY CLAIMS

SECTION I BILLING AND CLAIMS

Ambulatory Surgery Center (ASC)

Ambulatory Surgery Centers can be submitted on a CMS 1500

Dialysis

- Medicare guidelines are utilized when processing ESRD services. Medicare rules apply.
- Authorization is required for initial start of dialysis only. This applies to all members including members where PHP is secondary.
- Physicians do not require separate authorization. They may use the facility authorization.
- Value codes and amounts are required when billing for the administration of Erythropoietin (EPO)
- EPO's over 37.5 (the value code amount) with an EPO revenue code billed (634 or 635) require rolling lab report

Durable Medical Equipment

An exclusive contract for all DME services is in place. Equipment not provided by the contracted vendor requires prior authorization including services rendered to members where PHP is secondary.

DME procedure codes beginning with L, K, and E require the following modifiers

- NU – New
- RR – Rental
- RP – Repair
- E1399 requires a description

Home Health

- Services not provided by the contracted vendor require prior authorization including services rendered to members where PHP is secondary.
- Effective with dates of service on or after October 1, 2007 AHCCCS revised coding for home health nursing visits.
- Home health nursing visits of 2 hours or less in duration or multiple visits that do not exceed a total of four (4) hours in one day are to be reported with HCPCS code **G0154**.
- When a visit exceeds two hours in duration, or multiple visits exceed four hours in a single day, services should be billed using HCPCS code **S9123** when services are provided by a RN and **S9124** when services are provided by a LPN.

Coding for Home Health Nursing:

SECTION I BILLING AND CLAIMS

AHCCCS - Coding for Home Health Nursing

Provider Type		Intermittent - Brief Visit (Billed in 15 minute Units for visits of 2 hours or less in duration, up to a total of four hours per day)		Continuous - Hourly (Billed in Hourly Units for visits of more than two hours in duration or services exceeding four hours in a single day)	
		RN	LPN	RN	LPN
		HCPSC Code	HCPSC Code	HCPSC Code	HCPSC Code
Medicare Certified Home Health Agency	2, 23	G0154	G0154	S9123	S9124
State Certified Home Health Agency	39, 81, 95	G0154	Not Covered	S9123	S9124
Independent Nurse	46	G0154	Not Covered	S9123	S9124

Hospice

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.

- Services must be billed on a UB-04 claim form using bill types 81x, 82x.
- The valid third digit codes for bill frequency for hospice claims are 0-5, 7, 8.
- The following revenue codes are valid for hospice claims: 651; 652; 655; 656 and 657.
- Units must be reported with each revenue code.
- Services are billed one time for every month of service.

Laboratory

Fee-for-service PCP's and Specialist may bill certain CPT codes and receive reimbursement on a fee-for-service basis:

Please refer to Section F for additional information.

Radiology

- Providers must bill with the correct modifier (26 for professional or TC for technical) if billing for other than the global service.
- Diagnosis code 799.9 is invalid for radiology services. PHP requires at least one valid diagnosis.
- Please refer to the current prior authorization guideline for those services that require authorization

Skilled Nursing Facilities (SNF)

Case rates based on the level of care provided during a specific length of stay have been developed. Level of care is determined by the case manager assigned to the SNF. Please check with the prior authorization department if you are not certain what level of care has been assigned

SECTION I BILLING AND CLAIMS

- Type of bill must be 21x for SNF is rev codes 190-194.
- SNF Level 5 and Level 6 are to be billed using 194 rev code with the appropriate bill type. The line item should state Level 5 or 6 and the expected payment for that Level of care.
- Admit and discharge hour is required except for interim bills.
- A detailed itemized bill is required for all members with Part B Medicare coverage only. The billed charges must match the EOB submitted or the claim will be denied. PHP is financially responsible for services not covered by Medicare Part B when there is an AHCCCS covered authorized benefit provided.
- Services must be billed on a monthly basis only. Claims with overlapping service months will be denied with instruction to resubmit with corrected dates.
- When a member is admitted to an acute care facility and returns to the skilled nursing facility, the bill must be split to reflect that the member was transferred and readmitted to the skilled nursing facility. The patient status must reflect that the member was transferred, including the discharge hour.

See the following page for a list of Rev Codes and the allowed bill types.

Revenue Codes		Allowed Bill Type(s)
190	Custodial	86X
191	Level I	110 – 179, 211 – 228, 611 - 628
192	Level II	110 – 179, 211 – 228, 611 - 628
193	Level III	110 – 179, 211 – 228, 611 - 628
194	Level IV	110 – 179, 211 – 228, 611 - 628
199	Vent/Dialysis	651 - 678

EMERGENCY TRANSPORTATION

Supplies are billed by the ambulance service and not the supply company.

Billable code range = A0010 – A0999

No authorization is required for emergency transportation; however, the pick up point and destination is required. A trip ticket or a notation on the claim form is sufficient.

ALS services that are not supported by the services billed will be reimbursed at BLS rates.

Ambulance wait time is subject to medical review and requires the trip ticket be included with claim submission.

GENERAL INFORMATION

Prior Period Coverage

Prior Period Coverage (PPC) extends from the beginning date of an AHCCCS recipient's eligibility to the date prior to the recipient's date of enrollment with the healthplan. PHP reimburses providers for covered services rendered to eligible members during PPC in accordance with AHCCCS guidelines.

SECTION I BILLING AND CLAIMS

- PPC members can be identified by rate codes - with 3 numbers and a letter.
- Capitated providers are reimbursed fee-for-service for medically necessary covered services rendered to eligible members during PPC.
- Providers have 180 days from the day member eligibility is posted to submit PPC claims.
- There are no prior authorization requirements during the PPC time frame.
 - The health plan is responsible for reimbursing providers only for emergency medically necessary services rendered during the PPC period. If the health plan denies for lack of medical necessity an inpatient hospital stay that includes both PPC and prospective enrollment, the entire stay will not be paid.
 - Prior authorization requirements do apply in accordance with the provider's contract once prospective enrollment begins.

Critical Care Codes

- Critical Care 99291 is payable for the first hour.
- Code 99292 (additional ½ hour) may be payable with documentation (medical notes) and time, if deemed appropriate. The total time spent with the patient must be noted in the medical record

General Requirements

- Box 33 should always indicate the entity name as provided to the IRS, AHCCCS, and PHP.
- When box 31 on the CMS 1500 form has "Signature on File", the health plan will accept this as long as the processor can determine the servicing provider. If only the group name appears in box 33 and the processor is unable to determine the servicing provider, the claim will be denied.
- If the same service is performed on the same day and by the same provider, documentation must support it.
- If a claim is received with dates of service that fall after the received date the entire claim will be denied.
- Diagnosis codes that require a 4th or 5th digit will be denied if not submitted with appropriate code. The health plan never changes or alters a diagnosis code.
- CPT codes 99050 and 99058 are not payable codes.
- School/sports physicals are not a covered benefit.
- Members cannot be billed for AHCCCS covered services. This includes charges for copying medical records, completing any type of form(s), or "no-show" appointment
- Members requesting non-covered services must sign a detailed consent form prior to receiving non-covered services. The consent form must be reviewed prior to rendering the service and must be easy for the member to understand. The form must include the exact cost to the member of the service (non-covered benefit). The consent form must ask the member if they understand the procedure is not covered by their insurance and if they understand they will be charged for the services provided. General forms signed at a member's first visit are not considered written consent.