SECTION XI: Billing, Claims And Encounters

CLAIM SUBMISSION

ELECTRONIC DATA INTERCHANGE (EDI)

Care1st encourages you to submit your medical claims electronically.

Advantages include:

- decreased submission costs
- faster processing and reimbursement
- allows for documentation of timely filing

EDI is for primary and secondary claims only with the exception of claims when a member's primary insurance is WellCare Liberty (formerly ONECare) and their secondary insurance is Care1st, as our system automatically coordinates processing for these claims. If submitting secondary claims via paper include a red and white copy of the appropriate claim form (UB04 or CMS1500) sorted in the first position, with the primary insurance explanation of benefits attached.

Medical/Behavioral Health (CMS 1500& UB 04) Claims

Care1st works with CHANGE Healthcare 800.215.4730 for acceptance of EDI CMS 1500 & UB 04 claims. Our CHANGE Healthcare Payer ID is 57116.

Claims may be submitted electronically directly to CHANGE Healthcare or from your clearinghouse to CHANGE Healthcare. If you experience problems with your EDI submission, first contact your software vendor to validate the claim submissions and upon verification of successful submission, contact CHANGE Healthcare directly at 800.215.4730.

Note: Faxed claims are not accepted

Dental (J430D) Claims

Dental claims should be submitted directly to DentaQuest and information regarding paper and electronic claims as well as electronic funds transfers can be found in the Office Reference Manual on the DentaQuest website www.dentaquest.com.

ELECTRONIC FUNDS TRANSFER (EFT)

EFT allows payments to be electronically deposited directly into a designated bank account without the need to wait for the mail and then make a trip to the bank to deposit your check!

Medical/Behavioral Health Claims

The EFT form is available on our website under the Forms section of the Provider menu. If you do not have internet access, contact Network Management and we will provide you with the form.

SECTION XI: Billing, Claims And Encounters

HIPAA 5010 TRANSACTIONS

Care1st is compliant with the AHCCCS implementation of all 5010 transactions. Trading partners are required to begin sending electronic transactions in the 5010 format. We encourage you to reach out to your respective clearinghouse to obtain specific instructions to ensure you understand how the changes with 5010 may impact your submissions and receipt of data. Some of the major changes with the 5010 claims submission process are listed below:

- Service and billing address: The service and billing address must be the physical address associated with the NPI and can no longer be a post office box or lock box. The pay to address may still contain a post office box or lock box.

- State and Postal Codes: State and zip codes are required when the address is in the US or Canada only. Postal codes must be a 9-digit code for billing and service location addresses.

  Rendering tax identification number: The rendering provider tax identification number requirement has been removed. The only primary identification number allowed is the NPI. Secondary identification numbers are only for atypical providers (such as non-emergent transportation) and we recommend you use the G2 qualifier. The billing tax ID is still required.

- Number of diagnosis codes on a claim: For electronic submissions, it is a requirement that diagnoses are reported with a maximum of 12 diagnosis codes per claim under the 5010 format and paper CMS 1500 submissions contain a maximum of 12 diagnosis codes per claim.

CLAIM ADDRESSES

Medical Claims:

Direct CMS 1500 and UB-04 claim forms (initial submissions and resubmissions) and medical records to:

Attention Claims Department
P.O. Box 31224
Tampa, FL 33631-3224

SECTION XI: Billing, Claims And Encounters

CLAIMS CUSTOMER SERVICE

Medical Claims (CMS 1500 and UB-04 Claim Types):

Claim status can be checked 24 hours a day, seven days a week online at www.care1staz.com.

Our Claims Customer Service Team is also available to assist you during the business hours listed below:

Monday – Friday 8:00 AM - 12:00 PM & 1:00 PM - 4:30 PM
Ph. 602.778.1800/866.560.4042 (Options in order 5, 4).

CLAIM LIAISON

Our *Claim Liaison* is an excellent resource and is available to assist your office via phone at 602.778.1800 x1877, through email at AZClaimsLiaisons@Care1stAZ.com, or in person with questions regarding claim submission and processing.

REQUIRED ID NUMBERS

AHCCCS ID

A six-digit AHCCCS provider ID number is required in order to bill services to Care1st. This number may be obtained by contacting the AHCCCS Provider Registration unit at 602.417.7670, Option 5. In the event that a provider's AHCCCS ID number changes, the provider is responsible for notifying Care1st of this change.

FEDERAL TAX ID

The Provider must also report the Federal Tax Identification Number (TIN) under which they will be paid. The Federal TIN (Employer Identification Number, EIN) must also be billed on the CMS 1500 form in Field 25.

NATIONAL PROVIDER IDENTIFICATION (NPI)

Care1st requires all providers to submit the rendering/servicing provider's NPI on every claim. Care1st requires that when applicable, the prescribing, referring, attending and operating provider NPI(s) also be present on claim submissions. Claims without the required NPI(s) will be denied.

Please work with your billing team to ensure that NPI(s) are submitted appropriately with each claim submission and call us if you have any questions or need assistance.

- To apply for an Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or contact National Provider Identifier Enumerator Call Center 800.465.3203 to request a paper application.

- If you have not yet notified Care1st of your NPI(s), please fax a copy of your NPI(s) confirmation to Network Management at 602.778.1875.

- Providers must also communicate their NPI(s) to AHCCCS Provider Registration. A copy of the NPI Number Notification, along with the provider's name, AHCCCS ID Number and signature of the provider or authorized signor may be mailed or fax to the following:

  AHCCCS – Provider Registration
  PO Box 25520
  Mail Drop 8100
  Phoenix, AZ 85002
  Fax Number: 602.256.1474

BILLING FOR SERVICES RENDERED

CLAIM FORMS

The Centers for Medicare and Medicaid Services (CMS) now requires providers to submit all claims on the newest version of each claim form.

- Practitioners – CMS 1500 (version 02/12)
- Facilities – UB-04
- Dental – J430D

Claims must be submitted on the revised CMS1500 Claim Form (version 02/12). Claims submitted on the old claim form will be denied.

Services can be billed on one of three forms: the CMS 1500 claim form for professional services, the UB-04 for inpatient and outpatient facility services, dialysis, nursing home and hospice services or the J430D for dental services. All providers must submit claim forms as documentation of services rendered, even if the provider has a capitated agreement with the health plan for the service.

TIMELY FILING GUIDELINES

When Care1st is primary, the initial claim submission must be received within six months from the date of service.

Secondary claim submissions must include a copy of the primary payer's remittance advice and be received within 60 days of the date of the primary payer's remittance advice or six months from the date of service, whichever is greater.

- Acceptable proof of timely filing documentation must establish that Care1st or its agent has received a claim or claim related correspondence
  - Acceptable examples of proof of timely filing include:
    - Signed courier routing form documenting the specific documents contained

- Certified mail receipt that can be specifically tied to a claim or related correspondence
- Successful fax transmittal confirmation sheet documenting the specific documents faxed
- Acceptable confirmation report from Emdeon (our sole electronic clearinghouse) documenting successful transmittal

▪ Unacceptable examples of proof of timely filing include:

- Provider billing history
- Any form or receipt that cannot be specifically tied to a claim or related correspondence
- Acceptance confirmation report from any electronic clearinghouse other than Emdeon

DUPLICATE CLAIMS

Care1st receives a large number of duplicate claim submissions as a result of claims being frequently resubmitted within 30 days from the date of initial submission.

To avoid duplicate claims, we recommend validating claims status after 14 days following submission and allowing 60 days prior to resubmission of a claim. The 60 days allows us to meet our goal of paying claims within 30 days from the date of receipt and also allows enough time for billing staff to post payments. Resubmission of claims prior to 60 days causes slower payment turnaround times.

Verify claim status prior to resubmitting a claim. Your claim status can be verified 24-hours a day, seven days a week on our website. Minimizing duplicate submissions reduces your administrative costs.

SCANNING TIPS

All paper claims are input into our system using a process called data lifting and must be submitted in a red and white format.

1. With the exception of a signature in box 31, handwriting is not acceptable on paper claims. All claims containing handwriting will be returned
2. Printing claims on a laser printer will create the best possible character quality
3. If a dot matrix printer must be used, please change the ribbon regularly
4. Courier 12 pitch non proportional font is best for clean scanning
5. Use black ink for all claim submissions
6. 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)*
7. Ensure that the claim form is lined up properly within the printer prior to printing

8. If a stamp is required, refrain from red ink as this may be removed during the scanning process
9. 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 from outside of the lined boxes have a tendency to "throw off" the registration of the characters within a box)*
10. Use an original claim form as opposed to a copied claim form as much as possible
11. 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)*

SECTION XI: Billing, Claims And Encounters

REQUIRED CLAIM FIELDS

The "required" fields to be completed on a **CMS 1500** Claim Form* are as follows:

Field	Description
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
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 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
24b	Place of Service
24d	Procedures, Service or Supplies
24f	Charges (usual and customary amount(s))
24g	Units
24j	Rendering Provider's NPI
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 Location Where Services were rendered – when the address in box 33 is not the address where services where rendered, box 32 must be populated with the service location. **Note:** For transportation claims, the complete pick up and drop off address is required. If the Pick-Up location is an area where there is no street address, enter a description of where the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80')
33	Provider's Facility Name, Supplier's Billing Name (as registered with the IRS), Address, Zip code, and Phone Number
33a	Provider's Organizational NPI

Operative reports, consult notes, consent forms and/or any other documentation required in order to determine reimbursement status of a claim must also be attached.

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

Field	Description
1	Provider Name, Address, and Phone Number
3b	Medical Record Number
4	Bill Type
5	Federal Tax Number
6	Statement Covers Period
9	Patient Name
9	Patient Address
10	Patient Date of Birth
11	Patient Sex
12	Admission Date
13	Admission Hour (Inpatient only)
14	Type of Admission
15	Source of Admission (Inpatient only)
16	Discharge Hour (Inpatient only)
17	Patient Status (Inpatient and observation only)
19-28	Condition Codes
42	Revenue Code
43	Revenue Code Description
44	HCPCS/ Rates
45	Service Date – Required for outpatient billings with more than 1 DOS in box 6
46	Service Units
47	Total Charges by Revenue Code
50	Payer
51	Health Plan ID Number
52	Release of Information
56	Rendering Provider's NPI (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
74 a-e	Other Procedure Codes
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 Numbers (NPI Number only required if name field is populated)

SECTION XI: Billing, Claims And Encounters

OTHER INSURANCE

Care1st is always the payor of last resort and is secondary to Medicare and all other third party carriers. When the patient has other insurance, the primary insurance carrier must be billed first. When a patient notifies the provider of other insurance, Care1st must be notified. Care1st coordinates benefits, applying lesser of methodology as applicable, following AHCCCS Policy (ACOM 201 – Cost Sharing for Members Covered by Medicare and Medicaid and ACOM 432 – Benefit coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services). Please refer to our Prior Authorization Guidelines for prior authorization requirements. Prior authorization is required for some services when Care1st is the secondary payer.

BALANCE DUE CLAIMS

When submitting a claim for balance due, the provider must include a complete copy of the claim along with the other insurance carrier's Explanation of Benefits (EOB) or Remittance Advice (RA), include the remark code/remittance comments section of the RA. Care1st must receive any balance due claim within 60 days of the receipt of the primary carrier's EOB or RA or 180 days from the date of service, whichever is greater.

AHCCCS is the payor of last resort. If a member is enrolled with a Medicare Risk HMO, the member should be directed to their Medicare Risk HMO. However, if the Medicare Risk HMO does not authorize a Medicaid covered service, Care1st shall review the requested service for medical necessity and potentially elect to authorize it.

As the payor of last resort, Care1st has liability of benefits after all other third party payer benefits have been paid. Care1st will have no cost sharing obligation if Medicare or the other insurance payment exceeds the Care1st allowed amount for the service.

If the services billed are not a benefit from Medicare or the other insurance plan, Care1st may reimburse the procedure if the services are medically necessary. If Medicare or the other insurance disallows a service for not being medical necessary or did not adhere to the primary insurance criteria Care1st will not be financially responsible.

When a member is WellCare Liberty (formerly ONECare) primary and Care1st secondary our system will automatically coordinate processing for these services and submission of the primary remittance advice along with another claim will not be necessary. This is only when the member is both Care1st and Liberty. Please contact our Claims Customer Service Team if you have not received a remittance advice for both lines of business within 90 days.

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COST SHARING MATRIX

Covered Services	Care1st Responsibility	In Network	Out Of Network	Prior Auth Required
Medicare only covered services*	Cost Sharing responsibility for QMB Duals only	N/A	N/A	NO
AHCCCS only-not covered by Medicare	Reimbursement for all medically necessary services	YES	NO	YES/NO
AHCCCS and Medicare covered Services (except for emergent/pharmacy svcs)	Cost sharing responsibility only	YES	NO	NO
Emergency Services	Cost sharing responsibility only	YES	YES	NO
Pharmacy and Other Physician Ordered Services	Cost sharing responsibility until member reaches HMO Cap, then full reimbursement	YES	NO	YES/NO

*Care1st is not responsible for cost sharing for Medicare Only Services for Non-QMBs (Qualified Medicare Beneficiary, entitled to AHCCCS and Medicare Part A and B services).

MEMBER BILLING

In accordance with Arizona Administrative Code, providers are prohibited from billing AHCCCS members for covered services.

Arizona Administrative Code R9-22-702 states in part, "an AHCCCS registered provider shall not do either of the following, unless services are not covered or without first receiving verification from the Administration [AHCCCS] that the person was not an eligible person on the date of service:

1. Charge, submit a claim to, or demand or collect payment from a person claiming to be AHCCCS eligible; or
2. Refer or report a person claiming to be an eligible person to a collection agency or credit reporting agency"

Care1st members may not be billed, or reported to a collection agency for any AHCCCS **covered service**.

A member may only be billed when the member knowingly receives non-covered services, if the provider notifies the member in advance of the charges and the member signs a statement agreeing to pay for the AHCCCS non-covered services.

Provider cannot collect copayments, coinsurance or deductibles from members with other insurance regardless of the type of carrier. Providers must bill Care1st as the secondary plan and Care1st will coordinate benefits.

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CLAIMS RESUBMISSION POLICY

Resubmissions/reconsiderations must be received within the following time frames:

- 12 months from date of service
- 60 days of the date of recoupment or 90 days from the date of the reversed dispute decision, if greater than 12 months from the date of service
- 60 days from the date on the primary payer's remittance advice, if greater that 12 months from the date of service

Note: Care1st will re-adjudicate claims re-submitted by providers if an initial claim was filed within the original prescribed submission deadline of six months from the date of service.

RESUBMISSIONS/CORRECTED CLAIMS

When submitting a corrected/voided claim please utilize the format below:

- Resubmissions on CMS1500 forms must include indicator 7 and the original claim number in field 22 (EDI Loop 2300)
- Voided claims on CMS1500 forms must include indicator 8 and the original claim number in field 22 (EDI Loop 2300)
- For UB04 forms bill type XX7 (replacement) or XX8 (void) with the original claim number in field 64 (Loop 2300)

If you feel that you have identified a billing issue that may result in a larger volume or resubmissions, please work directly with your Network Management Representative to coordinate the project.

DUPLICATE OR ERRONEOUS PAYMENTS

Providers will refund promptly to Care1st any payment incorrectly collected from Care1st 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, Care1st 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

The Remittance Advice (RA) is an explanation of the payment arrangements that is sent out with the claims payment to the provider. The report identifies key payment information. If you have any questions regarding a RA, please contact Claims Customer Service or Network Management.

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REMITTANCE ADVICE COLUMNS AND DESCRIPTIONS

The following are the report columns and descriptions included in the RA:

HEADER

Company	The line of business (Care1st), logo and address
Vendor/	
Remit Date	Check payment Date
Vendor No.	A unique internal number identifying the pay to vendor
Check No.	The check number assigned .
Payment	The total amount being paid by the check
TIN	Tax identification number

CLAIM PAYMENT DETAIL

Claim Number	The Care1st internal document number assigned to the claim
Member	Member Name
State ID	AHCCCS ID
Patient ID	Patient ID submitted on the claim
Claim Provider	The Care1st internal unique provider ID number and rendering provider name
DRG	The DRG assigned for payment (when applicable)
Date Approved	Date adjudicated for payment/ denial in the Care1st claims system
POS	Place of Service submitted on the claim
Health Plan ID	N/A for Care1st
Payment To	Payment to Vendor or Member & amount
Invoice Number	The claim invoice number taken from the CONSTANT file and entered on the Enter/Update General Claims screen.
Dates of Service	Dates of service submitted on the claim
Procedure	The revenue code, HCPCS, or CPT code submitted on the claim
Procedure Description	A brief description of the service submitted
Qty	The total quantity/ units submitted for the service
Req. Amt	The billed amount for the procedure
Elig. Amt	The eligible amount for the procedure
COB. Amt	The amount paid by the primary carrier via coordination of benefits
Discount	The amount withheld for discounts (i.e. quick payment discount, contractual discount, etc.)
Copay	The member copayment amount
Coins	The member coinsurance amount
Ded Amt	The member deductible amount
Pay Amt	The payment amount for the service submitted
Adj Code	Reason code that defines claim payment

CLAIM AND REMIT TOTALS

Req. Amt	The total billed amount for the claim/ remit
Elig. Amt	The total eligible amount for the claim/remit
COB. Amt	The total amount paid by the primary carrier via coordination of benefits for the claim/ remit
Discount	The total amount withheld for discounts (i.e. quick payment discount, contractual discount, etc.) for the claim/ remit
Copay	The total member copayment amount for the claim/ remit
Coins	The total member coinsurance amount for the claim/ remit
Ded Amt	The total member deductible amount for the claim/ remit
Pay Amt	The total payment amount for the service submitted for the claim/ remit
Req. Amt	The billed amount for the procedure
Elig. Amt	The eligible amount for the procedure

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REMITTANCE ADVICES AVAILABLE ON WEBSITE

Medical

For your convenience, remittance advices are available for reviewing and printing on our website for up to 6 months from the date of payment, minimizing delay between receipt of dollars and the ability to post payment. Contact Network Management to obtain a login or confirm your login status. To obtain copies of a remittance advice older than 6 months, please contact claims customer service at 602.778.1800/866.560.4042 (Options in order 5, 4).

Dental

For information regarding dental remittances advices reference the Office Reference Manual (ORM) on the DentaQuest website at www.dentaquest.com.

BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICIAL HEALTH SERVICES EFFECTIVE 10/01/18

Effective 10/01/18 ACOM policy 432 was revised to reflect the AHCCCS Complete Care (ACC) model. This revision addresses the integration of behavioral health services into the AHCCCS complete care plans for purposes of benefit coordination, and delineation of financial responsibility for AHCCCS covered physical and behavioral health services.

For fully integrated members covered under an AHCCCS Complete Care (ACC) plan, the enrolled entity is responsible for both physical and behavioral health services for non-SMI (Serious Mental Illness) members. Payment for AHCCCS covered behavioral health services is indicated in **Attachment A, matrix of financial responsibility, responsibility by party.**

Please review the updated policy 432 and attachment A, matrix of financial responsibility, responsibility by party for changes effective 10/1/18 on the AHCCCS website.

http://www.azahcccs.gov/ > Plans/Providers > Guides-Manuals-Policies > AHCCCS Contractor Operational Manual (ACOM) > Chapter 400 Operations > 432 Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services

Direct path to Chapter 400:
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/432.pdf

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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 Care1st. Care1st reimburses providers for covered services rendered to eligible members in accordance with AHCCCS guidelines.
- Verify PPC by looking for rates codes with 3 numbers and a letter.
- Providers have six (6) months from the day member eligibility is entered to submit PPC claims.
- There are no prior authorization requirements during the PPC time frame.
- The Plan is responsible for reimbursing providers only for medically necessary services rendered during the PPC period. If the plan denies an inpatient hospital stay for lack of medical necessity the entire stay will not be paid for either the PPC or prospective time period.
- Prior authorization requirements do apply in accordance with the provider's contract once prospective enrollment begins.

IMPORTANT NOTES

- When box 31 on the CMS 1500 form has "Signature on File," this is acceptable as long as the processor can determine the servicing provider. When only the group name appears in Box 33 and the processor is unable to determine the servicing provider, the claim will be denied. Box 33 should always indicate the facility name as provided to the IRS, AHCCCS, and Care1st.
- If the same service is performed on the same day and by the same provider, the claim must be submitted with the applicable modifier and supporting documentation attached.
- 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 - 7th digit will be denied if not submitted with appropriate code. Care1st never changes or alters a diagnosis code.

MODIFIERS

Valid and approved AHCCCS modifiers should be used when submitting claims to Care1st. Claims that are submitted with an inappropriate or missing modifier will be denied. The following are a few commonly used modifiers and tips on appropriate usage:

***MODIFIER 25* (Separate identifiable E&M service)**
When an EPSDT visit (99381-99385 or 99391-99395) is performed in conjunction with a sick visit (99201-99245) for members less than 21 years of age, modifier 25 is required on the sick visit CPT code in order to be reimbursed for both the EPSDT visit and the sick visit. If both visits are performed in conjunction with VFC immunizations, the modifier 25 is required on both the E&M and EPSDT codes. Modifier EP is required on the EPSDT visit code. The sick visit is reimbursed at 50% of the applicable fee schedule. Please remember that both visits must be billed on the same claim form. See the SL modifier section below for an example of how to bill a sick visit, EPSDT visit and VFC vaccine administration.

EP MODIFIER
Modifier EP is billed in conjunction with 96110 for reimbursement of developmental testing utilizing any of the three AHCCCS approved Developmental Tool: PEDS Tool, MCHAT or ASQ. Providers must first complete the training for the tool that is utilized to be eligible for reimbursement for this service.

The EP modifier is also required on preventative EPSDT services (CPT codes 99381-99385, 99391-99395) and to designate all services related to the EPSDT well child visit, including routine vision and hearing screenings. For more information, see our blast fax communication from August 28, 2014 on our website and the AHCCCS Medical Policy Manual (AMPM) Chapter 400 Policy 430-29 Section H. See the SL modifier section below for an example of how to bill a sick visit, EPSDT visit and VFC vaccine administration.

***SL MODIFIER* (State supplied vaccine)**
Vaccines administered to members under the age of 19 are ordered through the Vaccines for Children (VFC) program. For a complete listing of eligible VFC codes, refer to www.azdhs.gov/phs/immun/act_aipo.htm. To be eligible for reimbursement, bill vaccines supplied through the VFC Program as outlined in the claim example below.

CLAIM EXAMPLE: Billing sick visit, EPSDT visit and vaccine code(s) for single date of service:

Patient (under the age of 19) makes appointment because of an earache. Office determines it is time for EPSDT evaluation and vaccine. Office bills:

- Both the sick and well diagnosis codes
- Sick visit is billed with appropriate E&M (99201-99245) with modifier 25
- EPSDT visit is billed with appropriate E&M (99381-99385 or 99391-99395) with modifier 25 and modifier EP
- Vision screening is performed as part of the EPSDT visit (92015) with modifier EP
- VFC vaccine code is billed with the applicable NDC and the SL modifier
- Vaccine administration code is billed with the SL modifier

MODIFIER 50 **(bilateral procedure)**
Modifier 50 is required for all bilateral procedures. Please refer to the current coding guidelines for a listing of appropriate bilateral procedures.

Bilateral procedures are billed on one line with 1 unit and the 50 modifier:

EXAMPLE:
Line 1: 69436, with "50" modifier, full dollar amount, 1 unit
Total payment: 150% of fee schedule

MODIFIER 59 **(distinct procedural service)**
Modifier 59 is required to identify a truly distinct and separate service and should not be used if the procedure is performed on the same site. When an already established modifier is appropriate, it should be used instead of modifier 59 (example modifier 91 for repeat clinical procedures). Care1st applies NCCI (National Correct Coding Initiative) bundling edits to claims. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission for consideration. Effective 01/01/15 four new HCPCS modifiers to define subsets of the modifier 59, used to define a "Distinct Procedural Service", are available for use:

- XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Records are required for modifier 59, XE, XS, XP & XU when billed with the following codes: 36600, 43210-43239, 45380-45398, 45900-45999, 46600-46615, 49560-49568, 51600-51720, 51725-51798, 52000-52318, 58100-58120, 62310-64640 or 69100-69999. Records are also required for these modifiers for 96372 billed with pain management procedures or 94640 billed with 94060.

MODIFIER 76 **(repeat procedure by same physician)**
Modifier 76 is required to identify repeat procedures preformed by the same physician. When multiple procedures are performed by the same provider, all services should be submitted on one claim on a single line when possible.

Example (No records required when all services billed on line or only a single repeat code has modifier 76)

- Line 1 – 73020/26 for units

Claims submitted with modifier 76 billed on the same code on multiples lines, or the same code with modifier 76 on multiple claims are subject to medical review and records are required with the claim submission in order to be considered.

Example (Records required for review)

- Line 1 – 73020/26 for 1 unit
- Line 2 – 73020/26/76 for 1 unit
- Line 3 – 73020/76 for 1 unit

***MODIFIER* 77** (repeat procedure by a different physician)
Modifier 77 is required to identify repeat procedures performed by different physicians. Claims submitted with modifier 77 do not require medical records when the modifier is billed on single procedure code on the claim.

MODIFIERS GP & GO (Therapy code modifiers)
Modifier GP is required to identify physical therapy services and is appended to the appropriate case rate, or therapy code. Modifier GO is required to identify occupational therapy services and is appended to the appropriate case rate, or therapy code. Please refer to your billing guidelines for coding requirements.

MODIFIER 91 (repeat clinical diagnostic laboratory test)
Modifier 91 is required to identify repeat procedures performed by the same physician. When multiple procedures are performed by the same provider, both services are submitted on the same claim. Claims submitted with modifier 91 are subject to medical review and records are required with the claim submission in order to be considered

***MODIFIER* SG (Ambulatory Surgical Center facility service)**
Modifier SG is required on surgical procedures to identify the facility billing and is not used for professional services.

***MODIFIERS QK, QX & QY* (Anesthesia with CRNA oversight)**
When anesthesia services are provided by a CRNA with oversight from a physician, the appropriate modifier is required (QK, QX, or QY).

Services are reimbursed to each provider (CRNA and supervising physician) at 50%.

ADDITIONAL MODIFIER CRITERIA

- When a complete laboratory service is performed (both professional and technical component), the service should be billed on a single service line with no modifier.

- Modifiers are required for all DME, Prosthetics and Orthotics and Ambulance services.

- When both the technical and professional component are performed by the same provider of service, the service code(s) should be billed on a single service line without a modifier, and not billed on two separate lines with the TC and 26 modifiers.

OPERATIVE REPORT

An operative report is required for the following surgical procedures:

- Multiple procedures with a total allowed amount greater than $5000.00
- Any surgical procedure billed with modifier(s):
  - 62, 66, 76, 77, 78, XE or XP – All Claims
  - 59, XS, XU – Claims with codes billed in the ranges under modifier 59 section
- Any unlisted procedures
- Any surgical procedure billed for a higher level of care than originally prior authorized

REFUNDS

When submitting a refund, please include a copy of the remittance advice, a letter or memo explaining why you believe there is an overpayment, a check in the amount of the refund, and a copy of the primary payer's remittance advice (if applicable) and a corrected claim (if applicable).

If multiple claims are impacted, submit a copy of the applicable portion of the remittance advice for each claim and note the claim in question on the copy. When a refund is the result of a corrected claim, please submit the corrected claim with the refund check.

Refunds are mailed to Care1st, Attention: Finance, 1870 W Rio Salado Parkway, Tempe, AZ 85281.

ANESTHESIA

Notes are required for all timed procedures and are subject to medical review. The specific anesthesia start and end time must be submitted on the CMS-1500 form. The total number of minutes is required in the unit field (25G).

The following are not reimbursable:

00938	99116
94656	99135
99100	99140

- Consultations of other evaluation and management code on the same day as an anesthesia administration are not payable. Consultations provided the day before anesthesia services are payable separately when prior authorization is obtained.

- Daily pain management following surgery is not a covered expense.

Certified Registered Nurse Anesthetists (CRNA) are reimbursed at 100% of the AHCCCS fee schedule.

When services are provided by a CRNA and oversight is provided by a supervision physician, the applicable modifier must be submitted on each claim. The QX modifier is billed with the CRNA service when medical direction is provided by a physician. The QY modifier is billed by the supervising physician to indicate medical direction was provided to the CRNA. The QK modifier is billed by the supervising physician to indicate that medical direction was provided to multiple concurrent anesthesia procedures.

As a reminder, the anesthesia record is required anytime the anesthesia starts and stops during a procedure.

ASSISTANT SURGEONS

Assistant surgeon bills are submitted with a modifier -80 or -81. These charges are reimbursed at 20% of the reimbursement rate of the assistant surgeon. Assistant surgeon charges submitted for a physician assistant, nurse practitioner, or clinical nurse specialist should be submitted with modifier AS.

DIALYSIS

- For facility billings, the type of bill must be 72x and the appropriate modifiers must be billed for the specific dialysis services.
- Admission date/hour and discharge hour should be left blank on dialysis services to avoid claims rejections.

- Physicians do not require their own authorization. They may use facility authorization.

GENERAL MENTAL HEALTH/SUBSTANCE ABUSE BILLING GUIDELINES

Integrated Clinics and Behavioral Health Outpatient Clinics

Services received at an Integrated Clinic or Behavioral Health Outpatient Clinic are billed under the clinic location as indicated below.

- Rendering Provider = service location, not a practitioner. The site specific NPI is used and is placed in the following location:
  - Paper claim-Box 24J

- EDI claim-Loop 2310B bill (Note: If Loop 2010AA: NM109 also contains the site location NPI, Loop 2310B can be left blank)

• Signature field is left blank for clinic facility billing. The signature field is located as follows:
  - Paper claim-Box 31
  - EDI CLAIM-LOOP 2300: CLM06

AHCCCS Registered Practitioner

Services rendered by an AHCCCS registered practitioner, i.e. Licensed Marriage/Family Therapist (LMFT), Licensed Professional Counselor (LPC), Licensed Independent Substance Abuse Counselor(LISAC), Physician (MD), Physician Assistant (PA), Nurse Practitioner (NP), Social Worker (LCSW) or a Psychologist, are billed under the rendering practitioner.

• Rendering provider = the practitioner. The practitioner's NPI is placed in the following location:
  - Paper claim-Box 24J
  - EDI claim-Loop 2310B

• Signature field is populated with the rendering practitioner's name. The signature field is located as follows:
  - Paper claim-Box 31
  - EDI claim-Loop 2300: CLM06

DURABLE MEDICAL EQUIPMENT

- Canes, crutches, standard walkers, standard wheelchairs and supplies do not require an authorization when provided by a contracted provider.

- Valid modifiers must be submitted with DME services to indicate NU (new) or RR (rental rate). Claims submitted without one of these modifiers will be denied.

EMERGENCY TRANSPORTATION PROVIDERS

Claims for emergent transportation, including transport transfer services to a higher level of care (such as member transfer from Skilled Nursing Facility to Hospital), must indicate Emergency in Box 24C. Emergent services do not require prior authorization; however non-emergent services must be authorized accordingly. Inter-facility transports require authorization.

The appropriate modifier for ambulance services must also be billed.
Fractional mileage is now accepted by AHCCCS and should be billed on transport claims when applicable. The full pick up address (or location if an address is not available) and drop off address are required in box 32 for ambulance services. If the pick-up location is an area where there is no street address, enter a description of where

the service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80'). Claims that do not contain this information will be denied.

For electronic claims, the pick-up location must be billed in loop 2310E and the drop off location must be billed in loop 2310F. No trip ticket is required if these fields are populated correctly.
For paper claims, a trip ticket is required on each claim. Pick-up and drop-off requirements are as follows:

1. Pickup and/or drop off location = facility, i.e. hospital, SNF
   - Street address, city, state, zip required in box 32
2. Pick up and/or drop off location ≠ facility
   - Street address, city, state, zip required in box 32
3. Pick up location = area where there is NO street address
   - Description of where service was rendered (e.g. 'crossroad of State Road 34 and 45' or 'exit near mile marker 265 on Interstate 80') required in box 32

Claims that do not contain the minimum requirements are denied.

Supplies provided during emergency transportation are to be billed by the ambulance service and not the supply company. Billable code range for supplies = A0010- A0999. Supplies are billed with 1 unit.

Ambulance wait time is not a covered benefit.

FAMILY PLANNING SERVICES

Authorization is NOT required for family planning services, but the diagnosis must indicate family planning.

Services not covered by AHCCCS for family planning include:

1. Services for the diagnosis or treatment of infertility
2. Abortion counseling
3. Abortions, unless one of the following conditions is met:

   a. The pregnant member suffers from a physical disorder, physical injury or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.

   b. When the pregnancy is a result of rape or incest.

c. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
    i. Creating a serious physical or mental health problem for the pregnant member
    ii. Seriously impairing a bodily function of the pregnant member
    iii. Causing dysfunction of a bodily organ or part of the pregnant member, or
    iv. Preventing the pregnant member from obtaining treatment for a health problem

Care1st requires a completed Federal Consent Form for all voluntary sterilization procedures, including claims submitted for sterilization services provided during the recipient's retro-eligibility period, prior period coverage (PPC). Federal consent is required for tubal ligations.

Federal consent requirements for voluntary sterilization require:

- 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 Consent Form.
- The recipient must be at last 21 years of age at the time the consent is signed.

FQHC/RHC PPS RATE

AHCCCS health plans reimburse FQHC/RHC claims at the PPS rate in accordance with AHCCCS billing requirements.

There are specific requirements for reimbursement, which are posted to the AHCCCS website in Chapter 10 FQHC/RHC Addendum of the AHCCCS Fee-for-Service Provider Manual. Please reference this Chapter for important claim submission details.

SECTION XI: Billing, Claims And Encounters

Reminders:

1. The billed amount for the T1015 must be greater than or equal to the PPS rate or lesser of is applied
2. The rendering provider on the claim is the FQHC not the practitioner. The site specific NPI and/or the FQHC entity name is placed in the following fields of the claim:

Medical Paper Claims	***Dental Paper Claims***	***Medical & Dental EDI Claims***
Box 24J and 32	Box 54 and 56	Loop 2310B and 2310C

3. The participating/performing practitioner information is listed the following fields of the claim:

Medical Paper Claims	***Dental Paper Claims***	***Medical & Dental EDI Claims***
Box 19	Box 35	Loop 2300 NTE segment

4. Services provided in some places of service outside the FQHC/RHC, i.e. services rendered in an inpatient hospital setting, should be billed under the servicing practitioner vs. the FQHC/RHC
5. When submitting a paper claim, populate box 31 on medical and box 53 on dental claims with 'Signature on file'. (For 837 submissions this field, loop 2300, clm, 06 should be left blank).
6. At a minimum, there should at least be 2 codes billed. The T1015 and the actual service(s) rendered. All services performed at the visit should be billed on the same claim.
7. For maternity claims:
    - All prenatal and post-partum visits should be billed by the FQHC/RHC site and will be paid the PPS rate
    - The delivery is billed under the practitioner that performed the delivery
8. Coordination with other primary insurance is applied to the whole claim to determine secondary payment
9. For members that have WellCare Liberty (formerly ONECare) and Care1st coverage, the secondary claim must be submitted to Care1st on paper with a copy of the Liberty remittance advice.

HOME HEALTH

- Nursing supplies are not considered routine. All supplies require prior authorization to be reimbursed.

- Any nursing visits not included in the per diem (more than one per month) or visits longer than two hours must be authorized by the case manager for reimbursement.

HOSPICE SERVICES

- Services must be billed on a UB-04 claim form using bill types 81x, 82x, the third digit must be 1 through 4 or 6 through 8.
- All UB-04 hospice/end of life claims require itemization, unless Medicare is primary.
- Care1st 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.

IMMUNIZATIONS/INJECTABLES

VACCINE FOR CHILDREN (VFC) PROGRAM

PCPs rendering services to children under the age of 19 and covered by AHCCCS must participate in the VFC program and coordinate with the Arizona Department of Health Service Vaccines for Children (VFC) program in the delivery of immunization services. Through the VFC program, the federal government purchases and makes available to the states, free of charge, vaccines for children under the age of 19 who are Title XIX eligible, Native American, or Alaskan Native, not insured, or whose insurance does not cover immunizations.

Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule which is found at www.cdc.gov/vaccines or on our website www.care1staz.com (See Practice & Preventive Health Guidelines under the Provider menu). For more information regarding the VFC program or to enroll as a VFC provider please call the Vaccine Center at 602.364.3642. The VFC program updates its covered vaccines as needed. For a complete listing of eligible VFC codes, refer to http://www.azdhs.gov/phs/immun/act_aipo.htm#vfc.

When E&M services and VFC services are performed on the same day, billing for these services are submitted on the same claim. One administration fee is reimbursed for each immunization, including combination vaccines. To receive reimbursement for the administration of a VFC vaccine, bill the vaccine CPT code (including the NDC) with an SL modifier and the applicable vaccine administration code with an SL modifier. Administration fees should be billed on a single line, with the appropriate number of units.

OTHER INJECTABLES

J3490 (unclassified drug code) requires description & dosage and should only be used if there is no other appropriate code. A description of the specific drug is required along with the applicable NDC.

SECTION XI: Billing, Claims And Encounters

DRUG BILLING/NATIONAL DRUG CODE (NDC)

Drugs administered in outpatient clinical settings in accordance with Federal Deficit Reduction Act of 2005 require the NDC. All paper and electronic UB-04 and CMS 1500 claims must include the appropriate National Drug Code (NDC) number on claims for payments for drugs administered in an outpatient setting.

NDC is billed with an N4 qualifier when submitted electronically and must be billed in the following format: With 11 digits for the NDC, the unit of measure (F2, GR, ML, or UN) and the quantity (examples: N411111111111 F210 for electronic submission or 11111111111 F210 for paper submission)

Claim lines billed without the NDC code are denied.

J3490 is used for unclassified drugs – the unit of measure and dosage quantity should be billed following the NDC billing guidelines. The line level quantity billed should always reflect 1 (one).

LABORATORY

PCPs and Specialists may bill in office labs based on the Clinical Laboratory Improvement Amendments (CLIA) test complexity categorization provisions utilized by AHCCCS. In order for a lab to be payable, the lab must be allowed by AHCCCS to be performed in POS 11. Practices with CLIA certifications must ensure that each CLIA certification is on file at AHCCCS for each provider and that each provider has an agency code of 200 noted on the AHCCCS PR020 Licenses/Certifications screen. All other laboratory services, including drug screening, must be referred to Sonora Quest.

Sonora Quest patient service locations are available at www.sonoraquest.com by clicking on the patient service center locator tab. Web-based patient service center appointment scheduling is also available and offers members the ability to schedule an appointment for a convenient day and time, resulting in reduced wait time upon arrival at a patient service center. The web based scheduling system is available 24 hours per day. Walk-in appointments are still available during scheduled hours of operation as well, although appointments are encouraged.

MATERNITY SERVICES

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

Prior Authorization for total OB packages must be requested within 30 days of pregnancy confirmation.

SECTION XI: Billing, Claims And Encounters

Care1st reimburses obstetrical care as a total OB (TOB) package. To qualify for a TOB package, a minimum of 5 ante partum visits must be rendered in addition to the delivery. To confirm this requirement was satisfied, the appropriate delivery CPT procedure code is billed in addition to the ante partum visits. Ante partum and post partum visits are billed with the appropriate E&M CPT code (99211-99215) on individual service lines with 1 in the 'units' field for each date of service.

AHCCCS requires health plans to collect all dates of service for obstetrical care. This change does not impact policies related to global billing, however it requires that all dates of service must be reported on the claim [AMPM Policy 410 Section D(3)(f)]. Consequently, each ante partum date of service must be billed individually. Claims that are not billed in this format will be denied.

Total OB Example:

OB physician performs 6 ante partum visits between January 1 and April 30 and delivery occurs May 5.

- Line 1: Appropriate total OB care delivery CPT code
- *Line 2: 1st Ante partum visit billed with the date of service and E&M CPT code
- *Line 3: 2nd Ante partum visit billed with the date of service and E&M CPT code
- *Line 4: 3rd Ante partum visit billed with the date of service and E&M CPT code
- *Line 5: 4th Ante partum visit billed with the date of service and E&M CPT code
- *Line 6: 5th Ante partum visit billed with the date of service and E&M CPT code
- *Line 7: 6th Ante partum visit billed with the date of service and E&M CPT code
- *Line 8: Post partum visit billed with the date of service and E&M CPT code. *Claims for the total OB package can be billed prior to the post partum visit being rendered. Please be sure to submit the post partum visit once it is completed.*

*****Each visit must be billed on a separate line with the specific date of service and a unit of 1.

All services included in the TOB package are billed with the delivery. Reimbursement is made on the total OB care delivery CPT code.

To report services related to maternity care, use the appropriate CPT-4 office visit codes and the appropriate ICD-10-CM pregnancy diagnosis codes.

Prenatal care can be billed as fee-for-service if patient transfers to a high risk OB doctor or patient terminates from Care1st.

Pregnant women up to 21 years and younger are required to have an EPSDT visit. This visit should be billed with the appropriate date of service and $0.00 amount at the time the total OB package is billed. This service should be billed on a separate line from the prenatal visits.

CPT PROCEDURE CODES, VAGINAL DELIVERY

59400 Package Routine obstetric care including antepartum care (a minimum of five visits), vaginal delivery (with or without episiotomy and/or forceps) and postpartum care. Total OB package should be billed after delivery.

59409 Vaginal delivery only (with or without episiotomy), forceps or breech delivery. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59410 Vaginal delivery only (with or without episiotomy), forceps or breech delivery including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59610 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery.

CPT PROCEDURE CODES, CESAREAN DELIVERY

59510 Package Routine obstetric care including antepartum care (a minimum of five visits), cesarean delivery, and postpartum care. Total OB care should be billed after delivery.

59514 Cesarean delivery only with no postpartum or antepartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59515 Cesarean delivery only including postpartum care. Use when there are fewer than five prenatal visits and total OB authorization was obtained.

59525 Subtotal or total hysterectomy after cesarean delivery.

59618 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.

*Multiple births should be paid using the total OB code for the first birth and the delivery only code with a 51 modifier for subsequent births.

LABOR AND DELIVERY
Providers should use ASA code:

00857 Continuous epidural analgesia for labor and cesarean section

00955 Continuous epidural analgesia for labor and vaginal delivery

00850 Base (7) + time for cesarean section-8 total time units max

00946 Base (5) + time for vaginal delivery-8 total time units max

01960 Anesthesia for vaginal delivery only-8 total time units max

01961 Cesarean delivery only-8 total time units max

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery-8 total time units max

01968 Cesarean delivery following neuraxial labor analgesia/anesthesia-8 total time units max

01969 Cesarean hysterectomy following-8 total time units max

OB anesthesia does not require documentation. We pay the base units plus a maximum of 8 time units for labor and delivery anesthesia. Providers should not bill 01996 with anesthesia for delivery.

ADDITIONAL OB INFORMATION

- 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 provider change facility affiliation, Care1st must be notified regarding disposition of members. The authorization may follow the physician but final billings must be initiated by each facility and each facility must indicate the dates of service and charges that apply. The physician's facility that provides the delivery will be eligible for total OB reimbursement if the authorization is on file and the minimum numbers of visits have taken place.

- A total OB authorization includes all prenatal visits and postpartum care (including Prior Period Coverage dates). When a patient transfers care to another provider, a new OB auth must be obtained.

- Any additional surgical procedures performed during the delivery admission must also be reported along with appropriate diagnosis. If a postpartum tubal ligation is performed, the signed consent form must be submitted with the claim.

- Providers must bill each prenatal visits on a separate service line with 1 unit each on the CMS 1500 claim form.

- No prior authorization is required for assistant surgeon services on cesareans. Assistant surgeon services are not covered for vaginal deliveries, **only** for cesareans.

- OB claims need a minimum of five visits in order to qualify and be paid for a total OB package rate. If no prenatal visits are billed with total OB package codes 59400, 59510, 59610, or 59618 the claim will be denied.

- If a claim indicates pregnancy terminated, patient transferred care, or patient moved out of state, the provider(s), total OB authorization will still cover all charges incurred up to that point to be paid fee-for-service. The reason for discontinuation of care should be indicated on the CMS 1500 form.

- The operative report, prior authorization and the Federal consent form are required for sterilization services. Consent form must be signed 30 days prior to sterilization. Total Hysterectomies do not require an authorization if performed on an emergency basis and they never require a federal consent form.

- 2D OB ultrasounds (3 or more) require prior authorization

MID-LEVEL PROFESSIONALS (NP'S & PA'S)

NPs and PAs are reimbursed at the Care1st Midlevel Fee Schedule.

DEVELOPMENTAL SCREENING TOOLS

AHCCCS approved developmental screening tools should be utilized for developmental screenings by all participating PCPs who care for EPSDT age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. The developmental screening should be completed for EPSDT members during the 9 month, 18 month and 24 month EPSDT visits. A copy of the screening tool must be kept in the medical record.

Additional reimbursement may be received when:

1. One of the AHCCCS approved screening tools (listed below) is completed during a 9, 18 or 24 month EPSDT visit:

a. Parents' Evaluation of Developmental Status (PEDS)
b. Modified Checklist for Autism in Toddlers (M-CHAT-R/F)
c. Ages & Stages Questionnaire (ASQ)

2. PCP is trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics;
3. The screening is billed separately from the EPSDT visit using CPT code 96110 with an EP modifier.

RADIOLOGY

Providers must bill with either a 26 (professional) or TC (technical) modifier for correct reimbursement. When billed with no modifier, provider is indicating they provided both the technical and professional services. All services performed for a specific service date or date span must be billed on a single claim.

SKILLED NURSING FACILITY (SNF)

- The type of bill for facility billings must be 21x
- Revenue codes for room & board for SNFs is 190-194 and 199
- Medicare Part B Only does not cover respiratory therapy; it does cover occupational, physical and speech therapies.
- Medicare Part B Only providers are required to itemize their charges, items covered by Medicare Part B need to be identified.

* SNF providers cannot bill with overlapping months.

SURGERY PROVIDERS

- An operative report is required for the following surgical procedures:
    1. Multiple procedures with a total allowed amount greater than $5000.00
    2. Any surgical procedure billed with modifier(s) 62, 66, 76, 77, or 78
    3. Surgical procedures billed with modifier 59 when billed with the following codes: 36600, 43210-43239, 45380-45398, 45900-45999, 46600-46615, 49560-49568, 51600-51720, 51725-51798, 52000-52318, 58100-58120, 62310-64640 or 69100-69999
    4. Any unlisted procedures
    5. Any surgical procedure billed for a higher level of care than originally prior authorized

- Multiple procedures are paid at 100% of the applicable fee schedule for the primary procedure, and 50% of the applicable fee schedule for the next five procedures. When an operative report is required and not submitted, the claim will be denied for the operative report. Office procedures require office note's if an OP report is not available. In order to eliminate any delay in payment, submit an OP Report with a surgery claim.

- Planned surgeries require their own prior authorizations. Surgical trays (A4550) are not reimbursable.

MEDICAL CLAIMS REVIEW

The Medical Management (MM) Department has assigned the medical claims analysis responsibility to the medical claims analysts who are responsible for reviewing and analyzing all claims deemed appropriate for retrospective review. The MM Department uses the following guidelines, criteria, and coding indexes to review a claim:

- International Classification of Diseases-Tenth Edition (ICD-10)
- Current Procedural Terminology (CPT)
- CMS Common Procedure Coding System (HCPCS)
- Medicare Guidelines
- Milliman Care Guidelines®
- National Correct Coding Guide: Correct Coding Initiatives (CCI)
- UB Editor
- McKesson Claim Check

The following types of claims are reviewed by MM on a regular basis. Please note that this is not an all-inclusive list and is subject to change at any time.

- All Level-V Emergency Medicine Physician charges
- Inpatient claims that are set to pay at the inpatient outlier rate
- Multiple and Bilateral Surgeries over $500.00
- Inpatient PPC claims
- Observation over 24-hours
- Critical care
- Prolonged services
- Anesthesia unusual services
- Unlisted/ By report procedures

As needed, the results of the MM analysis are forwarded to the Sr MD for review and decision. All identified claims that do not meet the criteria may be subject to denial or reduction of reimbursement and are reviewed by the Sr MD or designee. All cases of potential fraud or abuse are referred to AHCCCS in accordance with Care1st's Fraud and Abuse policy.

The outcomes and aggregate adjustments are compiled, tabulated and presented monthly to the MM Committee by the Sr MD.

If appropriate, members will be referred to MM for monitoring and assistance with continuity of the member's care.

ENCOUNTER DATA

Care1st is required to submit a record (encounter data) of provider claims for all valid Medicaid covered services to AHCCCS. The required encounter data include paid claims, zero paid claims and select denied claims. AHCCCS uses the encounter data for many things, some of which are to:

- Evaluate health care quality
- Evaluate plan performance
- Develop provider payment rates which plans may use

ENCOUNTER DATA VALIDATION

As part of an annual federal requirement, AHCCCS may request medical records from practitioners and hospitals or claim copies for services provided to AHCCCS members during a previous AHCCCS contract year (October 1st through September 30th). This process is referred to as a Data Validation Study. The study audits the integrity of claims submitted to AHCCCS health plans and ultimately to AHCCCS Administration. Quality indicators are affected by the accuracy of the claims submitted and reimbursement to your practice can be negatively impacted by inaccurate claims submission.

Following the tips below will help ensure each Data Validation study is successful:

1. Medical record copies must be legible. Please check the ink in your printers or review the quality of the photocopies before records are packaged and mailed.
2. Physician signatures must be legible on all documentation per Medicare requirements. If the signature is not legible, the printed name should be included under the signature and must be legible.

3. All medical record documentation must have the date of services and the patient's name on every page.
4. Documentation for office visits/consults must support the level of service billed.
5. Documentation must support the number of units billed.
6. Documentation for time-based services (i.e. anesthesia) must include the time element.
7. Diagnoses must be reported to the highest level of specificity.
8. Ambulance mileage must be documented on the medical record.

Care1st appreciates and values your assistance and partnership during the annual data validation study.