Chapter 9

CLAIMS PROCESSING AND PAYMENT

CMDP out-of-home caregivers and members are not responsible for any medical or dental bills incurred for the provision of medically necessary services. Please note that requesting payment from, sending a bill to, or initiating collection against an out-of-home caregiver or member is prohibited and is in violation of federal and state laws, in accordance with Arizona Administrative Code R9-22-702 (F). Civil penalties may be assessed if a provider continues billing or pursuing collection actions toward a CMDP out-of-home caregiver or member for charges.

The CMDP Claims Unit adjudicates providers' claims, and is responsible for claims inquiries and research. Accuracy is extremely important in filing claims to ensure timely and accurate payment. Providers must meet CMS and AHCCCS standard reporting requirements.

In addition to paying providers, the Claims Unit is responsible for sending encounter information to AHCCCS. CMDP does participate in yearly Encounter Validation studies with AHCCCS. The purpose of the validation studies is to compare recorded utilization information from a medical record or other sources with CMDP's submitted encounter data. Any and all covered services may be validated as part of these studies.

Provider Information

It is important that CMDP has accurate billing information for providers on file. Please confirm with CMDP Provider Services that the following information is current in our system:

- Provider Name (as noted on the current W-9 form)
- AHCCCS Provider ID
- National Provider Identifier (NPI)
- Physical name and address
- Billing name and address (if different)
- Tax Identification Number

Physician/Mid-Level Practitioner Registration

Hospitals and clinics may not bill CMDP or the other AHCCCS health plans for physician and mid-level practitioner services using the hospital or clinic AHCCCS Provider ID number. Physicians and mid-level practitioners must register with AHCCCS and bill for services under their own AHCCCS Provider ID number. Services provided by nurse practitioners and physician assistants cannot be submitted using the doctor's provider registration.

Mid-level practitioners include:

- Physician assistants
- Registered nurse practitioners
- Certified nurse-midwives
- Certified registered nurse anesthetists (CRNAs)
- Surgical first assistants

Note: Physician assistants, certified nurse-midwives, and nurse practitioners are reimbursed at 90 percent of the AHCCCS fee-for-service (FFS) rates. Surgical first assistants are reimbursed at 70 percent of the AHCCCS FFS rates, and CRNAs are reimbursed at 100 percent of the rates.

Hospitals and clinics may register as group billers, and bill as an agent for physicians and mid-level practitioners. In these cases, the claims submitted to CMDP must include both the physician's/mid-level practitioner's ID number as the service provider and the hospital or clinic's group billing ID number.

Providers with questions about their CMDP registration may contact CMDP Provider Services at (602) 351-2245 or (800) 201-1795.

CMDP Member ID Number

This unique identifying number assigned by CMDP is found on the member's ID card. This number starts with 00. AHCCCS eligible (Title XIX) members will also have an AHCCCS ID number which starts with the letter A.

Be sure to include the CMDP ID number on all claims and documentation.

Missed Appointments

CMDP does not pay for missed appointments. Out-of-home caregivers are requested to notify providers at least one day in advance when a child is unable to keep an appointment. Please inform CMDP Provider Services if a child repeatedly fails to appear for appointments. CMDP will make every effort to resolve the problem.

Out-of-State Coverage

A member who is temporarily out of the state is entitled to receive benefits under any of the following conditions:

- Medical services are required because of a medical emergency,
- A particular treatment is required that can only be obtained in another state, or
- A chronic illness necessitates treatment during a temporary absence from the state, or the condition must be stabilized before returning to the state.

Providers can check CMDP member eligibility online at https://dcs.az.gov/cmdp/providers. Click on the "Claim Look-up" link under Provider Resources. Providers may also contact CMDP Member Services to verify eligibility prior to the member's appointment.

Acceptable Claim Forms

CMDP requires all providers to use one of three forms when billing for services, per AHCCCS requirements and guidelines.

Please note:

- The **CMS 1500** form is used to submit claims for all professional services, including ancillary services, ambulatory surgery centers, urgent care centers, professional services billed by a

hospital, and other providers as required by AHCCCS.
- A **UB-04** form is used to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long-term care facilities, hospice services, and other providers as required by AHCCCS.
- Claims for dental services should be submitted on the American Dental Association **ADA 2006** or **ADA 2012** claim forms. (The ADA 2006 will be phased out when ICD-10 is implemented on October 1, 2015.)

CMDP will not process claims received on any other type of claim forms. All AHCCCS billing guidelines and requirements must be followed. Instructions on completing the claim forms are found in these chapters of the *AHCCCS Fee-For-Service Service Provider Manual* (www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html)

CMS 1500 form - Chapter 5

- CMS 1500 form - Chapter 5
- CMS UB-04 form - Chapter 6
- ADA 2012 form - Chapter 7

General Billing Information

Claims will be considered for reimbursement only if billing requirements are met and the member is enrolled with CMDP on the date the service was performed. If prior authorization was required, the PA number must be entered in the appropriate field on the claim form. Submitting a prior authorization with the claim does not guarantee reimbursement. Reimbursement for services depends on the member's enrollment on the date(s) of service (DOS), medical necessity, limitations, and exclusions as stated in Article 60 of Title 5, Chapter 6 of the Arizona Administrative Code (A.A.C.).

- Claims must be legible and suitable for imaging and record retention purposes. Complete ALL required fields, and include additional documentation when necessary.
- The claim form will be returned unprocessed if illegible or if required documentation is missing. This could result in the claim being delayed or denied.
- Submit original claims through the mail. Facsimiles and emailed images are not accepted. To include supporting documentation, such as members' medical records, clearly label and send to the CMDP Claims Unit with the appropriate claim form.
- Electronic Data Interchange (EDI) is also available. To submit claims electronically please visit the CMDP website, https://dcs.az.gov/cmdp. If you need assistance becoming a trading partner, contact Provider Services at (602) 351-2245 or (800) 201-1795.
- When submitting electronic claims, include PA or PD numbers, EPSDT/PEDS forms, NDC codes, anesthesia units/times, etc., in the appropriate fields.

Prior Authorization (PA)/Predetermination (PD) for Service

See the Prior Authorization Requirements section in *Chapter 5* for additional information on PA requirements, and the medical and dental PD matrices. The medical and dental matrices are located online at https://dcs.az.gov/cmdp/providers.

Prior authorization is required for, but not limited to, the following:

- All rentals of durable medical equipment (DME)
- Medically necessary nonemergency transportation
- Specialty treatment follow-up (initial consultation does not require a PA)
- Therapy treatment services for physical, occupational, or speech therapies (initial consultation does not require a PA)
- Certain diagnostic testing (see medical PA Matrix for details)
- Genetic testing
- Outpatient surgeries
- Ambulatory surgery centers (PA separate from physicians)
- All inpatient hospital stays
- Total OB package
- Behavioral health services
- All orthodontia
- Certain dental procedures as described in the A.A.C. R6-5-6006(17).
- Services over AHCCCS-allowed units or frequencies.

The issuance of a PA/PD does not guarantee payment. The medical condition for which the authorization was issued must be supported by medical documentation, and the claim must be clean and submitted timely.

Codes to Use

CMDP accepts national standardized coding, which includes the Current Procedural Terminology (CPT Expert); the International Classification of Diseases, 10th Revision (ICD-10); HCFA Common Procedure Coding System (HCPCS); and the American Dental Association (ADA) Current Dental Terminology.

- **CPT:** Reporting medical services and procedures performed by physicians.
- **ICD-10-CM:** Reporting diagnoses/conditions, report out to the 6th or 7th digit, as required.
- **HCPCS:** Reporting non-physician procedures, such as ambulance services, durable medical equipment, and specific supplies
- **ADA:** Reporting of dental procedures.

Clean Claims and Timely Claims Filing

Providers are encouraged to bill for services as soon as possible after the services have been provided. Claims must be received within 6 months from the date of service. A *clean claim* must be received within 12 months of the date of service. CMDP will adjudicate clean claims within 30 to 45 days of receipt.

Per A.R.S. § 36-2904, a clean claim means a claim that can be processed without obtaining additional information from the service provider or from a third party. Clean claims do not include claims under investigation for fraud or abuse, or claims under review for medical necessity.

Claims lacking information necessary for entry into the CMDP data processing system will be denied, and a remittance advice will be mailed explaining reason for denial.

Proof of Timeliness

Proof of timeliness for claims generally includes the following data elements:

- Member name, date(s) of service, CPT/HCPCS codes
- Proof of address mailed to
- Proof of date mailed
- Proof of electronic or paper submission

Claims Submission

All claims submitted on hard copy should be an original and must be legible. Claims can also be submitted via Electronic Data Interchange (EDI), if you are a trading partner. For additional information on how to become a trading partner and submit claims electronically, visit the DCS website, https://dcs.az.gov/cmdp/providers.

Paper claims should be submitted to:

DCS/CMDP
Site Code C010-18
P.O. Box 29202
Phoenix, AZ 85038-9202

Resubmission

CMDP informs providers regarding the disposition of the claim through the Provider Remittance Advice. Claims will be denied if submitted with incomplete and/or inaccurate information. Providers have 12 months from the date of service to resubmit a denied claim using the following process:

- *CMS-1500 and UB-04*
  - Claims should resubmitted in entirety, to include all original lines if the claim contained more than one line. **Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.** An attached cover memo can also be used to clarify resubmitted information.
  - Corrected lines for UB-04 claims should be indicated in box 19 of the CMS-1500, or mark notations in the grid area of the claim form.
  - Resubmitted claims should be clearly marked "Resubmission" or "Corrected Claim."
  - **Claim Reference Number and PA number (if applicable) should be written on the resubmitted claim.**
  - Remittance advices for any paid or denied claims that pertain to the resubmission should be attached.
  - Requested documentation must be attached to ensure there is no delay in processing the resubmission.
- *Dental Claims ADA 2006*
  - Resubmitted claims should include all original lines if the claim contained more than one line. **Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.** An attached cover memo can also be used to clarify resubmitted information.
  - Resubmitted claims should be clearly marked "Resubmission" or "Corrected Claim."
  - **Claim Reference Number and PD number (if applicable) should be written on the resubmitted claim.**
  - Remittance advices for any paid or denied claims that pertain to the resubmission should be attached.

- Requested documentation must be attached to ensure there is no delay in processing the resubmission.
- X-rays are not required with the claim unless requested by CMDP.

Coordination of Benefits (COB)

Per Arizona Revised Statutes (A.R.S.) § 8-512(G), the Department of Child Safety (DCS) shall require that the hospital pursue other third-party payers before submitting a claim to DCS. Arizona Administrative Code (A.A.C.) R21-1-205 states that the department shall not pay for the cost of care and services payable through an insurance carrier which provides coverage for the eligible foster child.

As an AHCCCS contractor, CMDP is considered the payer of last resort. Providers are required to bill any known primary insurer prior to submitting a claim to CMDP. Upon receipt of reimbursement or denial from the third party, submit the claim and the explanation of benefits (EOB) from the third-party insurance company to CMDP. Website queries are not considered appropriate documentation.

Overpayments

A provider must repay CMDP for an overpayment received on a claim, in accordance with A.A.C. R9-22-713. Providers should attach documentation substantiating the overpayment (for example, the EOB if the overpayment was due to payment received from a third-party payer).

Recoupment

Under certain circumstances, CMDP may find it necessary to recoup or take back money previously paid to a provider. Overpayments and erroneous payments are identified through reports, medical record review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

CMDP will offset/recoup any monies owed from previous overpayments against future claims submissions, if possible. The remittance advice will show claims with the original claim numbers plus an "R" and/or "A" to show the Reversal and/or Adjustment. If an amount is due to CMDP and no future claims submissions are received within 30 days, CMDP will send a Refund Request letter with an explanation of the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the refund request. If payment is recouped for a reason other than third-party recovery (e.g. technical claims issue or no medical documentation to substantiate services rendered), the provider will be given additional time to provide the necessary information.

Billing Members

Per A.R.S. § 8-512(E), providers are reimbursed using AHCCCS fee-for-service rates. By report fees are established according to usual and customary rates. More information about the AHCCCS Fee-For-Service Schedule is found on the AHCCCS website, www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/.

In accordance with A.R.S. § 36-2903.01(L) and 42 CFR 447.21, billing a member, a financially responsible relative, or the member's authorized representative for any amounts exceeding what CMDP has reimbursed is in violation of federal and state law, and is just cause for assessing of civil penalty. There are no payments, fees, or co-payments for members or out-of-home caregivers. CMDP payments are considered payment in full. CMDP's non-payment or denial of a claim does not allow the provider to bill members or caregivers.

Claims Status Inquiries

Providers can track the status of claims via the CMDP Provider Services webpage, https://dcs.az.gov/cmdp/providers. Click on the Claim Lookup link under Provider Resources.

For assistance in checking claims status, payment status or requesting an additional EOB, email the Claims Unit at CMDPClaimsStatus@azdes.gov.

Well Child Health, Preventative Medicine, and EPSDT Visits

The EPSDT program, which includes oral health screenings and required oral health/dental services, applies to all eligible children enrolled in CMDP. In accordance with United States Code 42 USC 1396d(r), 1396a(a), 1396d(a), and A.A.C. R9-22-213, the EPSDT program provides primary prevention, early intervention, diagnosis, and medically necessary treatment of physical and behavioral health problems. **EPSDT exams are required for children every year after the child is 24 months of age.**

Billing codes 99381-99395 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial, or periodic, comprehensive medical examination.

Immunizations and ancillary studies involving laboratory, radiology, or other procedures are reported separately.

The following evaluation and management (E/M) codes are used to report the well child/EPSDT (preventive medicine) evaluation and management of infants, children, and adolescents. The appropriate well child care diagnosis code must be used or the claim will be denied.

CODE	DESCRIPTION (Office Visit, Health History, and Physical Examination)
New Patient	**Initial comprehensive preventive medicine evaluation and management** of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures.
99381	New patient, Infant – age under 1 year
99382	New patient, Early Childhood – age 1 to 4 years
99383	New patient, Late Childhood – age 5 to 11 years
99384	New patient, Adolescent – age 12 to 17 years
99385	New patient, Adult – age 18 to 20 years
Established Patient	**Periodic comprehensive preventive medicine reevaluation and management** of an individual including an age and gender appropriate history, examination, counseling/ anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s) and laboratory/diagnostic procedures.
99391	Established patient, Infant – age under 1 year
99392	Established patient, Early Childhood – age 1 to 4 years

99393	Established patient, Late Childhood – age 5 to 11 years
99394	Established patient, Adolescent – age 12 to 17 years
99395	Established patient, Adult – age 18 to 20 years

EPSDT Tracking Forms

Providers must document all age-specific required information relating to EPSDT screenings, and must use the AHCCCS EPSDT Tracking Forms or an electronic record that contains all the required elements of an EPSDT. EPSDT forms for the various age groups are found in the AHCCCS Medical Policy Manual, Appendix B. A link to the forms within the web-based policy manual is provided here: www.azahcccs.gov/shared/MedicalPolicyManual/.

The forms may also be obtained by contacting your CMDP Provider Services representative. The Centers for Medicare and Medicaid Services require AHCCCS (and therefore CMDP) to provide specific services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care.

Please do NOT alter or amend these forms in any way without discussion with the Maternal and Child Health Manager at CMDP. **Electronic medical records may be accepted in lieu of the EPSDT form if they provide all the required information from the EPSDT form, including provider name, electronic treating provider's signature, date and time.**

EPSDT forms should be completed and submitted with the claim. EPSDT forms pertaining to claims submitted electronically should be mailed to:

DES/CMDP
Site Code C010-18
P.O. Box 29202
Phoenix, AZ 85038-9202

Completed EPSDT forms may also be sent by:

- Fax to 602-265-2297
- Email to CMDP CMDPClaimsStatus@azdes.gov

Arizona's Vaccines for Children Program

The Vaccines for Children (VFC) Program in Arizona supplies all medically necessary vaccines for children and adolescents to providers free of charge. The **SL modifier** is used to indicate vaccines administered under VFC, and should be coded accordingly on the CMS 1500 claim form.

NOTE: Many hospitals no longer participate in the VFC Program providing newborns with their Hep B shots at birth, and many newborns will need to receive their Hep B immunizations at their first office visit.

As of January 1, 2013, when submitting a claim for vaccines, include the cost that reflects the administration fee and not that of the vaccine. Use immunization administration CPT codes 90460, 90461, 90471, 90472, 90473, and 90474 when billing for vaccines under AHCCCS programs, including CMDP. When submitting a claim for vaccines, remember that the NDC number is required for claim processing.

The NDC number is found on the drug container, e.g. vial, bottle, tube. The NDC submitted to CMDP must be the actual NDC number on the package or container from which the medication was administered. Claims may not be submitted for one manufacturer when a different manufacturer's product was administered. It is considered a fraudulent billing practice to bill using an NDC other than the one assigned to the drug administered.

NDC Definition

The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. For example:

xxxxx-xxxx-xx

The first 5 digits identify the labeler code, representing the manufacturer of the drug, and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

Some packages will display less than 11 digits, but leading zeros can be assumed and must be added when billing. For example:

Manufacturer's Number Format	Billing Format*
xxxx-xxxx-xx	0xxxxxxxxxx
xxxxx-xxx-xx	xxxxx0xxxxx
xxxxx-xxxx-x	xxxxxxxxx0x

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

For additional information on the Vaccines for Children program, visit the AHCCCS Online webpage, www.azahcccs.gov/.

Billing for Use of the PEDS Tool

Since January 1, 2006, the Parents' Evaluation of Developmental Status (PEDS) developmental screening tool has been utilized for developmental screening by all participating PCPs who care for newborn intensive care unit (NICU) graduates. Because of the at-risk nature of the foster care population, the tool may also be used for all CMDP members up to age 8.

For PCPs to receive reimbursement for conducting the PEDS screening, the provider must:

- Complete the PEDS training program, which is coordinated by the Arizona Chapter of the American Academy of Pediatrics through statewide conferences, an online course, and onsite provider training. Access the online course at http://www.azpedialearning.org/test1.asp, or

contact the AzAAP Best Care for Kids Program at pedstraining@azaap.org or 602-532-0137, Ext. 413, for more information about onsite training;
- Provide CMDP with a copy of the training certificate, or appear on the Arizona Chapter of the Academy of Pediatrics or AHCCCS lists of providers who have successfully completed the training; **and**
- Submit copies of the completed PEDS tools (PEDS Interpretation and the PEDS Score forms) to CMDP in the same manner that the EPSDT tracking forms are submitted with the CMS 1500 claim form. Remember:
  - **An EP modifier is required when using code 96110.**
  - Claims will be denied if the EP modifier is missing or the PEDS Tool forms are not attached when processing the claim. The results of these forms are reviewed by the EPSDT Coordinator for care coordination purposes.

Instructions for Specific Claim Types

Air and Ground Ambulance Service

Claims for ground and air ambulance service must be billed on the CMS 1500 claim form. Emergency ground transportation does not require prior authorization; however, providers must mark Box 24C to indicate emergency services on each applicable line. All other transports except emergency require the provider to notify CMDP within 10 days of the emergency transport, or the claim will be denied.

Non-emergency transportation requires prior authorization. Emergency air and ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:

- Medical condition, signs and symptoms, procedures, and treatment;
- Transportation origin, destination, and mileage (statute miles);
- Supplies, or
- Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

Ambulatory Surgery Centers

Ambulatory surgery centers (ASCs) are defined as certified, freestanding entities that operate exclusively for the purpose of furnishing outpatient surgical procedures. CMDP reimburses the ASCs per the AHCCCS Fee-For-Service (FFS) Schedule. The facility fee covers all services provided by an ASC in connection with rendering surgical procedures, including but not limited to nursing services, medical supplies, equipment, and use of the facility.

ASC Billing Procedures

- Ambulatory surgical facilities furnishing non-emergency surgical services must obtain prior authorization (PA) from CMDP for scheduled ambulatory surgery.
- The PA for the ASC is separate from the surgeon's PA.
- ASC-covered surgical procedures must be billed on the CMS 1500 form. There must be a clear indication in Box 19 if this is a facility fee or a professional component.
- Reimbursement is based on the payment rate for that specific procedure.
- The ASC must bill the principal or primary procedure (the procedure with the highest

reimbursement rate) on the first line of the CMS 1500 when multiple procedures are performed on the same member on the same day or at the same session.
    - Secondary procedures are to be billed with a modifier 51.
- If the ASC does not identify the primary procedure, CMDP will identify the first procedure listed on the claim as the primary procedure and will assign modifier 51 to the remaining procedures, identifying them as secondary.
    - Reimbursement of the primary procedure will be at the lesser of billed charges or the AHCCCS FFS rate.
    - Reimbursement for secondary procedure(s) will be the lesser of billed charges or 50% of the AHCCCS FFS rate.
- A bilateral procedure performed in one operative session is reported using modifier 50 appended to the single procedure line (not two separate lines), and is subject to the multiple surgery reduction.
- A bilateral procedure is reimbursed at no more than 150% of the AHCCCS FFS rate for a single procedure.

Dental Claims

- Claims for dental services should be submitted on the American Dental Association ADA 2006 or ADA 2012 Claim Form.
- Do NOT include x-rays with claim forms that are submitted for payment.
- Services provided by an anesthesiologist or medically-related oral surgery procedures should be submitted on the CMS 1500 form.
- AHCCCS has revised the Well Checkup allowance from *2 visits per year to 1 visit each 180 days.*

Inpatient Hospital Services

Effective October 1, 2014, Inpatient hospital services billed on the UB-04 are reimbursed using the All Patient Refined Diagnosis Related Groups (APR_DRG) payment methodology. Each inpatient hospital claim will be assigned an APR-DRG code and each DRG code is assigned a relative weight which is intended to indicate the average relative amount of hospital resources required to treat patients within that DRG category.

DRG payment will be applied to all inpatient claims from acute care hospitals except the following:

- Claims from a free-standing rehabilitation facility, free standing long-term acute care facility, and from a free standing psychiatric facility;
- Claims from an Indian Health Service facility or tribally owned or operated 638 facility;
- Claims paid by Tribal/Regional Behavioral Health Authorities (T/RBHAs) for behavioral health services;
- Claims for administrative services;
- Claims for transplant services;
- Claims in which admit and discharge are on the same day, and the discharge status does not indicate member expired; and
- Claims that are interim bills.

For more information regarding APR-DRG reimbursement visit the Fee-for-Service Provider Manual on the AHCCCS website, www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html.

Observation Services

Observation services are those reasonable services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. A physician, or other individual authorized to admit patients to the hospital or order outpatient diagnostic tests or treatments, must provide a written order of observation services. Medical review is performed in all cases of observation and hospital admission to determine medical necessity.

In general, observation status should not exceed 24 hours. This time limit may be exceeded if medically necessary, to evaluate the medical condition and/or treatment of a member. Exceptions to the 24-hour limit must have prior authorization.

Observation services that directly precede an inpatient admission to the same hospital must **not** be billed separately. These charges must be billed on the inpatient claim. The inpatient claim is priced utilizing the APR-DRG method.

Obstetrical Care Package

Providers are expected to bill for obstetrical care using the appropriate global packages, and file claims using the CMS 1500 claim form. Please follow the following procedures or the claim may be denied.

- Utilize CPT Evaluation and Management codes (99201-99215) or OB visits (59425-59426) to report prenatal visits.
  - The beginning date of service (DOS) is equal to the initial prenatal visit and the ending DOS is equal to the last prenatal visit prior to delivery.
  - Use one unit with the appropriate prenatal visit code.
  - Zero or the appropriate charge should be entered in the charge column.
- All OB care requires a PA.
- Two (2) ultrasounds are included in the OB package. PA is required for additional studies.
- Utilize global delivery codes (59400, 59510, 59610, and 59618)
- If the Primary Care Obstetrician (PCO) provides prenatal services but does not perform the delivery, the claim must indicate "prenatal visits only."

Skilled Nursing Facilities (SNF)

CMDP requires a prior authorization for all SNF services. CMDP only pays from the date of admission up to, but not including, the date of discharge, unless the patient expires.

Long-term care facilities must bill for room and board services on the UB-04 claim form. The table below summarizes the allowable revenue codes and bill types:

Revenue Codes	Allowable Bill Types
190 Subacute General	86X
191 Subacute Care Level I	110-179, 211-228, 611-628
192 Subacute Care Level II	110-179, 211-228, 611-628
193 Subacute Care Level III	110-179, 211-228, 611-628
183 LOA – Therapeutic (for home visit by recipient)	211-228, 611-628
185 LOA – Bed Hold (for short-term hospitalization)	211-228, 611-628

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-04 claim forms, using the appropriate bill types and patient status codes.

Correct Coding Initiative

AHCCCS and CMDP follow the same standards as the Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative (CCI) policy, and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, review the information at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

HCAC and OPPC

AHCCCS implemented measures looking at Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). There is a Medicaid rule, effective July 1, 2012, prohibiting or reducing payments when provider OPPC is identified.

National Drug Code (NDC)

Effective July 1, 2012, AHCCCS implemented billing requirements for drugs, vaccines, biological devices, and other devices, including contrast for radiologic procedures provided in outpatient clinical settings. More information regarding these requirements can be found in these AHCCCS resources:

- NDC Billing Requirements (www.azahcccs.gov/)
- Fee-For-Service Provider Manual, Chapter 5, Billing on the CMS 1500 Claim Form (http://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html)
- Fee-For-Service Provider Manual, Chapter 6, Billing on the UB-04 Claim Form (http://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html)

Ordering/Referring Provider

Effective January 1, 2012, AHCCCS began requiring identification of the ordering provider for certain CPT/HCPCS codes on 1500-type claims.

Claim submissions will be audited to ensure the ordering provider is documented for the following types of services:

- Laboratory
- Radiology
- Medical and surgical supplies
- Respiratory DME
- Enteral and parenteral therapy
- Durable medical equipment
- Drugs (J codes)
- Temporary K codes
- Orthotics
- Prosthetics
- Temporary Q codes
- Vision codes (V Codes) 97001-97546

Ordering providers can only be one of the following provider types:

- M.D.
- D.O.
- Optometrist
- Physician Assistant
- Certified Nurse Midwife
- Registered Nurse Practitioner
- Dentist
- Podiatrist
- Psychologist

Medical Review of Documentation Supporting Claims and Coding

Medical reviews are performed on a variety of medical record types, and include but are not limited to inpatient hospital review (concurrent review), prior authorizations, retrospective review of medical records related to claims audits, excessive utilization, and quality of care issues.

The most common claims audit scenarios where a provider is requested to submit medical records include:

- Anesthesia units exceeding allowable daily limit;
- Multiple portable x-rays or EKGs from one facility on same date of service;
- Dental and medical "house calls;"
- Excessive use of screening labs (to determine medical necessity/appropriateness);
- Behavioral health services for AHCCCS eligible members;
- Use of level 4 or 5 E/M visits on the same date of service as an EPSDT; and
- Providers with consistent patterns of upcoding multiple encounters with the same patient within short time periods.

Required Documentation for Claims

1500 Billed Service	Documents Required	Notes
EPSDT (well child) visits	EPSDT form or acceptable electronic version printout (must cover all required elements of the EPSDT)	CPT 99381-99385 CPT 99391-99395
EPSDT **and** office visit on same DOS	EPSDT form or acceptable electronic version printout and office visit note	CPTs shown above, plus 99204, 99205, 99214, 99215
PEDS Tool, MChat and ASQ	PEDS Interpretation and the PEDS Score forms, M-Chat form or ASQ form	CPT 96110 requires EP modifier
Missed abortion, incomplete abortion	History, physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise
Transportation	Ambulance trip report	Non-emergency transportation requires a PA

UB Billed Service	Documents Required	Notes
Inpatient *Required ** If applicable	Itemized statement* Admission sheet (face sheet)* Admission history and physical* Discharge summary or interim summary* Operative reports** Labor and delivery report** Emergency record**	All related records which substantiate medical necessity
Missed abortion/incomplete abortion	History, physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise

Claims Dispute Process

A *claim dispute* means a dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance. It is the formal way to request a review of a payment dispute. For instructions on the claim dispute process, see *Chapter 10, Grievances and Claim Disputes* in this provider manual.

Prior to submitting a claim dispute, CMDP encourages all providers to contact the Claims Unit or Provider Services at (602) 351-2245 or (800) 201-1795 for assistance in resolving any concerns.

Claim disputes must specify in detail the factual and legal basis for the dispute and the relief requested. Claim disputes challenging claim denials must be filed in writing with CMDP no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the date of a timely claim submission, whichever is later.

Enclose a claim form and all supporting documentation, including a copy of the remittance advice for the claim being disputed. Mail requests to:

Arizona Dept. of Child Safety
CMDP – C010-18
Attn: Grievance Coordinator
P.O. Box 29202
Phoenix, Arizona 85038-9202

Fraud and Abuse

Claims are examined for the sequencing and timing to determine if they are consistent with sound medical practice. If discrepancies are identified, a provider will be referred to the Compliance or Quality Management unit for further investigation. More information on fraud and abuse is found in *Chapter 11* of this provider manual, and on the AHCCCS Fraud and Abuse web page, https://azahcccs.gov/Fraud/Providers/.

Other Resources

Valid place of service (POS) codes with facility or non-facility designations are shown in the table below. POS codes are entered in Box 24B of the CMS 1500 claim form.

Code	Description	Payment Rate Facility (F) or Non-Facility (NF)
03	School	NF
04	Homeless Shelter	NF
11	Office	NF
12	Home	NF
13	Assisted Living Facility	NF
14	Group Home	NF
15	Mobile Unit	NF
19	Off-Campus – Outpatient Facility	F
20	Urgent Care Facility	NF
21	Inpatient Hospital	F
22	Outpatient Hospital	F
23	Emergency Room – Hospital	F
24	Ambulatory Surgical Center (Note: Pay at NF rate for payable procedures not on the ASC list)	F
25	Birthing Center	NF
26	Military Treatment Facility	F
31	Skilled Nursing Facility	F
32	Nursing Facility	NF
33	Custodial Care Facility	NF
34	Hospice	F
41	Ambulance, Land	F
42	Ambulance, Air or Water	F
49	Independent Clinic	NF
50	Federally Qualified Health Center	NF
51	Inpatient Psychiatric Facility	F
52	Psychiatric Facility, Partial Hospitalization	F
53	Community Mental Health Center	F
54	Intermediate Care Facility for Mentally Retarded	NF
55	Residential Substance Abuse Treatment Facility	NF
56	Psychiatric Residential Treatment Center	F
57	Non-Residential Substance Abuse Treatment	NF
60	Mass Immunization Center	NF

Code	Description	Payment Rate Facility (F) or Non-Facility (NF)
61	Comprehensive Inpatient Rehabilitation Facility	F
62	Comprehensive Outpatient Rehabilitation Facility	NF
65	ESRD Treatment Facility	NF
71	State or Local Public Health Clinic	NF
72	Rural Health Clinic	NF
81	Independent Laboratory	NF
99	Other Unlisted Facility	NF

CHAPTER APPENDIX

CMS-1500 Health Insurance Claim Form Sample
www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

UB-04 Inpatient and Outpatient Services Claim Form Sample
www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

ADA 2006 Dental Claim Form Sample
www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

EPSDT Forms Samples
Providers must use age-specific, AHCCCS approved EPSDT forms. These forms are available on the AHCCCS website, https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf.