

## UPDATE

# AHCCCS Copay Requirements

## Effective October 1, 2010

As a result of changes in Federal and State laws and regulations, including provisions of the Deficit Reduction Act of 2005, AHCCCS will expand member copay requirements effective October 1, 2010. The expanded copay requirements, which are described in AHCCCS Final Rule A.A.C. R9-22-711, include mandatory copays for certain populations, higher optional (nominal) copay amounts for certain populations, and clarification of the services and populations which are exempt from both mandatory and optional copays. The expanded copay requirements will result in a modest cost savings to the State.

### Mandatory Copays:

AHCCCS members who will have mandatory copays for certain services beginning October 1, 2010 are:

- Transitional Medical Assistance (TMA) members (Copay Level 50 see AHCCCS Copay Grid on page 3-5 of this communication)
- "Childless Adults" and MED members (also referred to collectively as the "AHCCCS Expansion Population" or the "TWG (Title XIX Waiver Group) Population."). **IMPORTANT:** The mandatory copays described below for Childless Adults and MED (TWG) members are on hold for the month of October 2010 due to an injunction. While the injunction is in place, these members are subject to the "nominal (optional)" copays (Copay Level 20 or 21 see AHCCCS Copay Grid on page 3-5 of this communication). This updated copay information is also available using the various eligibility verification systems.

Mandatory copays **permit** providers to **deny** services to members who do not pay the copay. However, certain services (such as emergency services) are exempt from mandatory copays, and specific members (such as individuals under the age of 19) are also exempt from copays. Please be aware that payments to providers have to be reduced by the amount of a member's copay obligation *regardless of whether or not the provider successfully collects the mandatory copay.*

### **Mandatory copays do not apply to:**

- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- Children eligible to receive services from the Children's Rehabilitative Services program
- People who are in nursing homes, residential facilities such as an Assisted Living Home or who receive Home and Community Based Services such as attendant care or a visiting nurse.
- People who receive hospice care

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**Services that will not require a copay include:**

- Hospitalizations
- Emergent use of an emergency room
- Family Planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women

**AHCCCS Copay Grid**

The AHCCCS Copay Grid on page 3-5 of this communication outlines the copays by member type and the circumstances provided to us by AHCCCS for when each mandatory copay is applicable.

Please be aware that there is a hierarchy of services used to determine the copay amount. With the exception of prescription drugs (where a copay is charged for each drug received) only one copay may be assessed for services obtained during a visit. A visit is considered to be all services received in one day from a single provider, or components of the same service received in one day from multiple providers (i.e. a surgery in an ASC where both the ASC and surgeon provide the same service)

**How to Determine if a Member has a Mandatory Copay**

AHCCCS Online, <https://azweb.statemedicaid.us/Home.asp>, has the most current eligibility and copay information for all AHCCCS members. If you are not registered to use this system, you may register by choosing the “Click Here” link under “New Account”. The Co-Payment section at the bottom of the first page of the member’s eligibility screen indicates the member copay level and provides a link to the AHCCCS Copay Grid (also located on pages 3-5 of this communication), which provides you the detail on the mandatory copay levels and applicable services.

**Copay Tracking**

AHCCCS Administration will track each member’s specific copay levels by service type, and this information will also identify those members who have reached the 5% copay limit. AHCCCS will further identify whether the member is subject to a mandatory or a nominal copay and when copays cannot be charged, i.e. the service or member is exempt from copays. Copay information will be available using the various eligibility verification systems. Refer to the sample chart attached.

Complete information regarding copayment requirements can be found at:

<http://www.azahcccs.gov/commercial/Downloads/CopayLetterProviders9-29-10.pdf>,

<http://www.azahcccs.gov/commercial/ProviderBilling/copayments.aspx>

We urge you and your staff to review the documentation on the AHCCCS website very closely. Our Provider Network Operations team also is available for assistance and you may call us at any time

***Thank you!***

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**Provider Network Operations**

**Phone 602.778.1800 or 866.560.4042 (Options in order: 5, 7)**

**Fax 602.778.1875**

Visit our website at [www.care1st.com/az](http://www.care1st.com/az)

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**AHCCCS Copay Grid**

<b>Member Copay Level</b>	<b>Description</b>	<b>Mandatory, Optional or Exempt</b>	<b>Copay Service(s)</b>	<b>Copay Amount</b>	<b>Services Identified as:</b>
<b>00</b>	Exempt from CoPays	Exempt - No copays for any services	None	None	None
<b>20</b>	Nominal - Traditional	Optional - Services cannot be denied for failure to pay a copay	Pharmacy	\$2.30	Pharmacy Form type; <b>for each</b> NDC Code not indicated as Family Planning.
			Office Visits	\$3.40	<b>For a “visit”</b> ; Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Outpatient Professional Therapies	\$2.30	<b>If no copay for a “visit” imposed above; For a “visit”</b> ; Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
<b>21</b>	Nominal - HIFA Parents	Optional - Services cannot be denied for failure to pay a copay	Pharmacy	\$2.30	Pharmacy Form type; <b>For each</b> NDC Code not indicated as Family Planning.
			Office Visits	\$3.40	<b>For a “visit”</b> ; Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.

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Member Copay Level	Description	Mandatory, Optional or Exempt	Copay Service(s)	Copay Amount	Services Identified as:
21	Nominal - HIFA Parents	Optional - Services cannot be denied for failure to pay a copay	Outpatient Professional Therapies	\$2.30	<b>If no copay for a “visit” imposed above; For a “visit”;</b> Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
40	TWG (MED; Non-MED; AHCCCS Care)	Mandatory - Services may be denied for failure to pay a copay	Generic Pharmacy	\$4.00	Pharmacy Form type; <b>For each</b> NDC Code not indicated as Family Planning and w/ <b>Generic Drug</b> Indicator of “Y” or a <b>Generic Available Indicator of "N"</b> .
			Brand Pharmacy	\$10.00	Pharmacy Form type; <b>For each</b> NDC Code not indicated as Family Planning and w/ <b>Generic Drug</b> Indicator of "N" or a <b>Generic Available Indicator of “Y”</b> .
			Office Visits	\$5.00	<b>For a “visit”;</b> Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Non-Emergency Use of the ER	\$30.00	Facility Form type (OP); ER Revenue Code 045X Billed with an Admit Type of 2 or 3 OR a HCPCS/CPT Code of 99281; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
50	TMA (Transitional Medical Assistance)	Mandatory - Services may be denied for failure to pay a copay	Pharmacy	\$2.30	Pharmacy Form type; <b>For each</b> NDC Code not indicated as Family Planning.

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Member Copay Level	Description	Mandatory, Optional or Exempt	Copay Service(s)	Copay Amount	Services Identified as:
50	TMA (Transitional Medical Assistance)	Mandatory - Services may be denied for failure to pay a copay	Office Visits	\$4.00	<b>For a “visit”</b> ; Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Outpatient Professional Therapies	\$3.00	<b>If no copay for a “visit” imposed above; For a “visit”</b> ; Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Surgeries (In Office; Outpatient non-emergent; ASC's)	\$3.00	<b>If no copay for a “visit” imposed above; For a “visit”</b> ; Professional Form Type (1500); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
					<b>OR</b>
					Facility Form type (OP); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
					<b>OR</b>
					Provider Type ASC (43); Professional Form type (1500); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.

**Visit** - a visit equals all services received in one day from a single provider, or components of the same service received in one day from multiple providers (i.e. a surgery in an ASC where both the ASC and surgeon provide the same service).