

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

Care1st works with Emdeon (WebMD) 800.215.4730 for acceptance of EDI CMS1500 claims. Our Emdeon (WebMD) Payer I.D. is **57116**. Claims may be submitted electronically directly to Emdeon (WebMD) or from your clearinghouse to Emdeon (WebMD).

UB-04 submitters may also submit electronically through the SSI (contact SSI's help desk 800.880.3032).

NOTE: EDI is for primary claims only, any claims that require secondary payments must continue to be sent on paper with a copy of the primary EOB attached.

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!

Providers also have the ability to view remits online; allowing no delay between receipt of dollars and the ability to post payment.

The EFT form is available on our website www.care1st.com/az under the Provider drop down menu under *Forms* section to download the EFT form. If you do not have internet access, contact Provider Network Operations.

CLAIM ADDRESS

Direct claim submissions to:

Attention: Claims Department
2355 East Camelback Rd #300
Phoenix, AZ 85016

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CLAIMS CUSTOMER SERVICE

Claim status can be checked 24 hours per day online at www.care1st.com/az or by using our interactive voice response system (IVR).

In addition, you can contact our Claims Customer Service Team at 602.778.1800 (Options 5, 4) during the business hours listed below.

Monday – Friday 8:00 a.m.-12:00 p.m. & 1:00 p.m.-4:30 p.m.

CLAIM LIAISON

Our *Claims Liaison* is a great resource and is available to assist your office via phone, e-mail 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.

The AHCCCS ID number must appear in Field 33 of the CMS 1500 claim form along with the provider's facility name.

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 that all providers submit the rendering/servicing provider's NPI on every claim. In addition, when applicable, the prescribing, referring, attending and operating provider NPI(s) must also be present on claim submissions. Please work with your billing team to ensure that NPI(s) are being submitted appropriately with each claim submission.

- To apply for your Individual NPI and/or Organizational NPI online, go to www.nppes.cms.hhs.gov or call 800.465.3203 to request a paper application.

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- If you have not yet notified Care1st of your NPI(s), please fax a copy of your NPI(s) confirmation to: Provider Network Operations NPI Contact 602.778.1875

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. The claim forms were revised to incorporate the required NPI fields:

- Practitioners – CMS 1500 (08/05)
- Facilities – UB-04
- Dental – J400 (ADA 2006 version)

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 J400 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.

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 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 remittance advices. We also recommend that you verify claim status prior to resubmitting a claim.

SCANNING TIPS

All paper claims are input into our system using process called data lifting.

1. Printing claims on a laser printer will create the best possible character quality
2. If a dot matrix printer must be used, please change the ribbon regularly
3. Courier 12 pitch non proportional font is best for clean scanning
4. Use black ink for all claim submissions

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5. 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*)
6. Ensure that the claim form is lined up properly within the printer prior to printing
7. If a stamp is required, refrain from red ink as this may be removed during the scanning process
8. 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*)
9. Use an original claim form as opposed to a copied claim form as much as possible
10. 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*)

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 Facility Where Services were rendered
33	Provider’s Facility Name, Supplier’s Billing Name (as registered with the IRS), Address, Zip code, and Phone Number

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* 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.

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
14	Type of Admission
15	Source of Admission (Inpatient only)
16	Discharge Hour (Inpatient only)
17	Patient Status (Inpatient only)
19-28	Condition Codes
42	Revenue Code
43	Revenue Code Description
44	HCPCS/ Rates
45	Service Date – 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)

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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, the Care1st must be notified. Please note that the allowed amount shall be based upon the lesser of Care1st's or third party carrier's fee schedule, less the paid amount by the third party carrier(s) any remaining balance shall be paid by Care1st as coordination of benefits.

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). 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.

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

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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).

CLAIMS RESUBMISSION POLICY

Care1st's policy regarding claims resubmission states that providers may resubmit claims that have been adjudicated by Care1st, but the resubmission must be received by Care1st within twelve (12) months of the date of service. Care1st will re-adjudicate claims re-submitted by providers only if an initial claim had been filed within the original prescribed submission deadline of six (6) months from the date of service.

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 Provider Network Operations.

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REMITTANCE ADVICE REPORT COLUMNS AND DESCRIPTIONS

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

Company	Number, name, address, and telephone number of the company defined in the general ledger on the Company Name and Address Maintenance screen and assigned to the LOB on the Enter/Update Line-of-Business Codes screen.
Vendor/Subscriber	Name and address of either the vendor or subscriber, depending on who is being paid for the claim. The vendor is defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. The subscriber information is defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Vendor No.	The code identifying the claim vendor defined on the Enter/Update Vendors screen and entered on the Enter/Update General Claims screen. If the vendor has multiple addresses, “*An” displays to the right of the vendor number, where n represents the vendor’s address number used.
Check No.	The check number pulled from the MASTER. CLAIM file.
Payment	The amount being paid by the check. The payment amount is pulled from the MASTER. CLAIM file.
Document Number	The claim document number defined either during claim entry on the Enter/Update General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Invoice Number	The claim invoice number taken from the CONSTANT file and entered on the Enter/Update General Claims screen.
Date Approved	The approval date of the general claim. The claim is approved on the Enter/Update General Claims screen and the date is stored in the MASTER.CLAIM file.
Member	The member’s number and name defined either on the Enroll Subscribers screen or the Enroll Additional Members screen.
Procedure	The claim document number defined either during claim entry on the Enter/Update General Claims screen or during claim entry of the Batch Claims Entry screen or while running the Load/Adjudicate General Claim Hold File program.
Qty	The number of times the procedure was performed between the From and thru dates. This information is entered on the Procedure Information screen.
Req. Amt	The requested amount for the procedure entered on the Procedure Information screen.
Elig. Amt	The eligible amount for the procedure. The eligible amount is The lesser of the requested amount or the maximum allowable amount, both of which are entered on the Procedure Information screen.
COB. Amt	The coordination of benefits amount entered on the Procedure Information screen.
W. Hold	The amount withheld by the health care organization from the payment amount. The amount withheld is based on the agreement made with the vendor, provider, or LOB and is entered on the Procedure Information screen.
Discount	The amount withheld by the health care organization for discounts. This is also based on the agreements made with the vendor, provider, or LOB. The discount is defined on the Regional Vendor Information screen and entered on the Procedure Information screen.
Copay	The amount the member paid for copayment defined on the Copay/Coinsurance Maintenance screen and entered on the Procedure Information screen.

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CLAIM PAYMENT DETAIL

Provider/ Member	The provider code, or the member number and name of the person who should receive the corresponding payment amount. Provider codes are defined on the Enter/Update Provider Codes screen and entered on the Enter/Update General Claims screen. Member numbers are defined either on the Enroll Subscribers screen or the Enroll Additional Members screen and entered on the Enter/Update General Claims screen.
Payment	The payment amount due to the provider or member. This amount is entered on the Enter/Update General Claims screen.

OTHER A/P TRANSACTIONS

Invoice No.	Invoice number (defined on the Enter Invoices screen) or memo number (defined on the Debit and Credit Memo Entry screen).
Type	The batch source of the invoice or memo. The type is defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Date Approved	The invoice or memo approval date defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Description	The invoice or memo description defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen. If the invoice was for a capitation payment, the comment will be “*Capitation Payment*.”
Amount	The invoice or memo total amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Payment	The invoice or memo payment amount defined on either the Enter Invoices screen or the Debit and Credit Memo Entry screen.
Less Discount	The total discount amount of the invoices and memos.
Total Transactions	The total payment amount of A/P invoices and memos that affect the amount of the check for the vendor or family.

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.

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IMPORTANT NOTES

- Critical Care (99291) is payable for the first hour. Code 99292 (additional ½ hour) is also payable with documentation (medical notes) and time, if deemed appropriate by Care1st.
- 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, we must have documentation to support it. If a claim is received with dates of service that fall after the received date the entire claim will be denied.
- Diagnosis codes that require a 4th or 5th digit will be denied if not submitted with appropriate code. 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), modifier 25 is required on the sick visit CPT code for reimbursement.

EP MODIFIER (Care1st AHCCCS)

Modifier EP is billed in conjunction with 96110 for reimbursement of developmental testing. Providers must first complete PEDS tool training to be eligible for reimbursement for this service.

SL MODIFIER (State supplied vaccine) (Care1st AHCCCS)

Vaccines administered to members 18 years and younger are ordered through the Vaccines for Children (VFC) program. For a complete listing of eligible VFC codes, refer to http://www.azdhs.gov/phs/immun/act_aipo.htm#vfc. Vaccines supplied through the VFC program must be billed with a modifier SL to be eligible for reimbursement.

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

Patient (18 or younger) makes appointment because of an earache. Office determines that it is time for EPSDT evaluation and vaccine. Office bills appropriate E&M code with modifier “25”, EPSDT code and vaccine with “SL” modifier

- Sick visit is billed with E&M in the 99201 through 99245 range with modifier “25”
- EPSDT visit is billed with E&M in the 99381-99385 or 99391-99395
- Vaccine code is billed with “SL” modifier

MODIFIER 50 (bilateral procedure)

Modifier 50 is required for all bilateral procedures. Effective for dates of service 1/1/2008 and after, procedures are billed on one line with a unit of 1 (see example below).

Dates of service prior to 1/1/2008: Each side of the bilateral procedure is billed separately. The 2nd line is billed with modifier 50 (see example below).

Line 1: 69436, full dollar amount, 1 unit - 100% of fee schedule

Line 2: 69436, with “50” modifier; full dollar amount, 1 unit - 50% of fee schedule

Total payment: 150% of fee schedule

Dates of service 1/1/2008 and after: bilateral procedure is billed on one line with the 50 modifier (see example below).

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 distinct and separate service. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission. As a reminder, it is not appropriate to use this modifier with the following CPT ranges: 77421-77427 or 99201-99499.

ANESTHESIA

Notes are required for all timed procedures and Anesthesiologists do not require an authorization. The specific anesthesia start and end time must be submitted on the CMS-1500 form.

The following are not reimbursable:

00938	99140
01997	P1

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62278	P2
94656	P3
94770	P4
99100	P5
99116	P6
99135	

- 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.

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.

DENTAL PROVIDERS

All dental providers must submit claims on the current ADA Dental Form with the following information: the servicing and contracted provider name, location, provider address, tax identification number, NPI, AHCCCS identification number and authorization number (if appropriate). General dentists may perform up to \$1,000 of AHCCCS covered therapeutic services per treatment plan. Treatment plans over \$1,000 must be prior authorized and have the authorization number submitted on the claim. The Dental Matrix provides detailed information regarding prior authorization requirements for all dental codes regardless of the cost of the total treatment plan. For the most current dental matrix, please contact Provider Network Operations or visit our website at www.care1st.com/az

DIALYSIS

- For facility billings, the type of bill must be 72x.
- Physicians do not require their own authorization. They may use facility authorization.

DURABLE MEDICAL EQUIPMENT

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

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- 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

- 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

*Authorization is NOT required for emergency transportation. Provider must indicate emergency on the CMS 1500 form. A trip ticket is required for all ambulance transportation services and must include the pick up point and destination, mileage, and services performed. Ambulance wait time is not a covered benefit.

**Inter-facility transports require authorization.

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:

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- 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). Prior authorization is required for tubal ligations and vasectomies. 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 least 21 years of age at the time the consent is signed.

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 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.

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- All UB-04 hospice 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 seeing children covered by AHCCCS ages 18 years old and younger must participate in the VFC program. Under the VFC program, the vaccines are made available to the providers free of charge. Reimbursement for the administration of the VFC immunizations is provided based on the provider billing the specific vaccine code with an SL modifier. AHCCCS does not allow reimbursement for the administration of VFC immunizations under the standard administration CPT codes (90465- 90474). 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. Care1st covers the administration of eligible VFC vaccines.

VFC COVERAGE CRITERIA

- Hepatitis A injection (90633) for members 1-5 years is a covered benefit. Any injection given to a Care1st member over 5 years old will be denied unless injection series began during an eligible age range. Please note the age the series began on the claim and your VFC log.
- It is important to note that CPT code 90715's description per the AMA is listed "...for use in individuals 7 years and older"; however, the FDA's description states: "...for children 10 years and older". AHCCCS is following the FDA description for age.

OTHER INJECTABLES

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

LABORATORY

Fee-for-service PCPs and Specialists may bill the following CPT codes and receive reimbursement on a fee-for-service basis. All other laboratory services must be

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performed by a contracted Care1st provider. Please refer to the Care1st Provider directory for contracted providers.

81000	81002	81003	82962
85013	86490	86580	
87210	86403	G0001	

Oncologists Only

85007	85008	85023	85024	85025
85027	85044	89050		

MATERNITY SERVICES

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

- Care1st will reimburse based on a total OB package. Prior Authorization for total OB packages must be requested within 30 days of the initial visit. All services should be billed after the delivery date. In addition to the appropriate delivery code, all prenatal visits must be reported using the 99213 CPT code. The dates of service reported on the claim should reflect all of the office visits being reported. The units' field should indicate the total number of visits being reported from the first date of service until the date of delivery. Failure to show the date span for Prenatal Care and the total number of visits in the unit field will result in the denial of the claim.
- To report services related to maternity care, use the appropriate CPT-4 office visit codes and the appropriate ICD-9-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.

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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

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- 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.

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- Providers must list a span of dates for prenatal visits with total number of visits in the unit field on the CMS 1500 claim form.
- No prior authorization is required for assistant surgeon services on cesareans, but they **do require** an Operative report. 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.

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

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

PEDS TOOL

PEDS (Parents' Evaluation of Development Status) is a standardized, fast, inexpensive screen for developmental and behavioral problems in children from birth to 8 years. It meets the standards set by the American Academy of Pediatrics for such measures. It uses the parents' own assessment of the child's development, as determined to be significant by full, peer-reviewed scientific validation studies, to assess the risk of the child having developmental or behavioral problems. The PEDS screening can be conducted at each EPSDT well child visit for those children that were born on or after 01.01.06 and who were in NICU following birth.

In order to bill for the use of the PEDS Tool and receive additional AHCCCS determined reimbursement:

- Complete the PEDS training (go to www.azpedialearning.org for additional information)
- Bill CPT 96110 with the "EP" modifier when the tool is used during an EPSDT visit
- Submit the PEDS score and interpretation form to the Quality Management Department along with the yellow copy of the EPSDT Form

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Care1st provides a monthly list of all children assigned to you who are due for EPSDT visits. In addition, when a NICU graduate is assigned to a physician, Care1st sends a letter identifying the baby as a NICU graduate along with an identification sticker that may be used on your chart.

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.

SOBRA FAMILY PLANNING SERVICES

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

- Contraceptive counseling, medications, supplies, and associated medical and laboratory examinations, including, but not limited to, oral and injectable contraceptives, intrauterine devices, diaphragms, condoms, foams, and suppositories.
- Voluntary sterilization (male and female)

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- Natural family planning education or referral to qualified health professionals

SURGERY PROVIDERS

- All surgery claims submitted to Care1st in excess of \$500.00 multiple or assistant surgery claims, and claims for surgeries resulting from medical complications must have an Operative (OP) Report attached. Multiple procedures are paid at 100% of the applicable fee schedule for the first, and 50% of the applicable fee schedule for the next five procedures. Any claim submitted without an OP Report will be denied and notification will be made to the provider for the OP 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-Ninth Edition (ICD-9)
- 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

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- Observation over 24-hours
- Critical care
- Anesthesia unusual services
- Unlisted/ By report procedures

As needed, the results of the MM analysis are forwarded to the CMO 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 CMO 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 CMO.

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