12 BILLING AND CLAIM SUBMISSION

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REFERENCES: CFR 42-433.316; CFR 42-455.410; A.R.S. § 36-551; A.R.S. § 36-2903.01(K); A.R.S. § 36-2903.01(L); A.R.S. § 36-2904(G), A.R.S. § 36-2904(G)(1), A.R.S. § 36-2907; A.R.S. § 36-2931 et seq; A.A.C. R9-29-30; ACOM 201; ACOM 203; ACOM 434

PURPOSE

This policy outlines the requirements for service providers when submitting claims to the Division of Developmental Disabilities (the Division) for services provided to Members eligible for Arizona Long Term Care Services.

DEFINITIONS

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "ALTCS" means the Arizona Long Term Care System.
3. "Internal Control Number" or "ICN" means claim reference number or internal control number unique to each claim and remains the same over the life of the claim.
4. "Clean Claim" means a claim that may be processed without obtaining additional information from the subcontracted

provider of care, from a non-contracting provider, or from a Third Party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

5. "Tribal Health Program" or "THP" means the program that provides medically necessary services for Division enrolled Members. The program provides coverage for acute, preventive, and behavioral health care services.
6. "Evaluation and Management Codes" or "E&M" means a category of Current Procedural Terminology (CPT®) codes used for billing purposes. The majority of patient visits require an E&M code. There are different levels of E&M codes, which are determined by medical decision making, time, and documentation requirements.
7. "Fee for Service" or "FFS" means a method in which doctors and other health care providers are paid for each service performed.
8. "Home and Community Based Services" or "HCBS" means one or more of the following services provided to Members: Attendant Care, Habilitation, Home Health Aide, Home Health Nurse, Occupational Therapy, Physical Therapy, Respiratory

Therapy, Respite Services, Speech-language pathology, and other comparable services as approved by the AHCCCS Director.

9. "International Classification of Diseases 10th revision or "ICD-10" means the diagnosis coding system used by physicians and facilities.
10. "Member" means the same as "Client" prescribed in A.R.S. § 36-551.
11. "Qualified Medicare Beneficiary Only" or "QMB Only" means Qualified Medicare Beneficiary under the federal program but does not qualify for Medicaid.
12. "Service Provider" means a person or agency that provides services to clients pursuant to a contract, service agreement or qualified vendor agreement with the Division.
13. "Third Party" means an individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan.
14. "Third Party Liability" or "TPL" means the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the

medical expenses incurred by a Member eligible for AHCCCS benefits.

15. "Void" means a reversal of a claim, with the entire claim amount being recouped.

POLICY

A. PROVIDER REQUIREMENTS

All service providers, including but not limited to out-of-state providers, those providing services under a State plan or under a waiver of a plan, attending and servicing providers both within and outside of a hospital setting, and billing providers shall meet the following requirements to be reimbursed for covered services provided to AHCCCS Members:

1. Enroll with AHCCCS;
2. Have an assigned AHCCCS Provider Identification Number; and
3. Register their National Provider Identifier (NPI) if applicable to the service provider type, with AHCCCS.

B. GENERAL BILLING REQUIREMENTS

1. Service providers shall adhere to the billing requirements observed by Medicare, Medicaid, and other Third-Party payers.

2. Service providers shall determine the extent of TPL coverage and bill all Third Party payers, including Medicare, before billing the Division.
3. Service providers shall adhere to applicable prior authorization requirements found in DDD Provider Manual Chapter 17 for all ALTCS/HCBS claims.
4. The service provider shall submit claims only for rendered goods or services.
5. The service provider shall enter their Federal Tax ID number associated with their Division contract on all claims.
6. The service provider shall enter their NPI on all claims, if applicable to the service provider type.
7. The service provider shall not submit claims to the Division if a Member is absent for any service.
8. The service provider shall adhere to the same timely filing and billing format requirements in this policy as is required for submitting initial claims for the following types of claims:
    a. Resubmitted claims;
    b. Corrected claims; and

c. Voided claims.

C. SERVICE DATES AND CLAIMS SUBMISSION TIME FRAMES

1. The service provider shall ensure that the last date of service billed is prior to or on the same date the claim is signed and submitted to the Division if the claim is covering a date range over which the service was provided.
2. The service provider shall submit claims for service rendered dates spanning within one month. If billing for multiple months, the service provider shall submit separate claims for each month.
3. The service provider shall adhere to the following time frames for submitting initial claims to the Division:
    a. No later than six months after the date of service.
    b. No later than six months from the date that eligibility is posted for claims involving retro-eligibility.
4. The service provider shall use the first date the item(s) were delivered to the Member as the date of service for durable medical equipment claims.

5. The service provider shall adhere to the following time frames when submitting corrected claims previously processed by the Division to achieve Clean Claim status:
    a. Within 12 months from the date of service.
    b. Within 12 months from the date eligibility was posted for claims involving retro-eligibility.
    c. Within 60 days of the last adverse action.

D. CLAIMS SUBMISSION REQUIREMENTS

1. The service provider shall refer to the Claims Submission Guides on the Division's website for instructions on submitting claims.
2. The service provider shall submit one of the following types of claims forms:
    a. Single claim entries via the WellSky professional billing system.
    b. Nationally standardized, original paper claim forms:
        i. CMS 1500 Form: For claims for professional services, including long term care and HCBS.
        ii. CMS 1450 (Institutional) or UB-04 Form: For claims for intermediate care facilities, hospital in-patient

and out-patient services, dialysis, hospice, and skilled nursing facility services.

iii. ADA 2012 Form: For claims for dental services.

c. Electronic claim transmittals:

i. 837P (Professional)

ii. 837I (Institutional)

iii. 837D (Dental)

3. Service providers shall submit claims with current code sets from the ICD-10, CPT®, Healthcare Common Procedure Coding System, Current Dental Terminology, and National Drug Codes.

E. BILLING DIVISION MEMBERS

1. Service providers shall not bill Members eligible for Medicaid, including QMB Only Members, for Division-covered services.
2. Service providers shall not bill Members for missed ALTCS/HCBS appointments.
3. Upon verbal or written notice from the Member that the Member believes the claims are to be covered by Medicaid, a service provider shall not do either of the following unless the service provider has verified through AHCCCS that the Member has

been determined ineligible, has not yet been determined eligible, or was not, at the time services were rendered, eligible or enrolled:

a. Charge, submit a claim to,or demand or otherwise collect payment from a Member who has been determined eligible for Medicaid unless specifically authorized.

b. Refer or report a Member who has been determined eligible for Medicaid, to a collection agency or credit reporting agency for the failure of the Member or person, who has been determined eligible, to pay charges for system covered care or services.

F. OVERPAYMENTS AND RECOUPMENTS

1. The service provider shall notify the Division of any overpayment by submitting a replacement claim to the Division to start the recoupment process.
2. The service provider shall refund the Division within 60 days from the date of notification of overpayment.
3. If an adjustment to a claim is needed, the service provider shall attach documentation substantiating the overpayment, such as

an Explanation of Benefits if the overpayment was due to payment received from a Third-Party payer.

4. If it is necessary to void a claim, the entire payment shall be recouped by the Division and the service provider shall not make direct repayment to the Division.
5. Upon recouping payment from an erroneous payment or overpayment, the Division shall generate a remittance advice showing the original allowed amount, and the new (adjusted) allowed amount for the processed claim.
6. The service provider shall not send a check for the overpayment unless otherwise requested by the Division.

G. MEDICAL REVIEW

1. The Division shall conduct medical review of claims to determine the medical necessity, appropriateness, utilization, and quality of services provided.
2. Service providers shall submit additional documentation for claims identified in the Division claims processing system as near duplicate claims to determine whether it is appropriate to

reimburse multiple providers for the same service on the same day for the same Member.

3. The service provider shall submit medical documentation to the Division for near duplicate payments when requesting an override.

H. SOCIAL DETERMINANTS OF HEALTH

1. Service providers shall routinely screen for and document the presence of social determinants of health.
2. The service provider shall include information about social determinants of health in the Member's chart.
3. The service provider shall include social determinants of health ICD-10 diagnosis codes on submitted claims to comply with state and federal coding requirements.
4. Service providers shall remain current in the use of social determinants of health ICD-10 codes.