

CHAPTER 16 – REMITTANCE ADVICE, ELIGIBILITY, AND COST SHARING

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REFERENCES: 42 CFR § 435.1103, A.R.S. § 36-2903, A.R.S. § 36-2904; A.A.C. R9-22-703, A.A.C. R9-29-301; ALTCS DES/DDD Contract YH6-0014 (Amendment 69), AHCCCS Fee-For-Service (FFS) Provider Billing Manual

This policy contains general information related to the Division of Developmental Disabilities (the Division) remittance advice, eligibility, and cost sharing. Policies regarding submission and processing of Long-Term Care services (LTC) and fee-for-service claims can be found in *Chapter 12 of the Division's Provider Manual* and are also communicated to providers via such channels as Provider Vendor Announcements.

In the absence of specific policies, the Division endeavors to follow the Arizona Health Care Cost Containment System (AHCCCS)/the Centers for Medicare and Medicaid Services (CMS) policy guidelines as closely as possible.

Definitions

- A. Cost Sharing - The Division's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.
- B. Dual Eligible Medicare Beneficiaries (Duals) - A Division member who is eligible for both Medicaid and Medicare services. There are two types of Dual Eligible members: QMB Duals and Non-QMB Duals (FBDE, SLMB+, QMB+)
- C. Full Benefit Dual Eligible (FBDE) - A Division member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.
- D. In-Network Provider - A provider that is contracted with the Division to provide services.
- E. Medicare Advantage Plan - A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include, Local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and Local and Regional Preferred Provider Organizations (RPOs).
- F. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.
- G. Medicare Part B - Coverage for medically necessary services like doctors' services, outpatient care, home health services, and other medical services.
- H. Medicare Part D - Medicare prescription drug coverage.
- I. Non-qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in



A.A.C. R9-29-101.

- J. Out of Network Provider - A provider that is neither contracted with nor authorized by the Division to provide services to its members.
1. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.
- K. Qualified Medicare Beneficiary Only (QMB Only) - A person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.
- L. Specified Low Income Medicare Beneficiary (SLMB) - Persons entitled to Medicare Part A whose incomes are between 100-120 per cent of the National Poverty Level. Medicaid also covers the beneficiary's Part B premium costs.
- M. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.

Remittance Advice

Remittance Advice explains the payment and any adjustments made to a payment during the adjudication of claims. The Division supplies a remittance advice document to the provider which provides the member identification number, member name, service code, Provider number, start date, end date, units, rate, payment amount, Third Party Liability (TPL) amount, and claim line identification. The remittance advice includes the formal claim dispute process and the correction/resubmission process for claims.

AHCCCS Prior Quarter Coverage Eligibility

Effective 1/1/2014, AHCCCS is required to expand the time period AHCCCS pays for covered services for an eligible individual, to include the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCS eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

- A. Received one or more AHCCCS covered services during the month.
- B. Would have qualified for AHCCCS at the time services were received if the person had applied for AHCCCS.

If the applicant is determined to qualify for AHCCCS covered services during any one or more of the three months prior to the month of application, then the individual will be determined to have "Prior Quarter Coverage" eligibility during those months. As a result, the AHCCCS will pay for AHCCCS covered services provided during those months.

AHCCCS will determine whether an applicant meets prior quarter coverage criteria. If the applicant



meets the prior quarter coverage criteria, providers will be required to bill the AHCCCS for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the member of prior quarter coverage eligibility.

Upon notification of prior quarter coverage eligibility, A.A.C. R9-22-703 requires the provider to promptly refund to the member any payments that have been received for services in an approved prior quarter period and must accept payment by AHCCCS as payment in full.

Providers failing to reimburse a recipient for any payments made by the recipient will be referred to the AHCCCS Office of Inspector General (OIG) for investigation and action.

For covered services received during the prior quarter which have not yet been reimbursed or billed the provider must submit a claim to AHCCCS.

AHCCCS Managed Care Contractors, including the Division, are not responsible for determining prior quarter coverage or for payment for covered services received during the prior quarter. Claims submitted to Division Managed Care Contractors, including the Division, for prior quarter coverage will be denied.

Providers may submit prior quarter coverage claims for payment to AHCCCS in one of the following ways:

- A. The HIPAA compliant 837 transaction
- B. Through the AHCCCS on-line claim submission process
- C. By submitting a paper claim form.

Billing requirements can be found at:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html>

All providers, including Regional Behavioral Health Authority (RBHA) and Tribal Regional Behavioral Health Authority (TRBHA) providers must submit a claim directly to AHCCCS. Pharmacy point of sale claims must be submitted to the AHCCCS Pharmacy Benefits Manager, OptumRx.

Prior Period Coverage for Division Member's

The Division provides Prior Period Coverage for the period of time prior to the Title XIX (Medicaid) member's enrollment with the Division during which time the member is eligible for covered services. Prior Period Coverage refers to the time frame from the effective date of AHCCCS eligibility (usually the first day of the month of application) until the date the member is enrolled with the Division. Once AHCCCS eligibility is approved, the Division receives notification from AHCCCS of the member's enrollment. Irrespective of the date of the member's enrollment with the Division, the Division is responsible for payment of all claims for medically necessary covered services, including behavioral health services and services provided by the Integrated RBHA, received during Prior Period Coverage. The Division will receive a Prior Period Coverage capitation for the cost of Prior Period Coverage.

Services received during Prior Period Coverage are paid by the Division. As mentioned above, the time period for Prior Period Coverage is from the effective date of AHCCCS eligibility until the date



of enrollment with the Division. For example, a member submits an AHCCCS application on April 15th, but the application is not approved for eligibility until sometime in May. The date the member is enrolled with the Division is shortly after the date of the eligibility determination approving AHCCCS coverage. The member's AHCCCS eligibility is retroactive to the first day of the month of application even though enrollment with the Division occurs at a later date. In this example, let's use May 10th as the date the member is enrolled with the Division; the member's AHCCCS eligibility is effective beginning April 1st. The Division is responsible for payment of AHCCCS medically necessary covered services retroactive to April 1st. However, the Prior Period Coverage time period is April 1st through May 9th

Hospital Presumptive Eligibility (HPE)

AHCCCS has developed a Hospital Presumptive Eligibility (HPE) process that allows qualified hospitals to temporarily enroll persons who meet specific federal criteria for full Medicaid benefits in AHCCCS immediately. Hospitals will use special features in Arizona's electronic application, Health-e-Arizona Plus (HEAplus), to process HPE applications.

Enrollment for this process is temporary and members are enrolled in Presumptive Eligibility.

Presumptive Eligibility will cover health care services only through the dates of the decision. Presumptive Eligibility coverage is temporary and will stop on the end date determined on the decision unless a full AHCCCS application is submitted.

AHCCCS will pay for AHCCCS covered services provided during this period of enrollment from registered AHCCCS providers. Claims are submitted directly to AHCCCS.

Retro-Eligibility

Retro-eligibility affects a claim when no eligibility was entered in the Division's billing system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

FFS claims are considered timely if the initial claim is received by the Division not later than six months from the Division date of eligibility posting. Claims must attain clean claim status no later than 12 months from the Division date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the date of eligibility posting. This time limit does not apply to adjustments which would decrease the original Division payment due to collections from third party payers.

Cost Sharing

This section defines the Division's cost sharing responsibilities for members that are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan. The purpose of this section is also to maximize cost avoidance efforts by the Division and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

- A. For QMB Duals and Non-QMB Duals, the Division's cost sharing payment responsibilities are dependent upon various factors:

1. Whether the service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid
2. Whether the services are received in or out of network (The Division only has responsibility to make payments to AHCCCS registered providers)
3. Whether the services are emergency services, and/or
4. Whether the Division refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. Title 9, Chapter 29, Article 3.

An exception to the Division's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the Division must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Division has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For the Division responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division Provider Manual, Chapter 57 - Third Party Liability.

B. QMB Duals

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their Division Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C.R9-22-2 or A.A.C. R9-28-2 from a registered provider is not liable for any Medicare copayment, coinsurance or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

Division Payment Responsibilities

The Division is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this Policy. Refer to the Division's *Provider Policy Manual, Chapter 4 - Covered, and Non-Covered Services*. These services include:

- Chiropractic services for adults
- Outpatient occupational and speech therapy coverage for adults
- Orthotic devices for adults
- Cochlear implants for adults
- Services by a podiatrist
- Any services covered by or added to the Medicare program not covered by Medicaid.

- A. The Division is prohibited from using the 09 coverage code to deny payment for medically necessary services to members who are both Medicare and Medicaid eligible. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and

Medicaid, and shall not be used to deny payment of claims.

- B. The Division only has responsibility to make payments to AHCCCS registered providers.
- C. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the Division’s network or prior authorization has been obtained.
- D. The Division must have no cost sharing obligation if the Medicare payment exceeds the Division’s contracted rate for the services. The Division’s liability for cost sharing plus the amount of Medicare’s payment must not exceed DDD’s contracted rate for the service. There is no cost sharing obligation if the Division has a contract with the provider, and the provider’s contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the Division must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if DDD has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.
- E. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS registered provider in or out of network the following applies (Table 1 and Figure 1):

Table 1: QMB DUALS	
WHEN THE SERVICE IS COVERED BY:	THE DIVISION MUST PAY: <i>(Subject to the limits outlined in this Policy)</i>
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: <ol style="list-style-type: none"> 1. The Medicare copay, coinsurance or deductible, or 2. The difference between the Division’s contracted rate and the Medicare paid amount.

FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES			
Services are covered by both Medicare and Medicaid			
<i>Subject to the limits outlined in this Policy</i>			
	EXAMPLE 1 (b. In Table 1 above)	EXAMPLE 2 (b. In Table 1 above)	EXAMPLE 3 (b. In Table 1 above)
Provider charges	\$125	\$125	\$125
Medicare rate for service	\$100	\$100	\$100



Medicaid rate for Medicare service (The Division's contracted rate)	\$100	\$90	\$90
Medicare deductible	\$0	\$0	\$40
Medicare paid amount (80% of Medicare rate less deductible)	\$80	\$80	\$40
Medicare coinsurance (20% of Medicare rate)	\$20	\$20	\$20
THE DIVISION PAYS	\$20	\$10	\$50

F. Non-QMB Duals

A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9, 9 A.A.C. 28, Article 2 from a provider within the Division's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22, Article 2. When the Non-QMB Dual Member elects to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.

1. Division Payment Responsibilities (In Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-2, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	THE DIVISION MUST <u>NOT</u> PAY:
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	THE DIVISION MUST PAY:
Medicaid Only	<i>Subject to the limits outlined in this Policy</i> The provider in accordance with the contract



By both Medicare and Medicaid	<p>The lesser of the following (unless the subcontract with the provider sets forth different terms):</p> <ol style="list-style-type: none"> 1. The Medicare copay, coinsurance or deductible, or 2. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (The Division's contracted rate).
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2. Division Payment Responsibilities (Out of Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracted provider the following applies (Table 3):

Table 3 NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	THE DIVISION <i>Subject to the limits outlined in this Policy</i>
Medicare Only	Has no responsibility for payment.
Medicaid only and the Division has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the Division has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the Division has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the Division has referred the member to the provider or has authorized the provider to render services or the services are emergent	<p>Must pay the lesser of:</p> <ol style="list-style-type: none"> 1. The Medicare copay, coinsurance or deductible, or 2. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

G. Prior Authorization



The Division can require prior authorization. If the Medicare provider determines that a service is medically necessary, the Division is responsible for Medicare cost sharing if the member is a QMB dual, even if the Division determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the Division must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Division must cover the cost of the service for QMB Duals.

H. Part D Covered Drugs

For QMB and Non-QMB Duals, Federal and State laws prohibit the use of Medicaid monies to pay for cost sharing of Medicare Part D medications.