Care1st Health Plan Arizona – April 2018

News you can use!

Billers' Corner

Provider Tips

Top 5 Denial Reasons and Reminders to Reduce Denials:

1. **Primary Insurance on file-Bill Primary Insurance:**
   - Verify coverage at each appointment
   - Use AHCCCS online to verify other coverage
2. **Duplicate Billing:**
   - Use the Care1st Web portal to confirm claim status at any time
   - Allow 45-60 days from the initial claim submission prior to resubmitting
   - Contact Claims Customer Service to assist with questions prior to submitting duplicates
3. **Patient Not Eligible on Date of Service:**
   - Confirm eligibility on AHCCCS online or with Care1st Member Services prior to claims submission
4. **Provider Not Contracted – Auth Required:**
   - Refer all laboratory services to Sonora Quest (our exclusive lab)
   - Refer to the Prior Authorization Guidelines on our website

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As requested at the 2017 Provider Forum: Modifier Clarification!!!

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) for members less than 21 years of age, modifier 25 is required on the sick visit CPT code in order to be reimbursed for both the EPSDT visit and the sick visit. If both visits are performed in conjunction with VFC immunizations, the modifier 25 is required on both the E&M and EPSDT codes. Modifier EP is required on the EPSDT visit code. The sick visit is reimbursed at 50% of the applicable fee schedule. Please remember both visits must be billed on the same claim form. Refer to the SL modifier section below for an example of how to bill a sick visit, EPSDT visit, and VFC vaccine administration.

EP MODIFIER
Bill modifier EP in conjunction with 96110 for reimbursement of developmental testing utilizing any of the three AHCCCS approved Developmental Tool: PEDS Tool, MCHAT or ASQ. Providers must first complete the training for the tool that is utilized to be eligible for reimbursement for this service.
EP modifier is also required on preventative EPSDT services (CPT codes 99381-99385, 99391-99395) and to designate all services related to the EPSDT well child visit, including routine vision and hearing screenings. For more information, see our blast fax communication from August 28, 2014 on our website and the AHCCCS Medical Policy Manual (AMPM) Chapter 400 Policy 430-29 Section H. See the SL modifier section below for an example of how to bill a sick visit, EPSDT visit, and VFC vaccine administration.

SL MODIFIER (State supplied vaccine)
Order vaccines administered to members under 19 through the Vaccines for Children (VFC) program. For a complete listing of eligible VFC codes, refer to www.azdhs.gov/phs/immun/act_aipo.htm. Bill vaccines supplied through the VFC Program as outlined in the claim example below.
CLAIM EXAMPLE: Billing sick visit, EPSDT visit and vaccine code(s) for single date of service:
Patient (under 19) makes appointment because of an earache. Office determines it is time for EPSDT evaluation and vaccine. Office bills:
- Both the sick and well diagnosis codes
- Sick visit is billed with appropriate E&M (99201-99245) with modifier 25
- EPSDT visit is billed with appropriate E&M (99381-99385 or 99391-99395) with modifier 25 and modifier EP
- Vision screening is performed as part of the EPSDT visit (92015) with modifier EP
- VFC vaccine code is billed with the applicable NDC and the SL modifier
- Vaccine administration code is billed with the SL modifier

MODIFIER 50 (bilateral procedure)
Modifier 50 is required for all bilateral procedures. Please refer to current coding guidelines for a listing of appropriate bilateral procedures. Bilateral procedures are billed on one line with 1 unit and the 50 modifier. *EXAMPLE:*
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 truly distinct and separate service, and is not be used if the procedure is performed on the same site. When an already established modifier is appropriate, use it instead of modifier 59 (example modifier 91 for repeat clinical procedures). Care1st applies Medicaid NCCI (National Correct Coding Initiative) bundling edits to claims. Claims submitted with modifier 59 are subject to medical review and office notes/operative reports are required with the claim submission for consideration. Use additional modifiers to define subsets of the modifier 59, in order to define a "Distinct Procedural Service":
- XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components of The Main Service