PROVIDER FORUM

September 2014

Agenda

- AHCCCS Insurance Requirements
- Prior Authorization Tips
- Care Management Program
- PCPs role in Dental Health
- Developmental Screening Tools
- AHCCCS Benefit Changes
- Claims
  - EPSDT and EP Modifier
  - Record Requirements for billing 59 modifier
  - Top 5 Claim Denials (PCPs and OB/GYNs)
  - OB Global Billing

AHCCCS Insurance Requirements

AHCCCS has updated the minimum insurance requirements for:

- Commercial General Liability
- Business Automobile Liability
- Worker's Compensation and Employers' Liability

AHCCCS Insurance Requirements Effective October 1, 2013

Commercial General Liability – Occurrence Form

- Policy should include bodily injury, property damage, personal injury and broad form contractual liability coverage.
  - General Aggregate $2,000,000
  - Products – Completed Operations Aggregate $1,000,000
  - Personal and Advertising Injury $1,000,000
  - Damage to Rented Premises $50,000
  - Each Occurrence $1,000,000

- Endorsements (See verbiage on AHCCCS Insurance Requirements Hand-Out)
  - Additional insured language
  - Waiver of Subrogation language

AHCCCS Insurance Requirements Effective October 1, 2013

Business Automobile Liability

- Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of the services under contract. The amount below is the minimum required.
  - Combined Single Limit (CSL) $1,000,000

- Endorsements (See verbiage on AHCCCS Insurance Requirements Hand-Out)
  - Additional insured language
  - Waiver of Subrogation language

AHCCCS Insurance Requirements Effective October 1, 2013

Worker's Compensation and Employers' Liability

- Workers' Compensation Statutory
  - Employers' Liability
    - Each Accident $ 500,000
    - Disease – Each Employee $ 500,000
    - Disease – Policy Limit $ 1,000,000

- Endorsements (See verbiage on AHCCCS Insurance Requirements Hand-Out)
  - Waiver of Subrogation language

AHCCCS Insurance Requirements Effective October 1, 2013

Additional AHCCCS Insurance information

- Endorsements
  - All endorsements must be verbatim – see attached
  - Blanket Endorsements are not acceptable

- AHCCCS Minimum Subcontract Provisions can be located at http://www.azahcccs.gov/commercial/Downloads/MinimumSubcontractProvisions_Acute.pdf

- Certificates of Liability including coverage levels, endorsements, and waivers of subrogation can be sent to Provider Network Operations by Fax 602-778-1875 or e-mail PNOaz@care1st.com

Prior Authorization Tips

- Prior authorization is required for some services when Care1st is the secondary payer. These services are specifically indicated on the Prior Authorization Guidelines.

- Your PA request will be processed more expeditiously if you fax the completed Treatment Authorization Request (TAR) with all supporting documentation and medical records.

- Please direct members to contracted providers. All services requested for a non-contracted provider require prior authorization.

- Please contact Care1st for the status of your PA request before sending a duplicate request.

Prior Authorization Tips Cont'd

- Routine vs Urgent authorization requests:
  - Please ensure your treatment authorization requests are checked "Routine" or "Urgent" as medically appropriate. This will result in faster turn-around of all authorization requests!
  - AHCCCS defines an Urgent request as:

    "*A request for services in which either the requesting provider indicates or the Contractor determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.*"

- Care1st Prior Authorization Guidelines are located on our website at: https://www.care1st.com/az/providers/priorauthreferencegrid.asp

Care Management Program

- Our Care Management program includes care coordination, social work, behavioral health and medical case management
- We work with the PCP to help manage the complex needs of our adult and pediatric populations
- We have the following types of care management services:
    1. Case Management
    2. Disease Management
    3. High Risk OB
    4. Pediatric
    5. Transplant
    6. Social Work
    7. Behavioral Health
    8. Chemical Dependency

Care Management Referrals

- We can assist our members with issues such as:
  1. Risk for Admission or Readmission
  2. Post-discharge care transition needs (DME, home health care)
  3. Disease and chronic condition management
  4. Acute/catastrophic condition support
  5. Treatment adherence/access to care barriers
  6. Caregiver support and other social service issues
  7. High risk pregnancies
  8. Non-emergent use of emergency department
  9. Overuse of controlled substances
  10. Behavioral health/drug/alcohol issues
- The Case Management Referral Form is available on our website at: https://www.care1st.com/az/providers/frequentlyusedforms.asp
- Please fax completed referral form to Care1st at (602) 224-4372.
- Our case managers will reach out to the member and alert you when contact is made, collaborating with your team as needed to increase continuity of care and treatment plan adherence.

Role of PCP in Dental Care

Statewide initiative to increase access to Dental Care

- Assignment of a DENTAL PROVIDER or DENTAL HOME
  - Members 1 – 20 years old are assigned to a Dental Provider similar to current PCP assignment
    - Goal: Initiate first dental visit by 1 year of age

The PCP is also key to dental care!

- Perform an oral health screening at each EPSDT visit
- Educate parents on the need/importance of good oral care
- Refer children to a dentist beginning at the first tooth eruption or by 1 year of age

Role of PCP in Dental Care

FLOURIDE VARNISH

- Following training on varnish application, PCPs and mid-levels are encouraged to apply fluoride varnish during EPSDT visits and bill for the service
  - Use code D1206 and diagnosis code V07.31
  - Begin varnish application at 6 months of age or at 1st tooth eruption
  - Continue application every 6 months up to 2 years of age

Training available at:

http://www.smilesforlifeoralhealth.org/buildcontent.aspx?tut=584&pagekey=64563&cbreceipt=0

- Upload a copy of your certificate to CAQH and it will be available to all AHCCCS health plans

Developmental Screenings

- Developmental screening should be performed at EPSDT Visits at 9, 18 and 24 month using one of the AHCCCS approved developmental tools.

- Additional reimbursement is available by:
  - Completing required training
  - Submitting the proof of training/certification to CAQH to Care1st
  - Bill with CPT code 96110 and EP modifier

Approved Developmental Screening Tools

- PEDS Tool
  - The Parent's Evaluation of Developmental Status (PEDS) tool – www.pedstest.com or www.forepath.org
  - Training can be found at the above links or www.azpedialearning.org/test1.asp
- ASQ
  - Ages and Stages Questionnaire (ASQ) tool – www.agesandstages.com
- MCHAT
  - The Modified Checklist for Autism in Toddlers (MCHAT) for children 16 – 30 months of age to screen for autism when medically indicated
- Information about training on Developmental screening tools can be found on the Arizona Department of Health Services website at
  - http://www.azdhs.gov/clinicians/index.htm
  - Click on Training Opportunities and then on Developmental Screenings

AHCCCS Benefit Changes

Benefit Changes effective October 1, 2014

- Insulin Pumps
  - Insulin pumps are covered benefits for all AHCCCS members
  - Were previously eliminated as a covered adult benefit on October 1, 2010.
- Orthotic Devices
  - Orthotic devices will only be covered for adults in the following circumstances:
    - Halos to treat cervical fracture instead of surgery
    - Walking boots instead of surgery or serial casting
    - Knee orthotics for crutch dependent ambulation instead of a wheelchair
  - Certificate of Medical Necessity is required to be reported to AHCCCS
- Both Insulin Pumps and Orthotic Devices require Prior Authorization

EPSDT and EP modifier

- Effective 04/01/14 the EP modifier is required with all EPSDT services.
- Modifier 25 is required when an E&M visit is billed with an EPSDT visit and is also required with the EPSDT visit when billed with vaccine administration.
- Claims are currently not being denied by Care1st when the EPSDT visit is not billed with an EP modifier as providers transition to the new billing guidelines
- EPSDT billing examples included in handouts

Billing the 59 modifier

- Medical records are required when modifier 59 is billed with any of the services below to support the use of the modifier.
  - Procedure code range 10000 – 69999
  - Procedure code 94640 (Inhalation treatment)
  - Top reason Care1st denies claims for records

Top 5 Claim Denials

1. Exact Duplicates
2. Authorization
3. Coordination of Benefits
4. Patient not eligible on DOS
5. Re-Billing with Records
   - Resources/methods to reduce these denials include the
     - Prior Authorization Guidelines on the Care1st website,
     - AHCCCS online/Care1st provider portal for eligibility/other insurance verification,
     - Submitting records when modifier 59 is billed with a service requiring review and waiting 60 days to re-bill claims.

Prenatal Visit Billing

OB Billing Changes:

- AHCCCS proposed new guidelines requiring all visits to be billed on individual lines with the date of service, for both total OB packages and fee-for-service.
- AHCCCS has determined they will implement the requirements.

Effective on all claims received on or after 11/1/14:

- 59425 or 59426 cannot be used for reporting individual prenatal visits.
- Each OB visit must be reported on an individual line with an E&M code and the date of service for each visit.
- Total OB package payment reimbursement will remain the same, as the individual line billed with E&M code will deny as part of the global package.
- Fee for Service claims can be billed with 59425 or 59426, but the individual visits must still be reported with an E&M code on each line with the corresponding date of service.

Copy of blast fax with billing examples included in handout

Q & A