

Claims Clues

A Publication of the AHCCCS Claims Department

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Dialysis Claims to Face Medical Review

Free-for-service dialysis claims submitted to the AHCCCS Administration are subject to medical review.

Dialysis facilities are reimbursed a composite rate, and services included in the composite rate may not be billed separately unless they are provided more frequently than specified by policy. AHCCCS follows Medicare requirements for billing and reimbursement of dialysis services.

Services that are billed separately because they were provided more frequently than specified by policy must be justified by supporting documentation. The AHCCCS Medical Review Unit will review dialysis claims to determine if separate charges for services included in the composite rate are supported by the documentation.

If no documentation is submitted with the claim or if the documentation does not support the charges, those charges will be disallowed.

AHCCCS also is reviewing claims for dialysis services that have been paid since Aug. 1, 1995.

Providers who billed separately

for services normally included in the composite rate will receive a letter requesting documentation to substantiate the separate billing.

If the documentation is not received within 30 days or if it does not support the charges, payment for those services will be recouped.

Drugs included in the composite rate and which may not be billed separately include:

- Heparin and heparin antidotes
- Mannitol
- Glucose
- Antiarrhythmics
- Saline
- Antihypertensives
- Protamine
- Pressor drugs
- Antihistamines
- Local anesthetics
- Dextrose
- Antibiotics (if used to treat peritonitis associated with peritoneal dialysis)
- Albumin (if used as a volume expander)

Laboratory services that are included in the composite rate and which may not be billed separately include:

- All routine clinical chemistry tests.
- Hematocrit or hemoglobin and clotting time tests incident to dialysis treatments if performed per treatment or less frequently.
- Prothrombin time for patients on anticoagulant therapy, Serum creatinine, and BUN if performed weekly or less frequently.

The following laboratory services may not be billed separately if performed monthly or less frequently:

- Serum calcium
- Serum chloride
- Total protein
- CBC
- Serum bicarbonate
- Serum phosphorous
- Total potassium
- Serum albumin
- Alkaline phosphates
- SGOT
- LDH

If any of these services are performed more frequently than specified, they may be billed separately. The services may be covered only if medically justified by supporting documentation. □

AHCCCS to Require Tax ID on Claim Form

AHCCCS has begun to capture providers' federal tax identification numbers, and providers soon will be required to enter their tax ID numbers on claim forms.

AHCCCS began capturing tax IDs

on February 1. Effective May 1, all claims must include the providers tax ID number. Claims without a tax ID will be denied.

On a UB-92 claim form, the provider's tax ID is entered in Field 5 near the top of the form.

On the HCFA 1500 claim form, the tax ID is entered in Field 25 near the lower left corner.

On the Universal form used for pharmacy claims, the tax ID should be entered in the signature box in the middle of the form. □

Fee-for-Service Not Totally Eliminated by PPC

Yes, Virginia, there really is a fee-for-service recipient.

Lots of them, in fact.

The recently implemented 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 a health plan or program contractor.

Effective October 1, 1997, the plans and program contractors are responsible for reimbursing providers for covered services rendered during this PPC time frame.

These services formerly were reimbursed by AHCCCS on a fee-for-service basis.

However, implementation of PPC did not eliminate the fee-for-service population entirely. The fee-for-service population now essentially consists of four major groups:

- Recipients in the federal or state

Emergency Services Program (ESP)

- Recipients enrolled in Indian Health Services (IHS)
- On-reservation Native Americans eligible for long term care services
- The prior quarter period for recipients with prior quarter eligibility

When verifying eligibility, providers will be informed of a recipient's eligibility and enrollment status. If a recipient was fee-for-service on the date(s) of service, claims for this services must be submitted to the AHCCCS Administration.

Implementation of PPC makes verification of eligibility and enrollment extremely important, as plans and program contractors may establish policy requirements (e.g., prior authorization requirements) which differ from the AHCCCS

Administration's requirements for fee-for-service claims.

Providers may use any one of three verification processes.

The *Interactive Voice Response system (IVR)* allows an unlimited number of verifications by entering information on a touch-tone telephone. Call IVR at:

- Phoenix: 417-7200
- All others: 1-800-331-5090

The on-line *Eligibility Verification System (EVS)* allows providers to use a PC or terminal to access eligibility and enrollment information. For information on EVS, contact the Potomac Group:

- 1-800-444-4336

The *AHCCCS Verification Unit* is staffed 24 hours a day, 7 days a week. To contact the AHCCCS Verification Unit, call:

- Phoenix: 417-7000
- All others: 1-800-962-6690 ☐

Provider Should Not Return Check to Correct Overpayment

Fee-for-service providers who receive an overpayment from the AHCCCS Administration should *not* return the overpayment to AHCCCS unless specifically requested to do so.

Providers should submit either an

adjustment or a void, whichever is appropriate, of the paid claim. Documentation substantiating the overpayment, such as an EOB if the overpayment from AHCCCS resulted from payment from another third party payer, should be attached.

If a provider returns an overpayment, AHCCCS will proceed with the adjustment process and recoup the overpayment. It will then be necessary to issue a new check to the provider, resulting in a delay in the appropriate reimbursement. ☐

Cover Sheet Needed When Faxing PA Information

Providers who fax documentation to the AHCCCS Prior Authorization Unit should ensure that a cover sheet accompanies the documentation.

The cover sheet should list the

provider's name and AHCCCS provider ID number, the name of a contact person, a telephone number and a fax number.

This will enable an AHCCCS PA nurse to contact the provider in case additional information or

clarification is needed before services can be authorized.

Without such information, authorization may not be established, and claims may be denied.

The PA Unit's fax number is 256-6591. ☐