TO: ARIZONA ASSOCIATION OF HEALTH CARE LAWYERS

FROM: Jerry Gaffaney, President, Secretary/Treasurer

DATE: June 30, 2016

July 19, 2016 PROGRAM ANNOUNCEMENT

"Avoiding Common Pitfalls in Billing Arizona's Medicaid System

Date: July 19, 2016
Time: 12:00 noon to 1:00 pm
Place: Lewis Roca Rothgerber Christie at Collier Center
201 East Washington Street, 3rd Floor

Ben Runkle will be discussing common claiming errors made by AHCCCS-registered providers, including "incident to" and locum tenens billing. He will also leave time following his presentation to answer questions about other topics involving the AHCCCS Program.

Benjamin Runkle currently holds the position of Associate General Counsel for the Arizona Health Care Cost Containment System ("AHCCCS"). Mr. Runkle began his legal career representing criminal defense clients for Gallagher & Kennedy and later accepted an appointment as an Assistant Attorney General for the Office of the Arizona Attorney General. Prior to joining the legal profession, Mr. Runkle worked as a police officer and firefighter/paramedic in Indiana.

This program will be held on July 19, 2016 at 12:00 noon at Lewis Roca Rothgerber Christie's office in Phoenix. Lunch will be served - $10 for AAHCL members/$15 for non-members.

Please RSVP in advance by e-mail to CLovejoy@dickinsonwright.com. You may pay at the door or send your check in advance (payable to AAHCL) to Jerry Gaffaney, Dickinson Wright 1850 North Central Avenue, Suite 1400, Phoenix, Arizona 85004. Whether or not you pay in advance, you must RSVP prior to the program.

This program will count for one (1) credit hour of continuing legal education.

CALL IN INFORMATION: To access the teleconference, use any of these dial-in numbers: 1-866-496-2887, 602-262-5301 or 602-385-0230. Enter this Bridge number: 5218. Enter this Participant PIN number: 95218

For CLE credits and materials for this program, please contact Cyrie Lovejoy.

OFFICE DIRECTIONS – www.lrrc.com/phoenix#directions

Take I-10W to Washington Street. Exit and turn left at Washington Street for 2 miles and follow it to Collier Center (Bank of America building, including Kincaid's and Hard Rock Café), located on the south side of Washington Street. Turn left into the parking garage just before 2nd Street. Collier Center is on the southeast corner of 2nd Street and Washington.

Take the garage elevators up to the 2nd floor (Collier Center Lobby), then take the second bank of elevators to Lewis Roca Rothgerber Christie's 3rd floor for the AAHCL Meeting.

AHCCCS
Arizona Health Care Cost Containment System

Avoiding Common Pitfalls in Billing Arizona's Medicaid System

Benjamin C. Runkle
Associate General Counsel
AHCCCS
Office: 602-417-4514
Benjamin.Runkle@azahcccs.gov

Background

- AHCCCS oversees Arizona's Medicaid and behavioral health systems (except ASH).
- Medicaid is funded through a combination of State and Federal funding.
  - Current budget is approximately $12 billion.
  - Federal funding level varies by program/year.
- Over 60,000 health care providers deliver services to 1.8 million AHCCCS members.

Background

- Approx. 90% of AHCCCS members enrolled in contracted health plans ("MCOs").
- Remaining 10% receive insurance directly from AHCCCS on fee-for-service basis.
  - Native Americans – Amer. Ind. Health Program
  - FES – Federal Emergency Services
- Provider must submit claim to member's enrolled plan as of the date of service.

Timing is Everything

Missed Deadlines – One of the most common (and easily avoidable) billing errors.

Timeliness – Initial Claim

- A.R.S. 36-2904(G); A.A.C. R9-22-703 & 705
- Generally, provider must submit claim within one of the following time limits, whichever is later:
  - Six months from date of service;
  - For inpatient hospital stays, six months from date of discharge; or
  - Six months from date of eligibility posting.
- MCOs may contract with provider for shorter timeframes.

Timeliness – Clean Claim

- Clean Claim = claim that may be reprocessed without obtaining additional information.
- Generally, provider must submit a clean claim within one of the following time limits, whichever is later:
  - Twelve months from date of service;
  - For inpatient hospital stays, twelve months from date of discharge; or
  - Twelve months from date of eligibility posting.

Timeliness – Claim Dispute

- A.R.S. 36-2903.01(B)(4); A.A.C. Title 9, Chapter 34, Article 4
- Claim dispute must be filed within one of the following time limits, whichever is later:
  - Twelve months after date of service;
  - Twelve months after eligibility posted; or
  - Sixty days after date of claim denial.
- Claim dispute must be in writing. Must detail the factual and legal basis for the dispute.

Claim Dispute Issues

- AHCCCS and MCOs not governed by ERISA or A.R.S. Title 20. *See* 29 U.S.C. 1002 & 1003; A.R.S. 36-2903(L).
- EMTALA may require that a person receives a medical screening evaluation; however, no law obligates AHCCCS to pay for that screening for a FES member unless that screening is necessary for treating an "emergency medical condition." *See* 42 U.S.C. 1396b(v); 42 C.F.R. 440.255.

Claim Dispute Representation

- A non-attorney, third-party biller may not request a state fair hearing or represent a provider at hearing.
- A.R.S. 36-2903.01(B)(4) and Supreme Court Rule 31(d)(12) allows a duly authorized agent who is *not charging a fee* to represent a person in AHCCCS proceedings.
- A.R.S. 36-2903.01(B)(4) clarifies that a legal entity may be represented by an officer, partner or employee.

Using Another Provider's ID

1. Payments to Providers
2. No "Incident To" Billing
2. Limitation on Locum Tenens

Payments to Providers

- 42 C.F.R. 431.107, A.R.S. 36-2904, and A.A.C. R9-22-703, 705 & 714 require providers to enter into a provider agreement with AHCCCS as a condition of receiving payment from AHCCCS or a MCO.
- 42 C.F.R. 455.410 requires AHCCCS to enroll and screen "all ordering or referring physicians or other professionals providing services under the State Plan" or a waiver.
- Neither AHCCCS nor the MCOs may pay an unenrolled (*i.e.* unregistered) provider.

Payments to Providers

- Excluded Individuals. 42 U.S.C. 1128a, 42 C.F.R. Parts 455 & 1002, and SMDLs #08-003 & #09-001.
- No Medicaid money may be used to pay anyone excluded from participation in federal healthcare programs.
  - For example, Medicaid cannot make a payment to a hospital if the payment includes services rendered by an excluded medical assistant.
  - Excluded persons cannot furnish administrative and management services unless wholly unrelated to federal healthcare programs.

Payments to Providers

- A.A.C. R9-22-714(B) requires AHCCCS and MCOs to pay the provider who "personally furnishes the service." This regulation includes services performed during supervision of:
  - Medical residents or dental students;
  - Physical Therapy, Occupational Therapy or Respiratory Therapy Assistants (4 A.A.C. 24, 43 and 45); or
  - Midwives or Speech-Language Pathologist Assistants (9 A.A.C. 16).

Reassignment of Provider Payments 42 C.F.R. 447.10; A.A.C. R9-22-714

- Provider may reassign payment to:
  - A government agency or to comply with a court order;
  - The provider's employer if reassignment is a condition of employment;
  - An inpatient facility or entity operating an organized health delivery system; or
  - A business agent if agent's compensation is not dependent on collecting the payment, and is related to cost of processing the billing and not on percentage of amount billed or collected.

Reassignment of Provider Payments

- Any entity submitting claims to AHCCCS on another's behalf must be registered as a Group Biller.
- The provider must have a contract with the Group Biller authorizing the reassignment of payment and submit a Group Billing Authorization to AHCCCS.
- On the Claim Form 1500, the Group Biller would enter its NPI/ID into the Billing Provider box and the provider's NPI/ID into the Rendering Provider box.

No "Incident To" Billing

- In the Provider Participation Agreement, providers agree not to use another provider's ID number except in locum tenens situations and as allowed in AHCCCS policy.
- Except for QMBs, AHCCCS does not allow providers to bill for services rendered "incident to" the services of another.
- Only the services listed in A.A.C. R9-22-714(B) (slide 13) may be billed as though the supervising provider actually rendered the service.

No "Incident To" Billing

- Chapter 3 of the Fee-For-Service Billing Manual clarifies that mid-level practitioners must be listed as the rendering provider for the services they personally perform.
- This standard ensures that AHCCCS and the MCOs pay only the provider who personally furnished the service as required by A.A.C. R9-22-714.
- The March 2013 Claims Clues specifically noted that billing a mid-level's services under a physician's NPI would constitute an improper claim and/or encounter.

No "Incident To" Billing

- Policy Considerations – Cons
  - Doesn't allow provider to bill Medicaid in the same manner as the provider bills Medicare.
- Policy Considerations - Pros
  - Allows AHCCCS to know which provider actually performed the service when it receives a quality or fraud complaint.
  - Allows AHCCCS to verify Medicaid patient volume for EHR Incentive Payments.

Limitations on Locum Tenens ("LT")

- AHCCCS limits LT billing to the length of the LT registration with the AZ Medical Board (180 consecutive days once in a three year period).
- The LT physician must register with AHCCCS.
- On the 1500, list the NPI of the physician for whom the LT physician is substituting along with the Q6 modifier.
- The provider must keep a log detailing for whom the LT physician is covering.

Prior Period and Prior Quarter Coverage

Prior Period Coverage ("PPC")

- A.A.C. R9-22-101(B), 202(D), & 701.
- Describes that portion of time in which a person is eligible for AHCCCS but has not yet enrolled in a health plan.
- Begins on first day of month of application or first day of month of eligibility, whichever is later. Ends on date of enrollment with MCO.
- During PPC, a MCO cannot deny a claim for failure to obtain prior authorization or failure to obtain the service within the MCO's service area.

Prior Quarter Coverage

- A.A.C. R9-22-303 & 703(H)
- Applicant may be eligible for AHCCCS benefits (Medicaid only) during any one of the three months prior to application if:
  - The Applicant received at least one AHCCCS-covered service during the month; and
  - The Applicant would have qualified for AHCCCS benefits on the date of service (even if dead at time of application).

Prior Quarter Coverage

- A provider must bill AHCCCS for services rendered during prior quarter coverage.
- Do not bill the member's current health plan.
- The provider must reimburse any payments made by a member for services rendered during prior quarter coverage and accept AHCCCS' payment as payment in full.

Balance Billing

Balance Billing

- Under A.R.S. 36-2903.01(K) and A.A.C. R9-22-702, a registered provider must accept an AHCCCS or MCO payment as payment in full.
- A registered provider may seek payment from a member only if one of the exceptions in A.A.C. R9-22-702(D) apply.

Exceptions to Balance Billing Prohibition

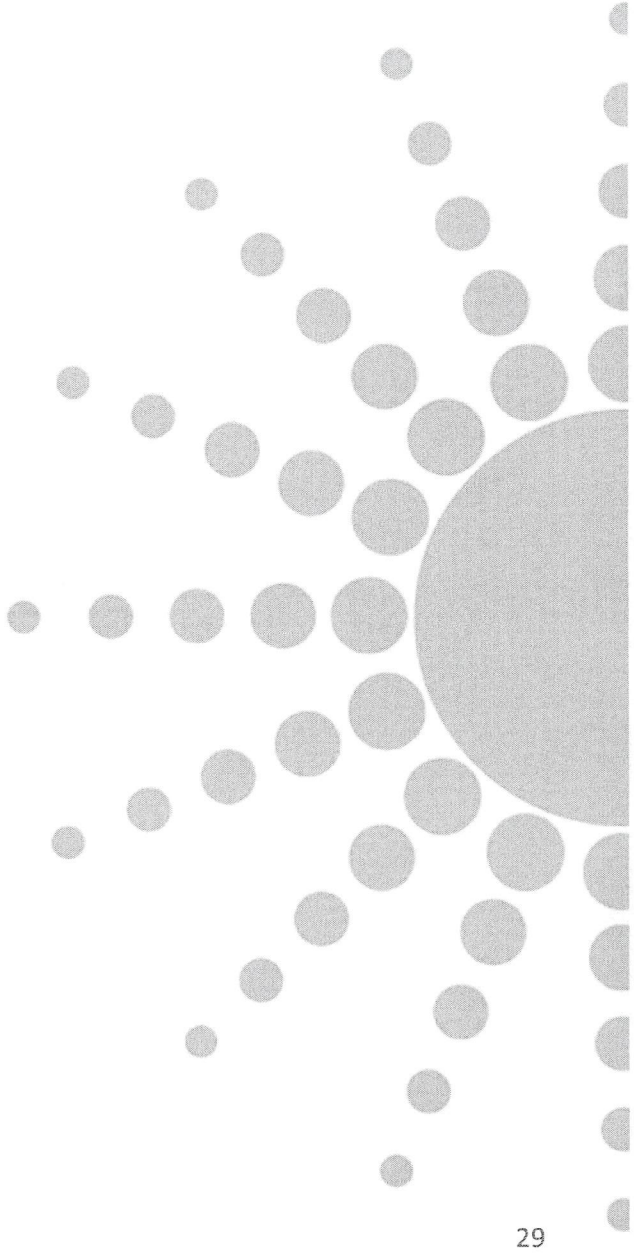
- Collect co-payment under A.A.C. R9-22-711.
- Collect payment for uncovered or unauthorized service if member signed a specific written agreement to pay prior to receiving the service.
- Member ineligible for AHCCCS on date of service.
- Member intentionally withheld or provided inaccurate information re Medicaid eligibility and provider suffered harm as a result.

Balance Billing

- Includes charging AHCCCS members an "admin fee" or "initiation fee" as a precondition to obtaining services.
- Includes charging AHCCCS members an additional fee to receive covered services using special technologies or items.
- If provider continues to charge member after notification to cease, AHCCCS could assess penalty of up to three times the amount charged.

Questions?

Thank You.



AHCCCS
Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need