Banner University Health Plans

Provider Newsbrief – Apr. 1, 2022

AHCCCS covers eyeglasses, replacements for members under 21

Vision services are covered for all AHCCCS Early Periodic Screening, Diagnostic and Treatment (EPSDT) members under 21 years of age. Vision services for all AHCCCS members under the age of 21 include regular eye exams and vision screenings, prescription eyeglasses, updates to a members eyeglass prescription, as well as repairs or replacements of broken or lost eyeglasses.

Per AHCCCS regulations, neither the health plan nor any contracted providers or dispensers of visual equipment, may place any restrictions for fixing or replacing broken or lost glasses.

Additionally, providers and dispensers shall not require members to agree to any upgrades. For any upgrade that is not AHCCCS covered, the provider/dispenser must ensure that the member or guardian is informed of and agrees to financial responsibility. The member/guardian must sign a document, in advance, that provides a clear description and approximate cost of any service or supply not covered by AHCCCS. Members do not need to wait for their next planned screening and can call the BUHP customer service number (800-582-8686) for help.

The Covered Services Page on the AHCCCS website has also been updated to clarify this coverage - https://azahcccs.gov/Members/AlreadyCovered/coveredservices.html

A flyer has been developed for members by AHCCCS and can be found on the Office of Individual and Family Affairs (OIFA) page - https://azahcccs.gov/AHCCCS/Downloads/EyeglassCoverage_2022-2-22.pdf.

Participating Provider Information Requirement Effective June 1, 2022

As of June 1, 2022, AHCCCS providers must begin to report the individual practitioner who rendered services on professional and dental service claims. This requirement impacts all claims for AHCCCS providers registered as integrated clinics (Provider Type IC), behavioral health outpatient clinics (Provider Type 77) and clinics (Provider Type 05).

Claims for dates of service on and after June 1, 2022 will be denied by AHCCCS and its Managed Care Organizations if the individual practitioner who performed the services associated with the clinic visit is not reported. See Exhibit 10-1 of the AHCCCS Fee-For-Service Provider Billing Manual for billing instructions for proper claims submissions.

Questions? Contact David Rudnick at david.rudnick@azahcccs.gov.

FQHC Billing Guidelines Reminder

BUHP has recently conducted evaluation of our processing of FQHC/RHC claims in accordance with published AHCCCS Billing Guidelines and have noted some discrepancies related to the Guidelines specific to handling when Medicaid is a secondary payer to either Medicare or Third-Party Coverage. As a reminder, key point of these Guidelines are noted below and referenced in the link to the AHCCCS webpage.
For a copy of the **FQHC Billing Policy per AHCCCS,** type the link below in your browser:
https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap_10AddendumFQHC.pdf

When Medicare Third-Party coverage primary claims will not reflect AHCCCS specific coding requirements, therefore the following steps must be taken:

- On the **1500 claim** form, Medicare's deductible/coinsurance/copay total amounts **must be reported** on the **T1015** claim line for reimbursement in the correct Medicare fields. The appropriate EM codes must be billed on successive lines with **0.00** billed amounts, while leaving the Medicare fields blank (do not enter 0's).

- If the Medicare claim did not crossover, **the FQHC/RHC must** submit the claim with the EOMB, even though the codes billed will not match the EOMB. The Medicare deductible/coinsurance/copay total amounts must be reported on the **T1015** service line, in the correct Medicare fields, for reimbursement. The appropriate EM codes must be billed on successive lines with **0.00** billed amounts, leaving the Medicare deductible/coinsurance /copay fields blank (do not enter 0's).

- When other coverage is paid as primary, the full other coverage payment paid by the other primary payer will be associated with the **T1015** service line only.

- The appropriate EM codes must be billed on successive lines with 0.00 billed amounts. A copy of the primary payer's EOB must be included with the claim. Since AHCCCS specifies the **T1015** coding, the billing and the EOB coding will not match.

Examples of Medicare or Third-Party Coverage (TBC) to Medicaid

Example Claim #1 – Medicare Primary/Medicaid Secondary

PROC: 99202	PROC: T1015	PROC: 84005
MOD:	MOD:	MOD: 26
DIAGNOSIS: R00.8	DIAGNOSIS: R00.8	DIAGNOSIS: R00.8
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
BILLED CHARGE: 0.00	BILLED CHARGE: 380.00	BILLED CHARGE: 0.00
MEDICARE APPROVED:	MEDICARE APPROVED: 380.00	MEDICARE APPROVED: 0.00
MEDICARE PAID:	MEDICARE PAID: 280.00	MEDICARE PAID:
MEDICARE DEDUCTIBLE:	MEDICARE DEDUCTIBLE: 0.00	MEDICARE DEDUCTIBLE:
MEDICARE COINSURANCE:	MEDICARE COINSURANCE: 100.00	MEDICARE COINSURANCE:

Example Claim #2 – TPC Primary/Medicaid Secondary

PROC: 99202	PROC: T1015	PROC: 84005
MOD:	MOD:	MOD: 26
DIAGNOSIS: R00.8	DIAGNOSIS: R00.8	DIAGNOSIS: R00.8
UNITS: 1.000	UNITS: 1.000	UNITS: 1.000
BILLED CHARGE: 0.00	BILLED CHARGE: 380.00	BILLED CHARGE: 0.00
TPL PAID: 0.00	TPL PAID: 180.00	TPL PAID: 0.00

New 30-month Wellness/EPSDT visit added for children

AHCCCS implemented changes to the AMPM Policy 430 and Attachment E, adding a new 30-Month EPSDT/Well-Child visit. This visit includes the provider requirement to complete one of the approved Developmental Screening Tools (ASQ, MCHAT or PEDS). These changes were made retroactively effective Oct. 1, 2021.

The 30-month, as well as all of the AHCCCS EPSDT Clinical Sample Templates (formerly known as EPSDT Tracking Forms), may be downloaded from the AHCCCS website at: https://www.azahcccs.gov/shared/MedicalPolicyManual/; scroll down to the sections of the manual and select Chapter 400; then look for 430 – Early and Periodic Screening, Diagnostic, and Treatment Services, Attachment E – AHCCCS EPSDT Clinical Sample Templates. Click on that link and it will download the file to your computer.

Special recommendations on blood lead level testing for refugees

If any of your patients are recent refugees, be sure to keep in mind some special recommendations for blood lead tests above and beyond the standard recommendations.

Recommendations on Blood Lead Testing for Refugees

Perform blood lead testing for the following groups upon entering the US:

- All refugee children less than 16 years of age
- All pregnant and lactating women and adolescent girls

Repeat blood lead testing for the following groups:

- All children less than 6 6ears of age within 3 – 6 months after initial screening, regardless of initial screening results
- Children and adolescents 7 – 16 years of age with an elevated blood lead level (EBLL) at initial screening

Older adolescents (over 16 years) should be tested if there is a high suspicion, such as a sibling with an EBLL or suspected environmental exposures. Repeat testing may be warranted.

For more information on blood lead screening and management for all patient/member populations, check out the ADHS recommendations at the link below:
https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/lead-poisoning/lead-screening-and-management-recommendations.pdf