CHR Resources for Standing Up Medicaid Reimbursement

Arizona Advisory Council on Indian Health Care

Learning Objectives

1. What services can be billed, what codes to use, and how many hours per month can be provided before being required to request prior authorization?
2. What health conditions or barriers must a member be experiencing in order for billing to be permitted?
3. What are the reimbursement rates for services?
4. What providers are eligible to bill?
5. How to fill out a claim form
6. Where to submit claims
7. What is timely filing?

Please note that this guidance is meant to assist with billing and NOT with the CHW/CHR certification process.

Billing Basics

Codes: What Services are Reimbursable?

CHW/CHRs play an integral part in the community and provide a wide-range of services. However, not all services are reimbursable via Medicaid.

When you are determining whether or not a service is reimbursable, **ask yourself the following questions**:

1. Can the service provided be billed with one of the 3 reimbursable codes? (98960, 98961, 98962)
2. Does the member meet the qualifications for billable services?
   - They must have either a chronic health condition, be at *risk* for developing a chronic health condition, or have a documented barrier that is affecting their health.
3. Does the service being provided meet the policy requirements?

Codes: What Codes are Reimbursable?

Ask Yourself: Can the service provided be billed with one of the 3 reimbursable codes allowed by CMS and AHCCCS?

Reimbursable Codes for CHR Services	
CPT Code	**Service Description**
98960	Education and Training for Patient Self-Management (30 minute increments)
98961	Education and Training for Patient Self-Management, with 2-4 Patients (30 minute increments)
98962	Education and Training for Patient Self-Management, with 5-8 Patients (30 minute increments)

Member Qualifications

Ask Yourself: Does the member meet the qualifications for billable services?

Members must have one of the below conditions or barriers:	
1.	A chronic health condition (e.g. heart disease, diabetes, asthma, depression, generalized anxiety disorder, etc.)
2.	Be at *risk* for a chronic health condition **Examples:** • High triglycerides and LDL coupled with a family history of early heart attack and stroke putting them at risk of heart disease and/or stroke • High fasting blood glucose and HbA1c levels, coupled with a family history puts them at risk of developing Type II Diabetes
3.	Have a documented barrier affecting health **Examples:** • Extreme Poverty • Lack of access to electricity and refrigeration, when medications require cold storage • Lack of social supports Think social determinants of health (SDOH) for this.

Service Qualifications

Ask Yourself: Does the service being provided meet the policy requirements?

Codes 98960, 98961, and 98962 all are allowable codes for CHR reimbursement. These codes allow for "education and training for patient self-management".

- **IMPORTANT:** While education and training for patient self-management can be applied to a host of educational areas that a CHR can provide to a patient…**only *certain* education and training topics fall under the allowable services that can be billed**

Qualifying Education and Training include:	
1.	Providing health system navigation and resource coordination
2.	Providing health education and training, including services to train and/or increase the member's awareness of methods and measures that have been proven to be effective in avoiding illness and/or lessening the effects of an illness. The content of the education shall be consistent with established healthcare standards
3.	Health promotion and/or coaching to provide information and training to members that enables the member to make positive contributions to their health status.

Billing Caps: How Many Hours of Service Can We Bill?

Daily Cap: **4 units** per member per day (**2 hours)**
Monthly Cap: **24 units** per month per member (**12 hours**)

Total units allowed are inclusive of all 3 billable codes.

For example:

- A member receives 4 units of 98960 on July 1, July 2, and July 31.
- That same member receives 4 units of 98961 on July 9 and July 12.
- They also receive 4 units of 98962 on July 15.

This is a ***total of 24 units for the month***, inclusive of all three (3) billable codes.
This is the maximum that the member can receive.

What if additional hours are needed?

- If additional services are required, prior auth must be requested. (PA is requested online through the AHCCCS Online Portal.)

Additional Coding and Service Caveats

Important: **G0019** (Community health integration services performed by certified/trained auxiliary personnel, such as a CHR, under the direction of a physician or other practitioner) and **G0022** (Community health integration services, additional 30 minutes increments) are ***not*** reimbursable for CHR programs under Medicaid.

- These G codes are only permitted for Medicare crossovers claims, or for when other primary payers (primary health insurance) are involved.
- In those cases, the providers would submit according to the primary insurance.

Please note that billing a code alone is not sufficient. The visit notes must substantiate that the code being billed for was a Medicaid-reimbursable service.

- In short, the provider must abide by the policies surrounding the service and provider performing the service, have all documentation needed, and bill the right code to get reimbursed. Record Keeping and Policy are important.

2024 Rates

The below rates are valid from 10/1/2023 to 9/30/2024. This aligns with the federal fiscal year.

These services **are NOT reimbursable at the All-Inclusive Rate (AIR).**

- These services are only billable at the **FFS Rate**.
- Rates for the education and training provided to patients for each 30 minutes of service:

Code	FFS Rate (AHCCCS)	Unit Time (Increment)	# of Patients
98960	$24.23	Per 30 minutes	1
98961	$11.54	Per 30 minutes	2-4
98962	$8.66	Per 30 minutes	5-8

The above rates are for 2024 and for members enrolled in FFS health plans only. Reimbursement may differ for members enrolled in AHCCCS Complete Care Health Plans.

Provider Types Eligible for Reimbursement

There are two ways that CHR services can be reimbursed.

1. For CHR Programs choosing to not register with AHCCCS, and instead wish to work with an already-registered AHCCCS provider to do their billing for them, billing can occur under the following provider types:

AHCCCS-Registered Provider Types			
638 FQHC (PT C5)	Community/Rural Health Center (PT 29)	Integrated Clinic (PT IC)	MD-Physician (PT 08)
Behavioral Health (BH) Outpatient Clinic (PT 77)	Federally Qualified Health Center (FQHC) (PT C2)	DO-Physician Osteopath (PT 31)	Physician Assistant (PT 18)
Clinic (PT 05)	Hospital (PT 02)	Registered Nurse Practitioner (PT 19)	

Provider Types Eligible for Reimbursement

There are two ways that CHR services can be reimbursed.

2. For CHW/CHR Programs who decide to register with AHCCCS, to bill for their own services, will register with AHCCCS as a **CHW Organization (Provider Type CH).**

PROVIDER TYPE NAME	PROVIDER TYPE	NPI NUMBER REQUIRED (YES/NO)	ACA SCREENING RISK LEVEL (LIMITED, MODERATE, HIGH)	ENROLLMENT FEE COLLECTED (YES/NO)	SITE VISIT PERFORMED (YES/NO)	REGULATORY AGENCY
COMMUNITY HEALTH WORKER ORGANIZATION	CH	N	H	YES	YES	Arizona Department of Health Services (for Community Health workers employed by the organization)

Claim Form Examples

Submitting Claims

Typically claims are submitted electronically.

However, if submitting via paper, then CHR services should be billed on the CMS 1500 Claim Form

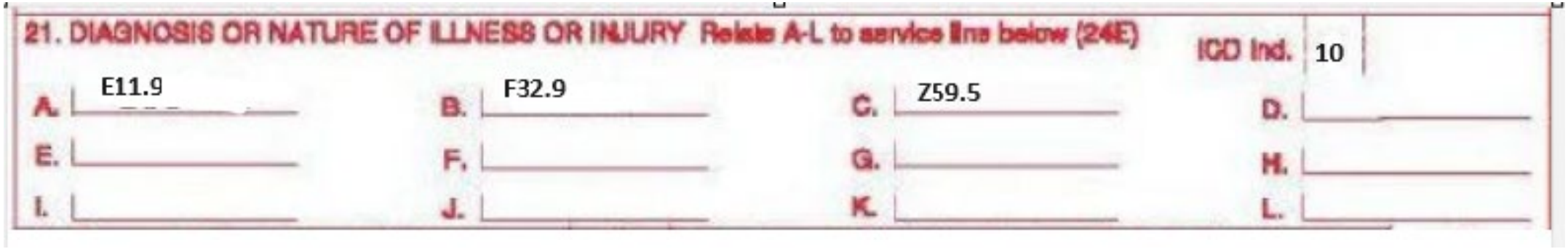
- Please read Chapter 5, CMS 1500 Claim Form and Claim Submission Requirements, of the DFSM FFS Provider Billing Manual for detailed claim form instructions.

The following slides cover some fields of interest for CHR programs

Fields of Interest: Field 21

Field 21 (A-K) is where you list all the ICD-10 codes (do not use ICD-9 codes) that pertain to the patient in question.

- This should include any social determinant of health codes that are noted by the CHR or referring provider.
- Note: Social Determinants of Health (SDOH) are often called “Z codes”. However, not all social determinant codes start with a Z, and not all “Z codes” are social determinants of health.
- Do not use DSM-4 diagnosis codes.
- Up to twelve diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.


21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 10

A. E11.9 B. F32.9 C. Z59.5 D.

E. F. G. H.

I. J. K. L.

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Fields of Interest: Field 24

Field 24 (A-J)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
																		ZZ	Taxonomy Code Here
05	01	24	05	01	24	12		98960					AB	96	92	4		NPI	
																		NPI	

- **A (Dates of Service):** If one day of service is being billed for use the same day as the From and To date.
- **B (Place of Service):** Use the appropriate place of service (POS) code. In the below example, POS 12 is used. POS will vary based off where the service was provided.
- **C (EMG):** This stands for emergency services. Do not enter anything here, since CHR reimbursable services do no meet the definition of an emergency service.
- **D (Procedures, Services or Suppliers):** This is where you would put the 98960, 98961 or 98962 codes. There are no modifiers available at this time.

Fields of Interest: Field 24

Field 24 (A-J)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
																		ZZ	Taxonomy Code Here
05	01	24	05	01	24	12		98960					AB	96	92	4		NPI	
																		NPI	

- **E (Diagnosis Pointer):** Under field E, you would refer to the ICD-10 Diagnosis Codes indicated in Field 21 (see above). So, for example, if the patient education provided under CPT code 98960, which is included in the below example, pertained to Diabetes (ICD-10 code E11.9) and Depression (ICD-10 code F32.9) then Field E would say AB. If it pertained to all three ICD-10 codes, including Z59.5 (Extreme Poverty, which is a social determinant of health ICD-10 code), then you would put ABC under field E.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.	10
A. E11.9	B. F32.9	C. Z59.5	D.		
E.	F.	G.	H.		
I.	J.	K.	L.		

Fields of Interest: Field 24

Field 24 (A-J)

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
														ZZ	Taxonomy Code Here
05	01	24	05	01	24	12		98960		AB	96 92	4		NPI	
														NPI	

- **F ($ Charges):** Providers put the monetary amount they are requesting here. You can see that they are requesting $96.92 in the below example. This is the allowable amount for 4 units of code 98960 ($24.23 per half hour unit). If a provider requests more than that, for example, and puts 200.00 (do not include dollar signs on the actual claim form) under the charges, they would still only receive the $96.92 if the claim was approved to pay. Putting a larger amount will not result in larger payment.
  - **Note:** If more than one unit of service was provided, enter the total charges for all units.
- **G (Days or Units):** Put the number of units here, paying attention to the number of hours the service was provided. Here, since CPT code 98960 is measured in half hour increments, you would put 4 units to indicate 2 hours of service on this day.
- **H (EPSDT/Family Planning):** Leave blank. This is not required.

Fields of Interest: Field 24

Field 24 (A-J)

- **I (ID Qual):** As a CHW Organization, you are not, at this time, required to have an NPI. However, you still must have a way to identify your organization when you submit claims. This is a field you would use to indicate this.
  - **Note:** If you *do* have an NPI, leave this field blank.
  - **What should you put if you DO NOT have an NPI?** Enter in the qualifier identifying if the number is a non-NPI. If you are using your Taxonomy Code, put ZZ. The Other ID# of the rendering provider should be reported in 24J in the shaded area.
- **J (Rendering Provider ID #):** See below. If you are using your Taxonomy code, you would put ZZ and the Taxonomy Code, instead of the NPI.

DIAGNOSIS POINTER	$ CHARGES	OR UNITS	Family Plan	ID QUAL	RENDERING PROVIDER ID #
				ZZ	Taxonomy Code

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Submitting Claims

Submitting Claims

Claims for Fee-for-Service (FFS) members, enrolled in the American Indian Health Program (AIHP), should be submitted to AHCCCS, Division of Fee-for-Service Management (DFSM). This claim submission is often a two step process, if documentation is required.

- As of August 2024, AHCCCS is not requiring additional documentation to be attached to claims for the services provided by CHW/CHR programs.
- If documentation is required in the future, you will:
  - Submit the claim using the AHCCCS Online Provider Portal
  - Submit documentation using the Transaction Insight Portal

Claim Submission

Claims should typically be submitted through the AHCCCS Online Provider Portal.

- The claim will be submitted under the AHCCCS-registered provider who your CHW/CHR Program is billing under.

Claims can also, in some cases, be submitted as a paper claim. This is **not the preferred method of submission and in some cases may result in unnecessary errors or the claim not processing correctly due to typos or illegibility.**

Submitting Documentation *for* Claims

Documentation Submission

- If documentation is required, you will submit it using the Transaction Insight (TI) Portal.
- This can be a *very* tricky process, as you need to attach the documentation to the claim itself using a special number.
- This number (PWK Number) must be typed in *exactly the same* on both portals (the AHCCCS Online Provider Portal and the TI Portal) in order for it to link to the claim successfully.

- AHCCCS Trainings on TI Portal:
  - https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/TransactionInsightPortal.pdf
  - https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/TIBCOForesightTransactionInsightTIWebUploadAttachmentGuide.pdf
  - https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2022/TransactionInsightPortalSetPurposeCode11.pdf

Timely Filing

What is Timely Filing?

Time Matters!!!

Per State law (ARS §36-2904 (G),) an initial claim for services provided to an AHCCCS member ***must be received by AHCCCS no later than 6 months after the date of service***, unless the claim involves retro-eligibility.

For claims filed by FFS providers:

- AHCCCS **must receive the initial claim** no later than ***6 months*** after the initial date of service.
- A **clean claim (a healthcare claim submitted by a provider, that processes through AHCCCS and pays without any errors)** must be processed by AHCCCS no later than ***12 months*** from the initial date of service.

Why are there two time frames?

As long as the **initial claim is received within that initial 6-month window**, ***corrections can still be submitted up to 12 months after the date of service***, even if the claim is denied due to an error.

- Do not void the initial claim if you are past that 6-month window. Voiding and resubmitting a claim "restarts the clock".

Timely Filling Scenarios

Scenario 1 for Fee for Service Providers

- **4/1/2024** - Your CHR program provides a service to a member on **4/1/2024**
- **10/1/2024** – Your program (stage 2)or the provider billing *for* your program (stage 1), does not submit the claim to AHCCCS until 10/1/2024
- **Result**: The claim will ***automatically deny for failure to comply with timely filing deadlines.***
- **Payment Received:** None. Your program will receive no payment.

AHCCCS will not be able to make an exception for this, since this timeframe is the result of ***state law.***

Timely Filling Scenarios

Scenario 2 for Fee for Service Providers

- **4/1/2024** - Your CHR program provides a service to a member on **4/1/2024**
- **6/1/2024** – Your program (stage 2)or the provider billing *for* your program (stage 1), does not submit the claim to AHCCCS until 6/1/2024
- **Result**: The claim will ***PROCESS***. It has met timely filing deadlines and was submitted before the 6 month window ended. (6 month window would end on 9/30/2024)

What Happens Next?

Once the initial claim is submitted within the timely filing deadline, the AHCCCS claims system will process the claim.

- If there are no errors, the claim will pay.
- If AHCCCS finds errors on the claim *or* if additional information is needed to substantiate the service provided, you will then have the opportunity to submit corrections or the additional documentation requested.


Pop Quiz Time!

Group Participation!

Timely Filling Scenarios

Scenario 3:

Date of Service: 4/1/2024

- **Claim submission date:** 9/30/2024

Does this claim deny for timely filing, or process?

Group Participation!

Timely Filling Scenarios

Scenario 3 *Continued!*

It met timely filing deadlines (by 1 day!) so the claim processes!

However...when AHCCCS reviewed the claim there were errors on it. So the claim actually denies on 10/7/2024.

AHCCCS sends a notice to the provider on 10/7/2023. The notice identifies an error in the service location and also requests additional documentation.

What does the provider need to do?

What day do they need to do it by?

Group Participation!

Timely Filling Scenarios

Scenario 3 *Continued!*

What does the provider need to do?

- The provider needs to submit a correction to the claim (DO NOT VOID THE INITIAL CLAIM). They will also need to provide additional documentation as requested.

What day do they need to do it by?

- Remember the initial Date of Service (DOS) was 4/1/2024. So the 12 month window for the "clean claim" processing will close on 3/31/2025.
- The provider needs to accomplish this all by 3/31/2024.

The claim now processes with the corrections and documentation submitted, and pays! Congratulations!

Other Noteworthy Items

Important Portals and Reference Publications

Important Portals

- **AHCCS Provider Enrollment Portal (APEP):** www.azahcccs.gov/APEP
- **AHCCCS Online Provider Portal:** https://ao.azahcccs.gov/Account/Login.aspx?ReturnUrl=%2f
- **Transaction Insight Portal:** https://tiwebprd.statemedicaid.us/AHCCCS/default.aspx

AHCCCS Reference Publications

- Fingerprint Background Check Policy:
  - https://www.azahcccs.gov/PlansProviders/Downloads/APEP/FCBC_OnePager.pdf
- AHCCCS Medical Policy Manual, 310-W, Certified Community Health Worker/Community Health Representative
  - https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310-W.pdf
- Community Forum (Pages 11 to 18):
  - https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/CommunityPresentations/2024/AHCCCSCommunityForum_20240415.pdf

Important Reference Publications

AHCCCS Reference Publications

- Community Forum (Video Presentation on YouTube):
  - https://www.youtube.com/watch?v=GuJA7mq7BKo
- Fee-for Service (FFS) Provider Billing Manual, Chapter 5, CMS 1500 Claim Form and Claim Submission Requirements:
  - https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap05.pdf
- Fee-for-Service (FFS) Provider Billing Manual, Chapter 10, Individual Practitioner Services (Pages 7-10)
  - https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf
- AHCCCS FAQs on CHW Voluntary Certification and Reimbursement:
  - https://www.azahcccs.gov/PlansProviders/Downloads/CHW/CHW_CHRFAQs.pdf
- AHCCCS Trainings on AHCCCS Online Provider Portal:
  - How to Submit a CMS 1500/Professional Claim Using the AHCCS Online Provider Portal: https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/ProfessionalClaim_AHCCCSOnline.pdf

Important Reference Publications

AHCCCS Reference Publications

- AHCCCS Trainings on AHCCCS Online Provider Portal:
  - How to Status a Claim Using the AHCCCS Online Provider Portal: https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/HowToStatusClaim_AHCCCSOnline.pdf
  - Correcting Claims, Voiding Claims and Replacing Claims: https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/CorrectingSubmission_VoidsAndReplacements.pdf
    - **VERY IMPORTANT:** Remember that if you are past timely filing you need to be extremely careful when it comes to voiding/replacing claims. Do *not* void a claim if it's past the 6 month mark. Instead do a correction or "replace" the claim.
- AHCCCS Trainings on TI Portal:
  - https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/TransactionInsightPortal.pdf
  - https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/TIBCOForesightTransactionInsightTIWebUploadAttachmentGuide.pdf
  - https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2022/TransactionInsightPortalSetPurposeCode11.pdf


Thank you!