Arizona Advisory Council on Indian Health Care

Community Health Representative (CHR) Resources for Standing Up Medicaid and Medicare Reimbursement

The below resource list is meant to assist Community Health Worker / Community Health Representative (CHW / CHR) Programs in billing AHCCCS (the State Medicaid program) and Medicare for services rendered.

Please note: This is a guidance document published by the Arizona Advisory Council on Indian Health Care (AACIHC) and does not supersede guidance issued by either AHCCCS or the Centers for Medicare and Medicaid Services (CMS).

- AHCCCS and CMS guidance serve as the final rulings for all guidance on billing for CHW/CHR services.
- It is the responsibility of all CHR programs and healthcare providers and billers to verify information independently prior to billing.

Voluntary Certification:
In order for Medicaid *or* Medicare-covered services to be billed, a CHW/CHR must be voluntarily certified.

- The certificate is issued by the Arizona Department of Health Services (ADHS).
- To become certified, a CHW/CHR must meet the qualifications to practice as a certified CHW/CHR, as outlined in Arizona Administrative Code (A.A.C.) R9-16-802, and work under the direction of an eligible AHCCCS-registered provider.

This guidance contained within this document is meant to assist with understanding setup of certain programmatic aspects and billing. This document does *not* provide guidance on the CHW/CHR certification process.

For additional information on requirements and how to obtain a CHW/CHR voluntary certification, please visit the Arizona Department of Health Services (ADHS) CHW Special Licensing website at: https://www.azdhs.gov/licensing/special/index.php#community-health-workers

The below Table of Contents contains links to the appropriate sections.
*****Updated sections as of 7/2024, 9/2024, 6/2025 are indicated in the document*****

Special thanks to Louisa O'Meara, Samantha Sabo, and Northern Arizona University for their expertise and work on this document, and to the CHW Coalition of South Dakota for their generous sharing of example templates online. You can find additional useful resources with these organizations:

- NAU Center for Community Health and Engaged Research: https://nau.edu/center-community-health-engaged-research/community-health-workers/
- CHW Coalition of South Dakota online at: https://chwsd.org/sd-medicaid-implementation/

Table of Contents

Important Takeaways

- **Certification MATTERS!** It affects ability of an organization to bill both Medicare and Medicaid.
- ***Billing can only occur for services provided to Medicaid and Medicare members by CHRs who have voluntary certification through the Arizona Department of Health Services.***
- CHR programs ***can employ CHR's who are not voluntarily certified***, but they ***cannot bill for services provided by them*** to AHCCCS members or to individuals enrolled in Medicare.
- To bill for services provided to Medicaid members, they must have a documented health condition or barrier for the service to be reimbursable.
- To bill for services provided to Medicare members, an assessment must have first been done and the individual must qualify for either CHI or PIN services.
- There are two ways for providers to be reimbursed for Medicaid services: either by entering into an agreement with one of the designated billing providers or by registering as an AHCCCS provider themselves.
- There are multiple publications on the AHCCCS website to help guide you (See AHCCCS Reference Publications section in this document)

Important Portals to Know

- 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
- Health Equity Services in the 2024 Physician Fee Schedule Final Rule: https://www.cms.gov/files/document/mln9201074-health-equity-services-2024-physician-fee-schedule-final-rule.pdf-0
- CHW Medicare Summary: https://www.paahec.org/post/medicare-to-start-paying-for-community-health-worker-services

- SDOH Assessment Information:
  - http://www.nachc.org/research-and-data/prapare/toolkit/
  - https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf
  - https://bit.ly/2GTkKUu
  - https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/social_determinants.html

- Medicare.gov CHI Services: https://www.medicare.gov/coverage/community-health-integration-services

- CHI Services Summary: https://www.astho.org/topic/resource/changes-to-2024-medicare-physician-fee-schedule-for-chi-services/

- Webinar Series on 2023/2024 Funding: https://www.healthlawlab.org/wp-content/uploads/2024/03/Funding-for-CHWs-and-Navigators-New-Medicare-Codes-Webinar-Slides_2023.pdf

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 (Slidedeck, pages 11 to 18): "CHW/CHR Organizations and Services"
  - https://www.azahcccs.gov/AHCCCS/Downloads/PublicNotices/CommunityPresentations/2024/AHCCCSCommunityForum_20240415.pdf

- Community Forum 4/2/2024 (Video Presentation on YouTube) "Full Implementation: CHW/CHR" -- provides overview of AHCCCS reimbursement pathways for CHW services
  - 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
    - 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

I. Arizona Medicaid Reimbursement for CHR Services

Stages of the Medicaid Reimbursement "Roll Out"

AHCCCS rolled out Medicaid reimbursement in 2 stages:

Stage 1

CHW/CHR Programs began billing for services rendered, under the AHCCCS ID of an ***existing AHCCCS provider***, on April 1, 2023.

- A good option for Community-Based Organizations (CBOs) or Localities that have historically provided CHW/CHR services, but have not been involved in Medicaid programmatically, and for those CBOs and Localities that lack the infrastructure or funds to employ their own billers/professional coders.

Stage 2

CHW/CHR Programs may ***register themselves as an AHCCCS-registered provider, and bill under their own AHCCCS ID***.

- This new provider type (PT) is called a **"CHW Organization"**
- **Valid as of April 2024**

Who can register as a CHW Organization?

- Community-Based Organizations (CBOs)
- Localities
- Tribal Organizations
- Other institutions employing ADHS certified CHW/CHRs

Medicaid: CHR Billing 101

Tips to Get You Started with Medicaid Reimbursement

Stage 1: Billing under an existing AHCCCS Provider

Things to Keep in Mind

- When billing under an already existing AHCCCS provider (one that is already registered with AHCCCS), the provider whom your team will be billing for services under will already have an account set up to do billing for Medicaid Services.

- This includes having an account registered for the AHCCCS Online Provider Portal (the online portal where claims are submitted) and the Transaction Insight Portal (aka: TI portal, or the portal where documentation is attached to claims). They will either add someone from your team to their existing account, so your own biller can submit claims, *or* they will submit claims on your behalf.

Stage 2: Billing as a CHW Organization – New Provider Type

Things to Keep in Mind

- For programs that choose to register as an AHCCCS provider, they will need to ensure they not only register with AHCCCS and meet all requirements, but they are also keeping all files and records on hand for CHR certifications.
- This includes keeping past CHR certification records.
    - Example: Copies of CHR Certifications
        - CHRs renew their certification every 2 years through ADHS.
    - **Record Keeping**: Your organization must maintain records longer than their current certification time frame. Your CHR program should not dispose of past proof of CHR certification, simply because they had their certification renewed and entered a new certification cycle.
    - **Why?** If a past claim that the CHR program submitted is audited, you will need to have that past CHR certification on hand to provide during the review/audit process. The health plan will need proof that the CHR was certified when the service was rendered. Help your organization out by keeping comprehensive and tidy records.

Claim Form

- **CHW services must be billed on a 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.

Coding

- The following information is a high-level overview of what codes have been approved for reimbursement for CHW/CHR programs, and the anticipated list of provider types that a CHW/CHR program can bill under. Please keep in mind this information is preliminary and may be updated when AHCCCS releases their FAQ.
- **Provider Reimbursable Services** - Education and training for patient self-management conducted by a qualified non-physician healthcare professional using a standardized curriculum. This service involves face-to-face sessions with the patient (which could include caregivers or family members) billed in 30-minute increments.

Billing Codes

Codes to be reimbursed are:

- 98960 – education and training provided for an individual patient for each 30 minutes of service.
- 98961 – for a group of 2 to 4 patients
- 98962 – or a group of 5 to 8 patients

****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. For more information see the below sections on 'Records to Keep on File' and 'Policy Aspects of Billing'.

Important: Codes like **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.

Billing Caps

A maximum of 4 units per member per day, and 24 units per month may be billed.

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.**

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

Provider Types Eligible for Reimbursement

There are two ways that CHR services can be reimbursed.

1. **Billing under an existing AHCCCS Provider (Stage 1):** For CHW/CHR Programs that choose 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:
   - 638 FQHC (PT C5)
   - Behavioral Health (BH) Outpatient Clinic (PT 77)
   - Clinic (PT 05)
   - Community/Rural Health Center (PT 29)
   - Community Health Worker Organization (PT CH)
     - *Billing can occur and be done by another CHW Organization*
   - DO-Physician Osteopath (PT 31)
   - Federally Qualified Health Center (FQHC) (PT C2)
   - Hospital (PT 02)
   - Integrated Clinic (PT IC)
   - MD-Physician (PT 08)
   - Physician Assistant (PT 18)
   - Registered Nurse Practitioner (PT 19)

2. **Billing as a CHW Organization (New Provider Type) (Stage 2):** 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).**

Medicaid: Rates

FFS Rates for 2025***

The below rates are valid from 10/1/2024 to 9/30/2025. This aligns with the federal fiscal year.

- These services will not be reimbursable at the All-Inclusive Rate (AIR).
- These services are only billable at the FFS Rates.
- Rates for the education and training provided to patients for each 30 minutes of service:

Code	FFS Rate (AHCCCS)	Unit Increment (Time)	# of patients
98960	$25.46	Per 30 minutes	1
98961	$12.30	Per 30 minutes	2-4
98962	$9.15	Per 30 minutes	5-8
The above rates are for 2025 and for members enrolled in FFS health plans only.			

ACC Health Plan Rates for 2025

- Rates will vary based on provider agreements with each health plan. Rates can be discussed with each ACC Health Plan directly, when applying to become a provider.

Medicaid: Documentation and Record Requirements (for Successful Claim Submission)

As of June 2023, AHCCCS is not requiring additional documentation to be submitted with claims. **However,** AHCCCS ***may request additional documentation*** at any time.

If AHCCCS later requests documentation that a provider is unable to provide, the claim may be subject to recoupment. Recoupment entails the provider reimbursing the State of Arizona's Medicaid program for the funds initially disbursed for the claim.

This is standard practice for all Medicaid programs nation-wide.

Why?

- Providers requesting *any form* of Medicaid reimbursement (including from MCOs) must maintain documentation to substantiate that the service provided was:
    1. A Medicaid-eligible service, *and*
    2. Provided by an eligible AHCCCS provider.
- This is both a federal *and* state requirement.

As a provider it is vital that you maintain documentation to prove compliance with AHCCCS and State policies regarding CHW/CHR services. Please keep on file the following items, as AHCCCS may request a copy at any time.

1. Proof of CHR Voluntary Certification
2. Referral from the Referring Provider
3. Information on Member Condition or Documented Barrier
4. Visit Notes

Additional Clarification on Documentation

1. **Proof of CHR Voluntary Certification** going back at least 10 years, for all employed CHRs.
    - **Why?** This will allow AHCCCS to ensure that the CHR providing the service was certified when the visit took place.

2. **Referral from the Referring Provider**
    - **Why?** Services must be deemed medically necessary and recommended by an eligible physician or licensed practitioner of the healing arts within the scope of authorized practice under State law. It is important to retain a copy of the referral as proof that the service rendered was medically necessary and endorsed by a healthcare provider.

Per AHCCCS guidance, available in their Frequently Asked Question (FAQ) Document here (https://www.azahcccs.gov/PlansProviders/Downloads/CHW/CHW_CHRFAQs.pdf), eligible physicians or licensed practitioners recommending services are limited to **(1)** those affiliated with the below Provider Types (PTs), which have **(2)** the category of service "COS01" (Medicine):

- 638 FQHC (PT C5),
- Behavioral Outpatient Clinics (PT 77),
- Clinics (PT 05),
- Community/Rural Health Centers (RHCs) (PT 29),
- Community Health Worker Organizations (PT CH),
- DO-Physician Osteopaths (PT 31),
- Federally Qualified Health Centers (FQHCs) (PT C2),
- Hospitals (PT 02),
- Integrated Clinics (PT IC),
- MD-Physicians (PT 08),
- Physician's Assistants (PT 18), and
- Registered Nurse Practitioners (PT 19).

The entity billing for CHW services should ensure that a recommendation/referral for services is contained in the member's medical record. AHCCCS does not require the use of a specific referral form, but the referral should indicate that it was made by an eligible physician or licensed practitioner with the category of service "COS01."

For further information on Categories of Service (COS) please see the AHCCCS document here: https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH09/DataSupplement/DocE-1AHCCCS_CategoriesService.pdf

***Note Re: Referrals from Childcare Services**: A common question received has been, "Can we receive referrals for CHR services from Childcare Services / Day Care?"

- Referrals from childcare services are not sufficient for CHR services to be initiated. Recommendations from childcare services would need to be sent to either the CHR organization or one of the above provider types, in order for a physician or licensed practitioner of the healing arts to review and make the referral themselves. The licensed practitioner would need to be acting within their scope of practice, and this will typically require that they see the baby/toddler/child prior to making the recommendation.

*** AHCCCS makes the final decisions as to what referrals are or are not sufficient.**

3. **Information on Member Condition or Documented Barrier**
    - **Why?** Medicaid-covered member education and preventative services by certified CHWs/CHRs can only be reimbursed to members with a (1) chronic condition, or (2) who are at risk of a chronic condition (i.e. pre-diabetes), or (3) have a documented barrier affecting their health. Per the DFSM Provider Billing Manual, Chapter 10, Page 8: "Documentation of at least one of the above conditions or barriers shall be documented in the member's medical record in order for CHW/CHR services to be reimbursable by AHCCCS."
    - It is important for CHW/CHR programs to abide by securing all protected health information (PHI), but to also maintain documentation that the member has one of the three qualifying conditions/barriers. This allows AHCCCS to reimburse for the service.

4. **Visit Notes** detailing what educational and training services were performed during the visit.
    - **Why?** CHR's provide a lot of services, but not all are Medicaid-eligible for reimbursement. Detailed visit notes will provide proof that it met the requirements outlined in AMPM 310 - W.
        - **Approved services include:**
            a. Health system navigation and resource coordination,
            b. Health education and training, including services to train and/or increase the member's awareness of methods and measures that have been proven effective in avoiding illness and/or lessening its effects. The content of the education must be consistent with established or recognized healthcare standards, or
            c. Health promotion and coaching to provide information and training to members that enables them to make positive contributions to their health status.
        - The member's medical record and visit note ***must substantiate*** and document which of these above reimbursable services were done, in order to be reimbursed.

All claims are subject to medical review, and these items may be requested by AHCCCS after the initial claim is submitted.

Please note this is discussing claims, not voluntary certification requirements.

Medicaid: Timely Filing

It is important for providers new to the billing process to know that **time matters.**

According to 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 claim no later than ***6 months*** after the initial date of service.
- A clean claim (that pays without any errors) must be received by AHCCCS no later than ***12 months*** from the initial date of service.
- 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.

Example Scenario:

- If your CHW/CHR program provides a service to a member on 4/1/2023, but the provider billing it does not submit the claim to AHCCCS until 10/1/2023, then the claim will *automatically deny.* Your program will receive no payment. AHCCCS will not be able to make an exception for this, so make sure all claims are submitted in a timely fashion to AHCCCS.
- Once the initial claim is submitted, if AHCCCS finds errors on the claim or if additional information is needed, you will then have the opportunity to submit corrections or the additional documentation requested.

Example:

- Date of Service: 4/1/2023
- Claim submission date: 9/30/2023 (last day for timely filing)
- AHCCCS reviews the claim and denies it due to errors: 10/7/2023
- Notice sent to provider: 10/7/2023
- Provider corrects the claim and/or provides additional documentation requested: 2/12/2024
  - Note: Do not void the original claim and replace it. Doing this would put your CHW/CHR program *past timely filing* as the February 2024 date is well past the 6 month initial claim submission. However, it is within the 12 month window from the initial date of service (DOS).
- AHCCCS reprocesses the claim: 2/15/2024
- AHCCCS approves the claim: 2/15/2024

Manuals for Reference

The AHCCCS FFS and IHS/638 Provider Billing Manuals have additional information on timely filing.

- **Fee-for-Service Provider Billing Manual:** https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html
- **IHS/638 Provider Billing Manual:** https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

Please note that timely filing deadlines are different for IHS/638 providers. For claims filed by IHS/638 providers:

- AHCCCS must receive the claim no later than ***12 months*** after the initial date of service.
- A clean claim (that pays without any errors) must be received by AHCCCS no later than ***12 months*** from the initial date of service.
- Due to the initial and clean claim filing dates being the same for IHS/638 providers it is vital that providers submit sooner rather than later.

Medicaid: Where Do Claims Need to be Submitted?

Where a claim is submitted depends on several factors, such as what health plan the member is enrolled in.

Adult Members Enrolled in an ACC Health Plan

- AHCCCS Complete Care (ACC) Health Plans are privately run Medicaid health plans in Arizona. They are also called Managed Care Organizations (MCOs) or ACC Health Plans.
  - If the individual your CHR program provides services to is enrolled with an MCO/ACC Health Plan, you will need to be registered with that ACC Health Plan.
  - Contact each AHCCCS Complete Care (ACC) Health Plan for specific information on this process. You will need to go through a separate registration process with the ACC Health Plan in question, and then submit claims through their portals and according to their processes. However, billing codes, units, and timely filing guidelines will remain the same.
  - Registration with each ACC Health Plan is at the discretion of the individual health plan, and additional documents and processes may be required to be accepted as an in-network provider.

Contact information for each health plan can be found here:

- https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html

Adult FFS Members Enrolled in AIHP

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 July 2023, 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

1. Claims should typically be submitted through the AHCCCS Online Provider Portal.
   a. The claim will be submitted under the AHCCCS-registered provider who your CHW/CHR Program is billing under.
2. 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.**

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

Medicaid Specific Area: Policy Aspects of Billing

There is more to billing than *just* the codes, units, rates, and submission of the claim. There is also the need to adhere to the policies surrounding the services provided by the CHR.

Licensing: All CHRs *must be* LICENSED

In order to bill, for either Medicare *or* Medicaid reimbursement, the CHR must be voluntarily certified through ADHS.

To bill for reimbursement by Medicaid, services provided by a CHR must have been performed by a CHR who went through and completed the voluntary certification process in Arizona, which is done through ADHS.

- CHR's do NOT register independently with AHCCCS (the State Medicaid agency).
  - ***CHR's are NOT and will NOT be providers who can independently bill.***
- Billing for CHRs is done through either an already existing provider type, or by the Community Health Worker Organization, if they are registered with AHCCCS as Provider Type CH.

Billing Provider Duties

- Providers billing for CHW/CHR services, due to the Arizona Administrative Code, AHCCCS policies, and 42 CFR Parts 405, 410, 411, 414, 415, 418, 422, 423, 424, 425, 455, 489, 491, 495, 498, and 600 [CMS–1784–F] are duty-bound to ensure the following:

- Ensure that the CHW/CHRs they are employing and billing for are maintaining a current certification as specified in A.A.C. R9-16-805.

- **Bill only for services provided by a certified CHW/CHR:**

- As specified in the AHCCCS Medical Policy Manual (AMPM), 310-W, the AHCCCS FFS Provider Billing Manual, and/or the Medical Coding resource webpage *when billing for a member enrolled in Medicaid*, or;

- Bill only for Medicare reimbursable services (Social Determinants of Health Assessment, Community Health Integration Services, or Principal Illness Navigation Services) ***when billing for a member enrolled in Medicare.***

- Maintain accurate and current records of all CHW/CHR certification documentation.

- Provide proof of certification of employed CHWs/CHRs upon request by the Contractor, AHCCCS, or Medicare.

Medicaid-Eligible Services

- There are three (3) CPT codes that are permissible for billing purposes.
  - 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)
- CHW/CHRs often provide a wide-range of services. Not all services are reimbursable via Medicaid. Services that *are reimbursable* are billable with one of the above three (3) CPT codes. These services are limited to:

1. Providing health system navigation and resource coordination; *and/or*

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; *and/or*

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.

When are Member Education and Preventative Services Eligible for Reimbursement for Medicaid?

To receive reimbursement, the member must have one of the below conditions or barriers:

1. A chronic health condition
2. Be at risk for a chronic health condition
3. Have a documented barrier that is affecting their health.

Telehealth and Medicaid

Per updates to the AHCCCS FAQs on CHR services, these may be provided via telehealth "so long as they align with the telehealth requirements outlined in the AHCCCS Medical Policy Manual (AMPM) 320-I."

- AMPM 320-I can be found here: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-I.pdf

Medicaid Specific Area: How to Register to become an AHCCCS Provider

Individual Community Health Workers/Representatives **do not register with AHCCCS.**

- The CHW/CHR must be employed by an AHCCCS-registered provider. This means they could work for one of the provider types listed under "Provider Types Eligible for Reimbursement" *or* they could work for an individually registered CHW Organizations, registered under 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)

CHW/CHR Programs intending to register under "Stage 2" as independent provider types (Provider Type CH) will need to register with AHCCCS.

Provider Name	Provider Type	Provider Classification	Link to Provider Registration Information
Community Health Worker (CHW) Organization	CHW	High Risk	https://www.azahcccs.gov/PlansProviders/Downloads/ProviderRegistration/PT_CH_CHWO.pdf

As **"high-risk"** providers, organizations enrolling as a "CHW Organization" will need to complete the following:

- Submit a complete application through the AHCCS Provider Enrollment Portal (APEP)
  - www.azahcccs.gov/APEP
  - Training on APEP:
- Complete a fingerprint-based criminal background (FBCB) check
- Complete a site visit
- Submit the list of certified CHW/CHRs that will be billing
- Pay an enrollment fee
- Providers should anticipate this process to take 60-90 days from the date of application

****AHCCCS has also published information via YouTube.

- https://www.youtube.com/watch?v=2RMINu59HJE

Steps to Register as an AHCCCS Provider

STEP 1: Prepare documentation in advance:

1. **W9 Tax Form** - Request for Taxpayer Identification Number and Certification – Any provider who will be receiving state/federal funds for services rendered or provided to Medicaid recipients must provide completed W9 tax form as part of the application process.

    a) The W9 form must have been signed within 12 months of the application.

    b) Contact Information:

    - The W9 form can be found on the IRS website.

2. **Current Professional Certifications or Licensures** – Providers must maintain current and ongoing certification or licensure when enrolling and participating in the Medicaid Program with an active status of the provider enrollment AHCCCS ID. CHR programs should ensure they have the CHR licensure of all individuals they are employing. These will need submitted to AHCCCS.

    a) The CHW/CHR Program can employee individuals who do not have active voluntary certifications. ***HOWEVER,*** they cannot bill AHCCCS for services rendered by individuals who are not voluntarily certified as a Certified Community Health Worker through the Arizona Department of Health Services (ADHS).

    b) Therefore, the CHW/CHR Program ***must*** have on file all voluntary certifications for all employees who are providing services to members, if the CHW/CHR Program intends to bill for those services.

3. **Employee Details** – As you go through the screens in APEP, there will be an excel spreadsheet for download. You should have the appropriate information for the certified CHW staff ready to enter in. Once you have done so you can re-upload it.

4. **Tribal Business License –** Any provider intending to operate within boundaries of Tribal lands must have an active, valid Tribal Business License.

5. **Signed and Dated Community Health Worker Organization Profile Form**

    a) The form to sign is located here: https://www.azahcccs.gov/PlansProviders/Downloads/ProviderRegistration/PT_CH_CHWO.pdf

    b) On Page 2, fill out the fields at the bottom of the form.

    c) **Signature, Printed Name, and Date Fields:** The authorized representative from your organization (usually the owner) will sign and date here.

    d) **Provider Name Field:** The name of your organization

e) **Provider ID Field:** This field can be left blank at this time. That is the ***future AHCCCS ID Number***, that is not yet assigned.

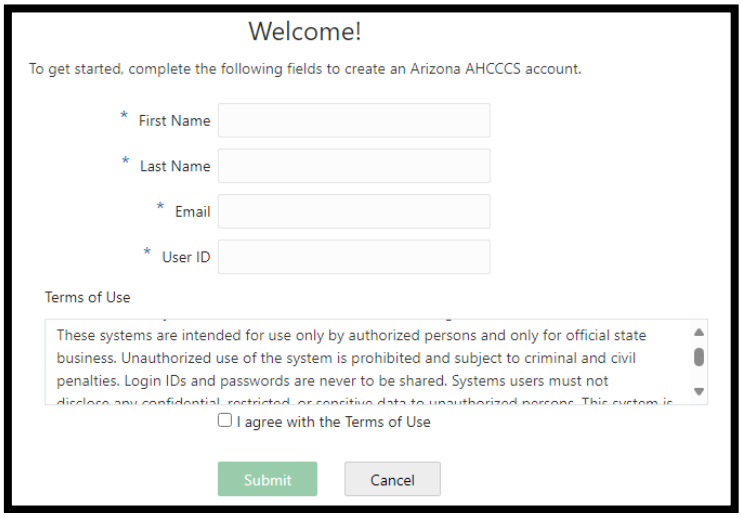
f) Upload document into APEP

Signature		Printed Name	
Date			
Provider Name		Provider ID Number	

6. **Provider Basic Information**
   a) This includes the following information:
      - Entity Name (CHW Organization Name)
      - Practice Location (Address)
      - Tax ID (See #2 above)
      - Billing Associations (if you have contracted with a third party to do your organization's billing on your behalf)
      - Ownership disclosures - This includes disclosure of ownership and control interests as well as disclosing any adverse actions the disclosed individuals may have (such as felonies, state exclusions, terminations and other actions). The ownership disclosures must match publicly available records such as the Arizona Corporation Commission.

STEP 2: Register with the AHCCCS Provider Enrollment Portal (APEP)

1. To register with APEP, go to this link: https://evobrix.az-apep.gov/UserRegistration



2. Once registered, and once you have all your needed documents gathered up, you can begin the registration process.
3. If you require technical assistance or have questions, you can contact AHCCCS Provider Enrollment at:
    - 1-800-794-6862 (In State - Outside of Maricopa County)
    - 1-800-523-0231 (Out of State)
    - APEPTrainingQuestions@azahcccs.gov

Trainings and Technical Support – Resources to Help Navigate APEP

- Videos:
    - https://www.azahcccs.gov/PlansProviders/APEP/APEPTraining/Videos.html
- Instructional Tutorials:
    - https://www.azahcccs.gov/PlansProviders/APEP/APEPTraining/Tutorials.html
- If you have additional questions about APEP that are not addressed in those materials, please contact the APEP team at: APEPTrainingQuestions@azahcccs.gov

National Provider Identifiers – Looking Forward: What is it and Will We Need One?

Currently AHCCCS ***is not requiring a NPI*** for the CH Provider Type. However, they will be requiring this in the future. Date is TBD.

You can get a head start on this process by applying for a **National Provider Identifier (NPI)**. The federal government typically requires providers who administer "medical and other health services" to obtain an NPI number. An NPI is a unique 10-digit identification number for covered health care providers.

a) Contact Information:

- National Plan and Provider Enumeration System (NPPES) webpage at https://nppes.cms.hhs.gov
- NPI Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

Medicaid Specific Area: AHCCCS Resources to Familiarize Yourself With

- Knowing how and when to file claims is key to getting paid successfully. AHCCCS offers a variety or resources to help providers with this, including billing manuals and trainings.
- Please note, this applies **only to members enrolled with the American Indian Health Program (AIHP) or other Fee-for-Service (FFS) programs.**
- To bill for Medicaid members enrolled with an AHCCCS Complete Care (ACC) Health Plan, please contact the individual ACC Health Plan (Managed Care Organization or MCO) for information on how to submit claims to them. Each health plan will have its own claim submission portal or process.
- However, the basic information presented in this guide regarding billing codes and units, timely filing guidelines, and record keeping will still apply.

For Fee-for-Service (FFS) Members

Billing Manuals:

- AHCCCS offers two billing manuals for providers to consult with billing questions. The CHR
- Fee-for-Service Provider Billing Manual: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html
- IHS/638 Provider Billing Manual: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

DFSM Provider Training Team:

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html
- Scroll to the middle of the page, and both video YouTube and PowerPoint training presentations can be found via a drop-down list, and you can search by topic of interest.
- For questions that you still have, after reviewing the billing manuals and watching the appropriate trainings, the DFSM Provider Training team can be reached at: ProviderTrainingFFS@azahcccs.gov

Fee-for-Service Health Plans Web Page:

- https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans

Medicaid Specific Area: AHCCCS Trainings to Review for Claims Submission

Video Trainings

- AHCCCS Fee for Service (FFS) Health Plans Overview Billing Resources for New Providers
- AHCCCS Website Overview AHCCCS Website Overview - Part 2
- AHCCCS Providers & Useful Materials on the AHCCCS Website Prior Authorization Requirements for Fee-for-Service Members
- Documentation Requirements for Claim Submission and Concurrent Review How to Read the Remittance Advice
- How to Register for an Account on the AHCCCS Online Provider Portal What is the Master Account Holder?
- How to Verify a Member's Enrollment Using the AHCCCS Online Provider Portal How to Submit a Prior Authorization Request
- Institutional Claims (UB-04) - Submitting Institutional Claims on the AHCCCS Online Provider Portal Submitting Professional Claims (CMS 1500)
- Submitting Dental Claims (ADA 2012) How to Check a Claim Status
- How to Submit a Replacement, Correction, or to Void a Claim Using the AHCCCS Online Provider Portal
- How to Register for an Account on the Transaction Insight Portal Transaction Insight Portal Training
- PDF PowerPoint Trainings

Claim Form Types:

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2021/ClaimFormTypes2021.pdf

Paper Claim Tips:

https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2021/PaperClaimsTips.pdf

Master Account Holder Training

When using the AHCCCS Online Provider Portal you need a main account to designate as the Master Account Holder, and they approve/deny/change settings on other user accounts): https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2022/AHCCCSOnlineProviderPortalMaster AccountHolder.pdf

- Submitting a Claim using the AHCCCS Online Provider Portal: https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2020/FALL2020_ClaimSubmission.pdf
- Claim Submission for Professional Claim Forms (CMS 1500): https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2021/ProfessionalCMS1500ClaimSubmissio n.pdf
- Claim Submission for Institutional Claim Forms (UB-04): https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2021/InstitutionalUB-04ClaimSubmissionJune2021.pdf
- Status a Claim using the AHCCCS Online Provider Portal (if you have a claim that was previously submitted, and you would like to see if it has been approved, denied, or pended for further review, this is how you do that): https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2020/FALL2020_HowToStatusAClaimUsingAOPP.pdf

II. Medicare: CHR Billing 101

Medicare Reimbursement "Roll Out"?

- As of 1/1/2024, Community Health Integration (CHI) services and Principal Illness Navigation (PIN) services performed by a CHW/CHR are billable to Medicare.

Medicare-Eligible Codes

There are multiple codes that are permissible for billing purposes. Please note, that Medicare services are billed to Medicare, and not to Medicaid.

- G0136 – Social Determinant of Health (SDOH) Assessment, occurring with an evaluation and management services (or wellness visit) performed a maximum of once every 6 months.
- G0019 – Services performed by certified or trained auxiliary personnel, including a CHW, under the direction of a physician or other practitioner; for first 60 minutes per calendar month. The national payment amount is approximately $79 (non-facility) or $49 (facility). (60 minute increments)
- G0022 – CHI services, for each additional 30 minutes per calendar month. The national payment amount is approximately $49 (non-facility) or $34 (facility). (30 minute increments)
- G0511- For use by FQHCs and RHCs - This general care management code is used by federally qualified health centers and rural health centers to bill for each CHI service and PIN service. The national payment amount is approximately $77. Please note that G0511 can be used for other things as well, like remote patient monitoring services, so you may be familiar with this code for other reasons.
- G0023 – Services performed by certified or trained auxiliary personnel, including a CHW, under the direction of a physician or other practitioner; for first 60 minutes per calendar month.). (60 minute increments)
- G0024 – PIN Services, for each additional 30 minutes per calendar month. (30 minute increments)
- G0140 - Used for PIN-Peer Support for Behavioral Health Conditions (first 60 minute increments)
- G0146 - Used for PIN-Peer Support for Behavioral Health Conditions (additional 30 minute increments)

CHW/CHRs often provide a wide-range of services. Not all services are reimbursable via Medicare. Services that are reimbursable are billable with one of the above codes.

Medicare: Rates

Rates for 2024

The below rates are from the 2024 Medicare Physician Fee Schedule and are meant to provide *general and non-specific guidance.*

- Rates can vary based off MAC Locality (Medicare Locality) and the below subset is simply an example. Rates can be slightly lower or higher.

Code	General Rates (Can Vary Based by Medicare Locality – MAC Locality)	Unit Increment (Time)
G0136	$24.62 (non-facility) or $10.45 (facility)	Varies but once every 6 months
G0019	$84.18 (non-facility) or $50.34 (facility	Per 60 minutes
G0022	$52.21 (non-facility) or $35.11 (facility	Per additional 30 minutes
G0511	$77	
G0023	$84.18 (non-facility) or $50.34 (facility	Per 60 minutes
G0024	$52.21 (non-facility) or $35.11 (facility	Per additional 30 minutes
G0140	$84.18 (non-facility) or $50.34 (facility	Per 60 minutes
G0146	$52.21 (non-facility) or $35.11 (facility	Per additional 30 minutes

Medicare: Where Do Claims Need to be Submitted?

Submit claims to Medicare, as normal. No change is needed in how claims are submitted.

Medicare: Providers

What Providers Can Initiate CHR Services (Performing the SDOH) Assessment?

Medicare billing providers, such as an MD, DO, NP, CNS, CNM, or PA can perform the initiating visit where the SDOH assessment is performed, and then order CHI or PIN services. To order the services, the billing practitioner must have identified an SDOH need that presented a barrier to diagnosis or treatment of the member's health conditions.

Caveats:

- The billing provider must provide ongoing general supervision to the CHRs providing CHI or PIN services. These services are considered "incident to" the professional services of the billing practitioner.
- Services may be initiated by an Evaluation and Management (E/M) visit, an Annual Wellness Visit, or a Transitional Care Management E/M visit. These services cannot be initiated by an inpatient admission or skilled nursing admission.
- Only one billing practitioner may bill for CHI services in a given month
- Clinical psychologists are not permitted to serve as the initiating provider at this time. [1]

Who Can Bill Medicare?

Medicare-billing providers and practices *only.*

The setup is very similar to how the 'phase 1' of the Medicaid billing rollout worked.

- While CH Provider Types, registered with the State Medicaid agency cannot bill Medicare directly for CHI services, they *can* enter into contracts with Medicare-billing practitioners.
- This means that CH Provider Types, who have registered with the State Medicaid agency, *and* who have entered into a contract with a Medicare-billing provider, have opened a pathway for billing *both* Medicaid and Medicaid for services provided by their CHW/CHWs.

[1] https://www.impactcarehq.com/wp-content/uploads/2024/08/CHI-PFS-Final-Rule-Summary.docx-6.pdf

Medicare: Documentation and Record Requirements (for Successful Claim Submission)

We generally recommend that records be retained for 10 years as a general practice, to reduce errors. When you have one standard for records retentions it is easier to maintain standards across the board.

- **6 Years -** HIPAA rules require a Medicare Fee-For-Service provider to retain required documentation for six years from the date of its creation or the date when it last was in effect, whichever is later.
- **5 Years** - CMS requires that providers submitting cost reports retain all patient records for at least five years after the closure of the cost report.
- **10 Years** – CMS requires Medicare Managed Care program providers retain patient records for 10 years.

Medicare Specific Area: Policy Aspects of Billing

Licensing: All CHRs *must be* LICENSED

In order to bill, for either Medicare *or* Medicaid reimbursement, the CHR must be voluntarily certified through ADHS.

Medicare

The Medicare rule states that all CHWs/CHRs who provide CHI services need to be "certified or trained to perform all included service elements, and authorized to perform them under applicable State laws and regulations." While, the final rule does not require a certain number of training hours, it instead ***defers to relevant state rules on CHW training and certification***.

- This means that, for Arizona, the CHW/CHR should be voluntarily certified through ADHS, if providers wish to bill for Medicare services.

Billing Provider Duties

Providers billing for CHW/CHR services, due to the Arizona Administrative Code, AHCCCS policies, and 42 CFR Parts 405, 410, 411, 414, 415, 418, 422, 423, 424, 425, 455, 489, 491, 495, 498, and 600 [CMS–1784–F] are duty-bound to ensure the following:

- Ensure that the CHW/CHRs they are employing and billing for are maintaining a current certification as specified in A.A.C. R9-16-805.
- Bill only for services provided by a certified CHW/CHR:
- As specified in the AHCCCS Medical Policy Manual (AMPM), 310-W, the AHCCCS FFS Provider Billing Manual, and/or the Medical Coding resource webpage *when billing for a member enrolled in Medicaid*, or;

- Bill only for Medicare reimbursable services (Social Determinants of Health Assessment, Community Health Integration Services, or Principal Illness Navigation Services) ***when billing for a member enrolled in Medicare.***
- Maintain accurate and current records of all CHW/CHR certification documentation.
- Provide proof of certification of employed CHWs/CHRs upon request by the Contractor, AHCCCS, or Medicare.

Medicare Code Clarifications:

Medicare: Social Determinants of Health (SDOH) Assessment

The assessment component allows a provider to assess any Social Determinants of Health (SDOH) or risk factors that may influence diagnosis or treatment of medical conditions that the patient has.

- Typically done at an evaluation & management visit, or a wellness visit
- Can be repeated every 6 months
- Takes approximately 5-20 minutes of the provider's time
- Requires use of an approved SDOH Screening Tool.

This MUST be done prior to initiation of services.

Medicare: Social Determinant of Health Screening Tools

A SDOH Assessment must be done, prior to CHI or PIN services initiating. Example screening tools for performing this assessment include:

1. The National Association of Community Health Centers' Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE) – This includes 15 core questions and 5 supplemental questions.
    - http://www.nachc.org/research-and-data/prapare/toolkit/

2. The Centers for Medicare & Medicaid Services Accountable Health Communities' 10-question Health-Related Social Needs Screening Tool (AHC-HRSN) - This is a self-administered tool.
    - https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf

3. The American Academy of Family Physicians has both a short- and long-form in both English and Spanish, as part of The EveryONE Project.
    - The short-form includes 11 questions. It can be self-administered or administered by clinical or nonclinical staff.
    - https://bit.ly/2GTkKUu

Medicare: Community Health Integration (CHI) Services

CHI Services address ***unmet social determinant of health (SDOH) needs*** that are significantly limiting the ability to diagnosis and treat the patient's medical problems.
Prior to billing for these services, there must have been an initial visit (like an evaluation and management visit or an annual wellness visit) between the patient and the provider, where the provider:

(1) Conducted an assessment for SDOH needs using an evidence-based assessment tool; and

(2) Proceeded to document the SDOH(s) that was/were interfering with the person's ability to treat medical problems they may have; and

(3) Established a treatment plan.

- Services provided ***must be:*** Directly related to the SDOH that has been documented in an initial visit, and the SDOH must pose a valid concern for the ability of the patient to maintain their treatment plan

Services can include things like:

- Conducting a person-centered assessment, facilitating goal setting, and providing tailored support to patients according to the provider's treatment plan.
- Coordinating patient services from a range of provider types (e.g., healthcare, home- and community-based services, social services), facilitating access to social services, and communicating with providers about patient goals, needs, and preferences.
- Coordinating care transitions, including follow-up after emergency department visits or discharges from hospitals or skilled nursing facilities.
- Supporting patients to participate in medical decision-making and use provider health education to help identify individual patient goals and preferences.
- Building patient self-advocacy skills to help them self-promote for better treatment
- Helping the patient access the healthcare system and navigate it, including identifying providers and making appointments.
- Assisting with social and emotional supports
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
- Drawing on lived experience to support patients to meet treatment goals.

Medicare: Principal Illness Navigation (PIN) Services

Prior to billing for these services, there must have been an evaluation & management visit; annual wellness visit; psychiatric diagnostic visit; or other Health Behavior and Intervention Services visit. At this visit they must have:

(1) Conducted an assessment for SDOH needs using an evidence-based assessment tool, and

(2) Established medical necessity for PIN services, and

(3) Established a treatment plan.

Principal Illness Navigation (PIN) Services assist Medicare enrollees with high-risk conditions, and they allow CHWs/CHRs to identify and connect patients with clinical and support services.

PIN services are for patients who have a disease that:

(1) Is considered a serious, high-risk diseases expected to last 3 months or more; *and*

(2) Requires a disease-specific care plan, that may require frequent adjustment in medication or treatment regimen or substantial assistance from a caregiver; *and*

(3) Places the individual at a significant risk of hospitalization, nursing home placement, or acute exacerbation/decompensation, functional decline, or death

Examples of conditions with significant risk of hospitalization, nursing home placement, or acute exacerbation/decompensation, functional decline, or death, include things like:

- Chronic Obstructive Pulmonary Disease (COPD)
- Cancer
- Congestive Heart Failure
- Dementia
- HIV/AIDS
- Severe Mental Illness
- Substance Use Disorders
- Uncontrolled Diabetes Type 1 or 2

Services can include things like:

- Person-centered assessment Identifying or referring patient (and caregiver or family) to appropriate supportive services
- Practitioner, home, and community-based care coordination
- Health education
- Building patient self-advocacy skills

- Health care access / health system navigation
- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
- Facilitating and providing social and emotional support
- Leveraging knowledge of the condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goal

Are any Medicaid or Medicare Members NOT Eligible to Receive CHR Services?

For Medicaid:

ALTCS Members are not eligible for these services.

- Members enrolled in ALTCS/Tribal ALTCS, or empaneled with an American Indian Medical Home (AIMH), already receive case management services that are reimbursed through an alternate mechanism; therefore, health system navigation and resource coordination services by a CHW/CHR are not billable/reimbursable.

AIHP Members enrolled with an American Indian Medical Home (AIMH) are not eligible for services related to diabetic education.

- Some AIMHs do diabetic education services. If the member is a part of an AIMH, check to see if they do diabetic education services. If the AIMH does, CHW/CHR services related to diabetes education are not billable/reimbursable.

For Medicare:

Home Health Services – Medicare patients who are already receiving home health services may not be eligible for CHI services.

III. Medicaid: Appendices

The following Appendices list out example claims and templates for use by CHW/CHR Organizations and Referring Providers.

Appendix A: Example Claim Forms

It is important to know that claims should be submitted electronically whenever possible. However, if a paper copy is submitted, we have offered some examples here.

For additional technical support and guidance, CHR Programs are welcome to outreach the AACIHC at iac-notifications@azahcccs.gov and we will do our best to connect you with additional resources.

AHCCCS also has an excellent Provider Training Team housed within DFSM.

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

Appendix B: Referral Template - Example

Documentation is important, and this includes having accurate and adequate information on the referral. Referrals are required for CHR services. Below is an example CHR referral form, based off existing forms used by some IHS facilities, that includes all necessary information to fulfill audit requirements.

Appendix C: Visit Note Template - Example

Documentation is important, and this includes having accurate and adequate information documented within the member's medical record, and on the visit note. A visit note must accurately describe what service was provided, so that it can be easily noted that the service met AHCCCS policy surrounding reimbursable services.

Appendix D: Referral and Service Plan Template - Example

Appendix D kindly provided by the CHW Coalition of South Dakota. Additional information can be found on the following pages, and on their website at: https://chwsd.org/sd-medicaid-implementation/

- To use this template CHW/CHR can take this "blank" referral/service plan to a provider, ask them to complete it, and once signed, the CHW/CHR organization can then begin billing for services for an eligible recipient. By indicating the qualifying condition(s) and/or barrier(s), the referring provider addresses the requirement for services to be medically necessary.
- This works well for Medicaid claims. However, please note, the SDOH assessment must still be done for Medicare members anticipated to receive CHI or PIN services.

Acknowledgements

Special thanks to Louisa O'Meara, Samantha Sabo, and Northern Arizona University for their expertise and work on the templates provided in Appendix B and C.

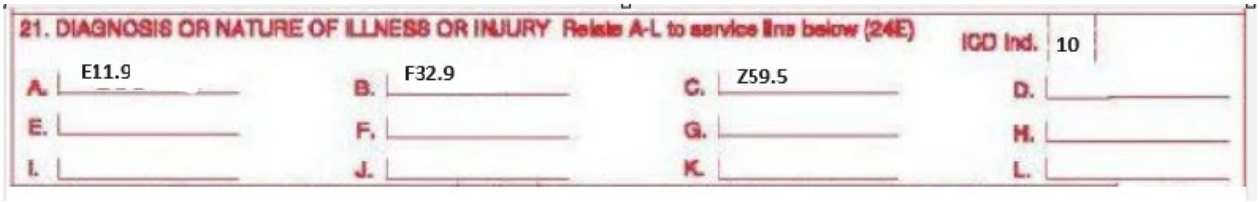
Special thanks to the CHW Coalition of South Dakota for allowing their template to be utilized as an example in other programs, which can be seen in Appendix D.

Appendix A: Example Claim Forms

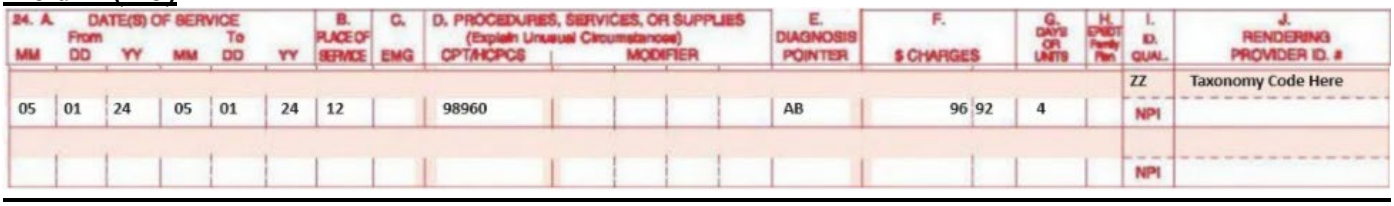
Typically claims are submitted electronically. However, if submitting via paper, then the CMS 1500 Claim Form should be used. Two fields (Fields 21 and 24) are important to make note of when submitting claims.

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.



Field 24(1-J)



- **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 96980, 96981 or 96982 codes. There are no modifiers available at this time.
- **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.

- **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.
- **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

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	

Appendix B: Referral for CHW Services - Please Fill out all Sections

PATIENT INFORMATION			
Patient Name (First, Last, Suffix)		**Medicaid ID?**	☐Yes ☐No **ID Number**
Date of Birth (mm/dd/yyyy)		**Gender**	☐Male ☐Female ☐Other
Patient Chart Number or HRN		**Tribe**	
Patient Mailing Address (Address, city, state, zip code)		**Community of Residence**	
Patient Physical Address (Address, city, state, zip code)			
Telephone Number (Ten Digit)		**Message Number** (Text)	

REQUESTED SERVICE		
☐ Health System Navigation and Resource Coordination ☐ Health Education/training ☐ Health Promotion/Coaching	☐ Home Safety Assessment ☐ HRSN Assessment ☐ Home Visit/Follow Up ☐ Welfare Check ☐ ADL	☐ Transportation ☐ Car Seat ☐ DME ☐ Other (explain)

REASON FOR REFERRAL (specify)

SIGNIFICANT MEDICAL/DENTAL/OTHER FACTORS TO CONSIDER	
Health Condition(s)	
ICD 10 Code(s) (if known)	
Barriers to managing health condition	
Health Related Social Needs (HRSN) Screening completed	☐YES ☐NO *If yes, document in patient record.
Identified HRSN	

INSURANCE INFORMATION						
Insurance/Payer Source	**Available**	**Name of Policy Holder**	**Policy Number**	**Group Number**	**Insurance Effective Date**	**Insurance End Date**
MEDICAID _____	☐YES ☐NO					
MEDICARE _____	☐YES ☐NO					
OTHER _____	☐YES ☐NO					
NO INSURANCE	☐YES ☐NO					

REFERRING PROVIDER INFORMATION	
Health Organization Employing Provider (Clinic, Hospital, Practice, etc.)	
Name and Title	
NPI Number	
Address	
Contact Number	
Signature	
Date	

CARE COORDINATION			
Patient Plan of Care Available?	☐YES ☐NO	**Recommended Visit Frequency**	
Patient's Primary Care Provider (PCP)		**Has Patient Granted Permission to Notify PCP of Patient Care Updates?** *If yes, send signed documentation	☐YES ☐NO
PCP Phone			
Other Care Coordination Notes			

****

FOR CHR OFFICE USE ONLY			
Date Received		**Staff Assigned**	
Follow Up Date		**Date Complete**	
Results Include outcome of referral, any patient concerns, follow-up/actions needed, and who on care team received outcome update			
Documented in Referral Tracking Form	☐ YES ☐ NO		
Supervisor signature and date			

_____

NOTES

Service Requested types

Listed service categories were developed in accordance with Arizona Medicaid billing policy. The following services are considered billable in the state of Arizona, as described below.

1. Health system navigation and resource coordination
2. Health education and training, including services to train and/or increase the patient's awareness of methods and measures that have been proven to be effective in avoiding illness and/or lessening the effects of an illness [including chronic disease]. The content of the education shall be consistent with established healthcare standards.
3. Health promotion and/or coaching to provide information and training to patients that enables them to make positive contributions to their health status. [Addresses not just health but also patient *environment.*]

Health Related Social Needs (HRSN)

According to the Centers for Medicare and Medicaid, "HRSNs are individual-level, adverse social conditions that can negatively impact a person's health or health care. Examples include food insecurity, housing instability, and lack of access to transportation. Identifying and addressing HRSNs can have many benefits, including improvements to individuals' health and reduced health care spending." In some states, CHR services to address HRSNs are reimbursable through Medicaid; consult with your state Medicaid office for more information.

Examples of HRSNs:

- Housing instability
- Safety needs
- Food insecurity
- Lack of education
- Utility needs
- Lack of access to transportation
- Financial strain
- Unemployment
- Lack of access to affordable health care or medicine
- Social isolation
- Stress

Appendix C: Visit Note Example

CHR Provider Code		Program Code	

PATIENT INFORMATION					
Date of Service		**Start Time of Visit**		**End Time of Visit**	
Patient Name			**Patient Chart # or HRN**		
Date of Birth (mm/dd/yyyy)			**Tribe**		
Patient Mailing Address			**Community of Residence**		
Physical Address or Location of Visit					
Visit Type	☐ In-Person ☐ By Telephone	**Number of people that education was provided to**		☐ 1 (Patient only) ☐ 2-4 Patients (Group) ☐ 5-8 Patients (Group)	
Telephone Number (Ten Digit)		**Message Number** (Text)			

Reason for CHR Visit
(Include information from care team referral)

SIGNIFICANT MEDICAL/DENTAL/OTHER FACTORS TO CONSIDER	
Previously reported health condition(s) *Include Health Problem Codes if applicable*	
Any changes to member health since last visit?	
Barriers to managing health conditions (new and old)	
Health Related Social Needs (HRSN) as noted by the CHR at time of visit (new and old)	
PATIENT REQUESTS & GOALS	

Did the patient request any assistance in health system navigation or any resources to help better manage their health? Did they ask for any referrals?		
Patient Request	**Information / Referral Provided**	**Date CHR will Follow-Up with Patient**

Describe any Direct Services provided by the CHR to the patient, to assist with health system navigation, during visit (i.e. assistance with applications, letters, etc.)	

Patient Health Goals (include target dates)			
Short-Term Goals (describe goal set by patient)		**Long-Term Goals (describe goal set by patient)**	
	☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try		☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try
	☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try		☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try
	☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try		☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try
	☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try		☐ Successful ☐ Partial Success ☐ Barriers Faced ☐ Did Not Try

Patient Described Confidence to Achieve their Health Goals	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (0 = no confidence in achieving goals; 10 = high confidence in achieving goals) **Reasons for Confidence Score (as described by patient):** **Stated barriers to accomplishing goals?**

VISIT NOTES

Objective Observations by CHR	
Visit Description (Brief summary)	
Describe any health education training, health promotion or coaching provided during visit	
Patient Plan – i.e. steps patient will take between this visit and the next to move towards accomplishing patient-set goals.	

Vital Signs / Measurements

BP	P	R	BG	T	HT (in)	WT (lb)	BMI	WC (in)	A1C

HC	VU – L R	VC – L R	LMP FPM

Abnormal values detected?	☐YES ☐NO	**If yes, describe action taken**

Provider Referral

Referral made	☐YES ☐NO	**Provider contact information**		**Date**	

Reason for Referral	

CHR Signature		**Date**	

Appendix D: Example Referral and Service Plan

Appendix D kindly provided by the CHW Coalition of South Dakota. Additional information can be found on their website at: https://chwsd.org/sd-medicaid-implementation/

<CHW Program Here and logo> **CHW Referral and Service Plan**		**<Program Address>** **<Program Phone Number>** *Please direct any questions or concerns to <name>*	
Date Order Written: _____			
Patient Information:			
Patient Name:		Date of Birth:	
Gender:	Male Female Other	Phone:	
Address:			
Referring Provider Information:			
Provider:		Provider NPI:	
Additional Providers:			
Provider Orders for CHW Services:			
Qualifying Condition(s): *(Please check all that apply, if applicable)*			
___ Asthma ___ Cancer ___ COPD ___ Depression ___ Diabetes ___ Heart Disease ___ Hypercholesterolemia ___ Hypertension ___ Mental Health Conditions		___ Musculoskeletal and neck/back disorders ___ Obesity ___ Prediabetes ___ High Risk Pregnancy ___ Substance Use Disorder ___ Tobacco use ___ Use of multiple medications (6 or more) ___ Other: _____.	
Qualifying Barrier(s): *(Please check all that apply, if applicable)*			
___ Geographic Distance from health services ___ Lack of phone *(Seeking care at incorrect location)*		___ Cultural/language communication barriers ___ Social Determinant of Health (SDoH) barriers	
___ Other: _____.			
CHW Objectives:			
_X_ Assess and assist with social determinants of health needs as related to qualifying condition(s) and/or qualifying barrier(s). _X_ Provide health system navigation and resource coordination as related to qualifying condition(s) and/or qualifying barrier(s). ___ Provide health promotion and coach regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs. ___ Provide health education regarding qualifying condition(s) and/or qualifying barrier(s) and subsequent social determinants of health needs. ***If the referral and service plan is not ordered by a recipient's PCP, Health Home Provider, or a dentist, the following written objective must be included:*** ___ Establish or re-establish primary care for an annual wellness visit (at a minimum). Other: _____ _____			
CHW Services:			
_X_ Health system navigation and resource coordination _X_ Health promotion and coaching _X_ Health education to teach or promote methods and measures that have been proven effective in avoiding illness and/or lessening its effects.			
Frequency and Duration of Services:			
Work with patient up to _4_ units per day (a unit is defined as 30 minutes) with a maximum of _20_ units per week. Assess			

CHW services after six months, or prior if patient is ready to be discharged from CHW services.
Care plan must be reviewed, at minimum, every six months.

Provider Signature **Date**

Once completed, please fax to:
<PHONE> Attn: CHW Program