



Arizona Department of Health Services

Office of Program Support

Children's Rehabilitative Services

Operations and Procedures Manual

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Introduction

The Office of Program Support (OPS) is within the Arizona Department of Health Services and provides oversight, coordination and monitoring to the Children's Rehabilitative Services Contractors (CRS). This document is a reference guide describing the procedural requirements between the CRS Sites, the Arizona Department of Health Services, Office of Program Support, and the Arizona Health Care Cost Containment System (AHCCCS). The Operations and Procedures Manual is available on the ADHS website and is to be used as the first point of reference when procedural questions arise.

Individuals with questions should contact their assigned Representative between the hours of 8:00 A.M. to 5:00 P.M. Monday through Friday.

Definitions

Aged Pended Encounter	An encounter that has pended for more than 120 calendar days, after the initial processing date at AHCCCS, without resolution.
AHCCCS	Arizona Health Care Cost Containment System
AHCCCSA	Arizona Health Care Cost Containment System Administration
AHCCCSA Error	A pended encounter which AHCCCS acknowledges to be the result of its own and has been communicated to the CRS Site by way of an edit alert, email, phone conversation, typed letter, Workgroup communication or other forum.
Check Register	A detailed log of all checks written and paid to providers for services rendered by a CRS Site. The check register should include, but is not limited to, check number, date the check was written, check amount, and provider name and ID.
Children's Rehabilitative System (CRS)	The data system used by ADHS/CRS.
Contract Year	A period from July 1 of a calendar year through and including June 30 of the following year.
CRN	Claim Reference Number, used to track and review encounters in the PMMIS system at AHCCCS.
Days	A calendar day unless otherwise specified
CRS Error	A pended encounter which ADHS/CRS acknowledges to be the result of its own error and has been communicated to the CRS Site by way of an edit alert, email, phone conversation, typed letter, Workgroup communication or other forum.

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Definitions

Deleted Encounter	A pending encounter that has been deleted from the PMMIS system at AHCCCS by request from a CRS Site because the encounter was sent to ADHS in error or should not have been sent to AHCCCS by ADHS.
Encounter	A record of a covered service rendered by a provider to a person enrolled with a capitated CRS Site on the date of service
Enrollment	The process by which a person is enrolled into the Contractor and DHS data system
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable Federal or State Law.
GSA	Geographic Service Area
ICN	Internal control number used in the CIS system
Override (of Encounter)	A process performed by a CRS Site to bypass a pending status on an AHCCCS encounter which will allow the encounter to adjudicate cleanly.
Pending Encounter	An encounter that was sent to AHCCCS from ADHS that did not cleanly adjudicate but resulted in an error, known as a "pending".
Provider	Provider refers to all providers under contract with a CRS Site or a CRS network that deliver services to CRS clients (any provider that the CRS Site will receive a claim/encounter from)
Quarter	Three months of the state fiscal year as broken into four quarters. July 1 through September 30 is referred to as the first quarter of the state fiscal year
Voided Encounter	An encounter previously accepted at ADHS or AHCCCS, but was voided by request from a CRS Site because the encounter was sent to ADHS in error or should not have been sent to AHCCCS by ADHS.

Related Information Resources

The CRS Site should use the following resources in addition to this manual:

- ADHS/OPS Tidbits Newsletter
- The ADHS/CRS Contract with each Site

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- AHCCCS Encounter Resources, including
 - Encounter Reporting Manual
 - Medical Policy Manual
 - Encounter Keys and Claims Clues Newsletters
 - Technical Interface Guidelines (TIG)
- Coding Documentation
 - UB-92 Manual/UB-04 Manual
 - ICD-9-CM Diagnosis & Procedure Code Manual
 - Physician's Current Procedural Terminology (CPT) Manual
 - HCFA Common Procedures Coding System (HCPCS) Manual
 - First Data Bank Blue Book
 - HIPAA Guidelines via www.cms.hhs.gov/HIPAAGenInfo

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Submission Schedules

Introduction:

The Office of Program Support (OPS) requires all CRS Sites to establish and adhere to a Submission Schedule when submitting encounters to ADHS/CRS for each of the form types (HCFA, UB, Dental or Drug). In addition encounter submissions will be monitored for volume consistency. The Submission Schedule and encounter volume are monitored and scored as part of each CRS Site's yearly Administrative Review.

Monitoring:

OPS Representatives will monitor their respective CRS Site's encounter submissions using the "Daily enc submission rpt" (attachment 1) and will include the results in the CRS Site Workgroup agenda for discussion. OPS Representatives are to follow the procedures listed in the Encounter Acceptance Rates Policy to produce the report.

Administrative Review Scoring:

Submission Schedules are monitored as part of the CRS Site's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

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Encounter Acceptance Rate

Introduction:

CRS Sites are required to maintain an encounter acceptance rate of 90% or greater. Acceptance rates are significant as they may be the first indication of possible systemic problems. The OPS monitors encounter acceptance rates daily. In addition, encounter acceptance rates are scored as part of each CRS Site's yearly Administrative Review.

Importing Daily Encounter Acceptance Reports:

CRS Sites place daily encounter files on the FTP server to be processed. The files are processed through the new day batch process on a daily basis by the ADHS/CRS IT department. Encounter acceptance rates are calculated by the IT Department based on the number of rejected encounters versus the number of accepted encounters. IT then places a text file containing all of the encounter acceptance data into the M:\Common\Program Support directory and in turn notifies OPS by email when completed. A designated OPS Representative imports the text file into the departments' established MS Access database. The OPS Representative then notifies the other OPS Representatives via email that the Daily Encounter Reports for a specific date have been imported to the MS Access database.

Reviewing Daily Encounter Acceptance Reports:

The OPS Representatives are required to review the CRS Site's acceptance rates on a daily basis using the Daily Detail Encounter Acceptance Report (Attachment 1). The following are the steps to be performed:

1. Open the "Daily enc submission rpt" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the Daily enc submission rpt_db.mdb file.
2. Select "Reports" from the Daily Encounters Main Switchboard screen.
3. When the Criteria Selection Form appears, click on the "Report: " drop-down dialogue box and select "Daily Detail Encounter Acceptance Report".
4. Enter a Start Date: in the format MM/DD/YYYY.
5. Enter an End Date: in the format MM/DD/YYYY.
6. Use the "CRS" drop down dialogue box to select the CRS number of which the report should reflect.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear and is broken down by form type.
9. Print the report by clicking on the "File" menu and selecting "Print". Store the printout in a three ring binder specific to the CRS Site.

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Analyzing Data:

OPS Representatives will examine their Site's encounter submissions to ensure a minimum 90% acceptance rate is achieved for each encounter form type. For any encounter form type that does not meet the 90% acceptance rate threshold, an explanation of the cause(s) is/are mandatory from the Site.

CRS Site Documentation:

CRS Sites are required to provide ADHS an explanation within 2 business days, when acceptance rates fall below the 90% minimum. OPS representatives will maintain this documentation by adding the explanations to the Daily Encounter Acceptance Report database. ADHS/OPS will consider systemic problems when analyzing the encounter acceptance rates.

Results:

If 90% minimum acceptance rates are not maintained for any one form type during the period of a quarter, a letter is sent to the RBHAs CFO before the end of the quarter notifying them that they could be placed in the testing environment (See Test Criteria Section of this manual). If the RBHA continues to average below 90% acceptance rates through the remainder of the quarter, the RBHA will be placed in the test environment at the end of the quarter. See Submission Test Criteria Section.

Conditions for placing a CRS Site into the testing environment:

- A new contract has been awarded to a Regional Behavioral Health Authority. All transactions including but not limited to:
 - 837P (Professional Encounter)
 - 837I (Institutional Encounter)
 - NCPDP (Drug Encounter)
- System modifications have been implemented in CIS i.e. "Covered Services and HIPAA" or as requested by OPS.
- The CRS Site fails to maintain an average 90% or greater acceptance rate on any form type for a period of one quarter
- The CRS Site fails to adhere to the established submission schedule for any form type for a period of one quarter.
- Submission volumes drop 50% from the number of records submitted during the previous quarter compared with the most recent quarter completed, for any form type.
- Upon removal from the testing environment due to satisfactory completion of the test criteria, a CRS Site may be moved back into test if any one of the first three submissions to production does not meet the 90% acceptance threshold. The CRS Site will then have

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to achieve a 90% or greater acceptance rate on a minimum of 3 additional test files, for each form affected, before being placed back into the production environment.

Administrative Review Scoring:

Acceptance rates are monitored as part of the CRS Site's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Daily Detail Encounter Acceptance Report

Daily Detail Encounter

Arizona Department of Health Services
Daily Detail Encounter Acceptance Report -
1/1/2007 - 3/31/2007
GSA -

Process Date	Total Enc.	Processed Enc.	Void	Void %	Accepted	Rejected	% Accepted
1/3/2007	13,211	13,211	0	0.00%	12,945	266	97.99%
1/25/2007	13,238	13,238	0	0.00%	13,013	225	98.30%
2/22/2007	14,936	14,936	0	0.00%	14,187	749	94.99%
3/29/2007	12,223	12,223	0	0.00%	12,019	204	98.33%
Total	53,608	53,608	0		52,164	1,444	97.31%
HCFA							
1/2/2007	136	0	136	100.00%	26	110	19.12%
1/5/2007	25,767	25,510	257	1.00%	25,452	317	98.78%
1/12/2007	12,411	12,407	4	0.03%	12,263	162	98.81%
1/22/2007	19,986	19,986	0	0.00%	19,787	201	99.00%
1/25/2007	13,612	13,612	0	0.00%	13,314	298	97.81%
1/31/2007	13,215	13,215	0	0.00%	12,928	292	97.83%
2/1/2007	310	310	0	0.00%	181	129	58.39%
2/8/2007	16,433	16,115	318	1.94%	16,326	107	99.35%
2/15/2007	17,650	17,343	307	1.74%	17,372	278	98.42%
2/22/2007	24,170	24,170	0	0.00%	24,073	97	99.60%
3/6/2007	17,968	17,967	1	0.01%	17,710	258	98.56%
3/9/2007	13,618	13,598	20	0.15%	13,516	102	99.25%
3/12/2007	363	362	1	0.28%	352	11	96.97%
3/13/2007	16,217	16,217	0	0.00%	16,165	52	99.68%
3/14/2007	318	318	0	0.00%	318	0	100.00%
3/23/2007	16,440	15,366	1,074	6.53%	16,368	72	99.56%
3/27/2007	669	628	41	6.13%	633	36	94.62%
3/28/2007	17,569	16,420	1,149	6.54%	15,635	1,941	88.99%
Total	226,852	223,544	3,308		222,419	4,466	98.04%
UB							
1/24/2007	800	800	0	0.00%	768	32	96.00%
2/28/2007	267	267	0	0.00%	240	27	89.89%
3/8/2007	3	0	3	100.00%	3	0	100.00%
3/27/2007	315	315	0	0.00%	285	30	90.48%
3/28/2007	16	16	0	0.00%	14	2	87.50%
Total	1,401	1,398	3		1,310	91	93.50%
Grand Total	281,861	278,550	3,311		275,893	6,001	97.88%

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Submission Timeliness/210 Report

Introduction:

CRS Sites are required to submit all encounters to ADHS within 210 calendar days from the ending date of service. Failure to submit an encounter within 210 calendar days will result in an untimely encounter and will be scored as part of each Site's yearly Administrative Review. In addition, encounters submitted greater than 210 days may result in a timeliness error during the AHCCCS Data Validation study.

Collecting the Data:

The CRS/IT department produces an encounter file that identifies all encounters submitted greater than 210 days from the end date of service. IT then places the text file containing all of the encounter data into the M:\Common\Program Support directory and notifies OPS by email when the file is ready to import. A designated OPS Representative imports the text file into the departments' established MS Access database. The OPS Representative then notifies the other OPS Representatives via email that the Daily Encounter Reports for a specific date have been imported to the MS Access database.

Accessing the 210 Report:

The following are steps necessary to access the 210 report:

1. Open the "Daily enc submission rpt" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Daily_encounters_database, then double-click on the Daily enc submission rpt_db.mdb file.
2. Select "Reports" from the Daily Encounters Main menu.
3. When the Criteria Selection menu appears, click on the "Report:" drop-down dialogue box and select "Over 210 Days Summary Report".
4. Enter a Start Date: in the format MM/DD/YYYY.
5. Enter an End Date: in the format MM/DD/YYYY.
6. Use the "CRS" drop down dialogue box to select the appropriate CRS Site.
7. Enter Notes in the "Notes" text box when applicable. To view notes at any time, check the "Collect all notes" box. Once notes are entered for a specific date, the notes will always be in the database.
8. Click on "Print". The report will appear with separate line for each form type.
9. Print the report by clicking on the "File" menu and selecting "Print".

Reviewing the 210 Report:

The OPS Representatives are required to review the 210 report to identify issues CRS Sites are having submitting timely encounters. The findings of the 210 report are a standard review item

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at the monthly CRS/OPS Workgroup meetings.

CRS Sites are required to provide an explanation if:

- More than five percent of their encounters are submitted over 210 days.
- An increase in untimely encounters is noted.

Administrative Review:

Encounters submitted to ADHS greater than 210 days from the end date of service are evaluated and scored as part of the yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

210 Report

<i>Arizona Department of Health Services</i>										
<i>Greater than 210 days Summary Report -</i>										
<i>1/1/2007 - 3/31/2007</i>										
<i>Daily Encounter Summary R</i>										
GSA -										
	Total Enc.	Processed Enc.	Voids	Void %	Accepted	Rejected	% Accepted	210 PD	210 %	
DRUG	64,030	64,030	0	0.00 %	62,686	1,444	97.33 %	270	0.51 %	
HCFA	227,016	223,704	3,312	1.46 %	222,680	4,466	98.05 %	1,771	0.80 %	
UB	1,401	1,398	3	0.21 %	1,310	91	93.50 %	63	4.81 %	
Grand Total	282,447	279,132	3,315		276,476	6,001		2,104		

% Accepted for value: HCFA/UB Accepted/Per wal: 100, DRUG Accepted/Total: 100
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Aged Pended Encounters/Pend Sanctions

Introduction:

CRS Sites must resolve all pended encounters from AHCCCS within 120 calendar days of the original AHCCCS processing date. Failure to resolve AHCCCS pended encounters within 120 days is known as an aged pended encounter and is subject to sanction, with exception to encounters that pended due to AHCCCSA or ADHS error. CRS Sites have the ability to work on correcting pended encounters through out the month.

AHCCCS Pended Encounters Cycle:

Monthly AHCCCS sends a file to ADHS containing all encounters that pended, or are still pending at AHCCCS, during that month's adjudication cycle. As soon as ADHS IT receives the file, it is reviewed for errors, placed into manageable file formats and promptly placed on the respective CRS Site's FTP server.

1. ITS sends encounter file to AHCCCS
2. AHCCCS returns pends
 - a. ITS downloads the report files from the AHCCCS ftp server and notifies OPS when they are available. Get notified by e-mail.
 - b. Files are dumped into
 - i. M:\systems\rpts\AHCCCS reports\
3. Extract each file from the zip file format and add a .TXT file extension and put in the directory under m:\systems\rpts\AHCCCS reports\convert files\files\IN IN079999. Place files in m:\systems\rpts\AHCCCS reports\convert files\files directory.
4. Use the macro in the AHCCCSre.doc file to convert each file to a word document format. There are 8 text files or health plan. Convert these files in m:\systems\rpts\AHCCCS reports\convert files\files\. Save the files with a ".doc" extension. AHCCCSre.doc is in m:\systems\rpts\AHCCCS reports\convert files\AHCCCS report converter\
5. Copy the converted word documents to the program support directory and inform the Encounter staff that they are available.
 - a. M:\ program support staff\AHCCCS reports\ HP_079873
 - b. Copy file EC9R179.txt to M:\ program support staff\AHCCCS reports\ HP_079873
6. Do not print reports EC97R179-079999 and EC9EM187-079999. Print a copy of the other summary reports and place in the AHCCCS Pended Encounter reporting binder.
7. Back up zip files to the monthly pend archive file located in M:\SYSTEMS\PEND\YYY\file backups\YYYY_MM_files.zip where YYYY and MM is the month and year of the pend cycle.
8. Balance H74ADJREP to AHCCCS EC9CM128 report. See reports marked 1 and 2. H74ADJREP comes from Pat.

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9. Balance C1 total to TOTAL from AHCCCS EC9CM187 report (Pended encounters summarized aging report)
10. To process Pend file use (“Kevin run form” along with run date from AHCCCS EC9CM187 report and date imbedded in pend file name)
 - a. If importing to an existing db make sure you re-name last months file to prevent it from being overwritten
 - b. Kevin run form. M:\SYSTEMS\PEND\YYYY\ master_pendYYYY.mdb
 - c. Pend file in M:\systems\rpts looks like e.g. dwn74607.20050205.txt
 - d. Creates file PENDED_RECORDS CURR.
 - e. Check “Sent to CRS” flag that it is “Y”
11. Balance C2 and C4 totals to the total pend file record count. If they don’t balance inform IT.
12. Use query which converts text fields to numeric data type and strips extra spaces from the text fields and adds comment placeholder.
 - a. 2 queries need to be run to do this:
 - i. CP175_Apnd_Converted_Comments_Q
 - ii. CP175_Apnd_Converted_Data_Q
13. Create new directory under drive “F”. F:\CRS_PENDS\YYYY_MM
14. Export the individual CRS files and put them in a zipped file in the directory created in step 13. There are 6 queries. Format is “Export_Pend_Data_<CRS ID>_Q”. Export these queries to the F:\CRS_PEND\YYY_MM directory. Get record counts to give to Javier.
15. Add the exported files to the CRS zip files out on the F:\CRS_PEND\YYY_MM drive. The file names are APEND_<CRS ID>.
16. Open form **ExportReports_FRM**. Press button “Export ALL CRS Reports”. If there are no error messages and the form comes back with “--- DONE ---” then the reports have been created in a new directory on your F drive under the F:\ CRS_PENDS directory (this directory must exist). E.g. F:\ CRS_PENDS directory\2006_1 would be for January of 2006.
17. Put the text file and the 2 report files into the appropriate zip file
18. Zip file Password: 2 digits CRS and “CRS” and 01. e.g. 03CRS01
19. Notify Javier that the files are ready with any caveats that may have occurred in the process, like dropped records.
20. Load zip file to CRS ftp directory
21. Create directory under M”\ Program support staff\CRS Info\CRS_PENDS\YYYY_MM
22. Backup all pend files (incoming and outgoing) in monthly zip files.
 - a. M:\SYSTEMS\PEND\YYYY\File backups\YYYY_MM_Files.zip.
 - b. There is PKZip batch file that is the basis to load the files. M:\SYSTEMS\PEND\Archive_2_zip_list.txt. The file will need to be modified each month to look for the right files.
 - i. For a later time the archive process could be automated using the command line arguments. Create a New Archive
To create a new archive, append the file name of the archive to create followed by the list of files to add to the archive. Note, the archive name

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must end in the .ZIP extension. The archive will be created in the current folder.

pkzipw <archive_name.zip> <list of files to compress, separated with spaces> e.g. pkzipw test.zip file1.doc file2.doc

An OPS Representative will immediately send an email to all the Sites stating that AHCCCS Pend files are available on the FTP server (Attachment 1). This email includes the deadlines of when each step of the pend corrections process is due to ADHS.

Sites are to immediately begin working the pends to meet all deadlines. All questions regarding the AHCCCS pended encounters should be directed to the appropriate OPS Representative.

Monitoring Pended Encounters:

To be proactive in reducing and/or eliminating sanctions due to aging pended encounters, OPS Representatives will work with Sites to address encounters pended more than 90 days. OPS Representatives shall take the following steps to monitor pended encounters:

1. Access “M:\Program Support Staff\AHCCCS Reports\HP_079999” and locate the Aging Pended Encounters snapshot files for each CRS, titled, “OPS_Pend_Rpt_Aging_CRS_XX” (XX being the CRS identifier). This file is available when the AHCCCS pend files are placed on the FTP server for CRS Site.
2. Print copies of the snapshot file for distribution and discussion at CRS Site Workgroup meetings. Make sure to address all pended encounters that have been pending greater than 90 days and have the CRS Site explain why the pend error is unresolved.
3. Follow up with the Site throughout the month to ensure the CRS Site has been able to correct aging pends and/or understand how to correct them.
4. Assure IT has completed SSRs for deletion of pended encounters due to ADHS error.
5. Contact the AHCCCS Technical Assistant Representative to ensure override requests are completed in a timely fashion.

Deleting, Voiding, and Overriding of Encounters:

Pended encounters must not be deleted or voided by a Site as a means of avoiding sanctions for failure to correct encounters within 120 days. The CRS Site shall document all Title XIX and Title XXI encounters deleted, voided or overridden encounters and maintain a record of CRNs with appropriate reasons indicated. See Deletion/Override Log section of this manual.

Preliminary Sanctioning Process:

AHCCCS on a quarterly basis distributes to ADHS/OPS via the FTP server their preliminary findings of sanctionable aged pended encounters (Attachment 2). The preliminary findings are divided into aged pended encounters that are excluded from sanction (Attachment 3) and those that are being sanctioned (Attachment 4). A summary of all sanctionable pended encounters are

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also placed on the FTP server by AHCCCS in the form of an Excel spreadsheet. The Encounter Manager or Supervisor is responsible for moving these files to the “M:\Program Support Staff\Encounters\Pend Sanctions\” folder. The Encounter Manager then provides each CRS Site with a letter defining the preliminary results and includes a CD containing the spreadsheet summary of the sanctionable aged pended encounters specific to the CRS Site for review and comment (Attachment 5).

Challenge Preliminary Findings:

The CRS Site is responsible for identifying any pends that they want to challenge in the preliminary report. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CIS screen prints
- Screen prints from the CRS Site’s internal system

OPS will review all challenges from the CRS Site and determine the documentation that will be forwarded to AHCCCS for consideration of reducing sanctions.

Final Sanction Determination:

Once AHCCCS reviews all challenges and/or additional documentation, a final decision is made as to which pended encounters are sanctionable (Attachment 6). The sanctions are then calculated (Attachment 7) according to age category. Office of Business Operations is notified of the final sanction amounts and funds are withheld from the sanctioned CRS Site’s capitation payment the following month. ADHS/OPS will send a letter to each CRS Site advising them of any final sanction amounts (Attachment 8). Whether sanctions are waived or not, a CRS Site is still responsible for correcting all pended encounters unless the error is on behalf of AHCCCSA or ADHS.

Sanctions are imposed according to the following schedule:

0 – 120 days	121 – 180 days	181 – 240 days	241 – 360 days	361 + days
No sanction	\$5 per month	\$10 per month	\$15 per month	\$20 per month.

Administrative Review Scoring:

Aged pended encounters are monitored as part of the CRS Site’s yearly Administrative Review. Administrative Review standards can be found in the Administrative Review Section of this manual.

AHCCCS Pends Availability and Correction Due Dates Email

IMPORTANT INFORMATION - December 2006 Pend Data

1) Pend Files are Ready

Your current pend file (APEND_rr.txt) is available on the OPS FTP server in the password protected zip file (APEND_rr.ZIP).
**Please note that your file contains all pended records (hard and soft). Do not work the soft edits.

<u>MONTH</u>	<u>CRS</u>	<u>RECS</u>	<u>FTP TO CRS</u>
2006-12	02	6,344	Y
2006-12	08	13,127	Y
2006-12	15	842	Y
2006-12	22	575	Y
2006-12	26	3,168	Y
2006-12	27	1,245	Y

2) Pend Reporting

Reports of all encounters pended at AHCCCS for the month of December 2006 have been generated and placed in your respective CRS directory on the FTP server.

3) Pend Processing Deadlines

A) DelDup File (AHCCCS Pend Overrides, & Subvention Deletions) **Due By: Noon 12/28/2006**

Use only the following combinations of Error and Reason Codes.

<u>Error Code</u>	<u>Reason Code</u>
	A001 Per CRS review, not a duplicate encounter
R410	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R480	D012 Recipient not AHCCCS eligible during dates of service (R410, R480)
R660	D017 Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)
H280	D018 Encounter not eligible to adjust (H280)
N027	D019 Drug not elig for Medicaid coverage (N027)

B) All other error codes should be adjudicated either through on-line correction of applicable data fields in the CIS system, or through submission of a full void transaction in the normal daily process.

All pended encounter on-line corrections and void transactions must be completed in CIS by 11:00 am 1/2/2007.

4) Pend Error Questions

Please feel free to contact your respective OPS Representative should you have any questions, or should you require any additional information.

Preliminary Sanction Summary

Preliminary Sanction Summary			
Quarter Ending:		June, 2006	
Plan ID:	079999	Plan Name:	ADHS
TSN:	79		
Age Category	Total Encounters	Sanction Amount	
181-240 Days	2	\$20	
241-360 Days	4	\$80	
TSN:	80		
Age Category	Total Encounters	Sanction Amount	
121-180 Days	1	\$5	
241-360 Days	4	\$80	
TSN:	81		
Age Category	Total Encounters	Sanction Amount	
121-180 Days	4	\$20	
181-240 Days	3	\$30	
TSN:	84		
Age Category	Total Encounters	Sanction Amount	
121-180 Days	1	\$5	
Plan Total	Total Encounters	Sanction Amount	
	19	\$200	

Pended Encounters Excluded from Preliminary Sanctions

Summary of Encounters Excluded From Preliminary Sanctions

Quarter Ending: June, 2006

Plan ID: 079999 Plan Name: ADHS.

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>TSN</i>	<i>Total</i>
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	79	6
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	A	80	90
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	93	12
A951	FORCE PEND FOR CONTRACTOR CORRECTIONS	I	79	28
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	81	78
P210	IHS SERVICE PROVIDERS ARE FEE FOR SERVICE ONLY	A	80	295
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	79	2
P340	PROVIDER SPECIFIC RATE NOT ON FILE FOR DOS	I	93	3
P353	RATE NOT FOUND ON PROV TYP TBL	I	79	6
R410	RECIPIENT NOT ELIGIBLE FOR AHCCCS SERVICES ON SERVICE DATES	A	80	1
R480	RECIPIENT NOT ENROLLED ON SERVICE DATES	C	81	6
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	81	12
R600	MEDICARE COVERAGE INDICATED BUT NOT BILLED	A	83	36
R632	MEDICARE APPROVED AND PAID NOT BOTH PRESENT	A	83	2
V151	OR RM BILL-ICD9 AND/OR HCPCS MUST = SURGICAL	I	79	6
V152	OR RM BILL-NO SURG ICD9 AND/OR HCPCS CODE PRESENT	I	79	3
Z610	EXACT DUPLICATE FOUND	I	79	6
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	80	1
Z615	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	I	79	6
Z620	NEAR DUPLICATE FOUND	I	93	2
Z720	EXACT DUPLICATE FOUND	A	81	4
Z720	EXACT DUPLICATE FOUND	A	83	8
Z720	EXACT DUPLICATE FOUND	A	79	12
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	83	1
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	79	58
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	210
Z725	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	272
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	80	3
Z745	NEAR DUPLICATE FROM DIFFERENT HEALTH PLANS	A	93	12
Z760	NEAR DUPLICATE FOUND - FROM-THROUGH DATES OVERLAP	A	81	1
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	94	8
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	84	47
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	83	129
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	93	352
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	79	510
Z805	EXACT DUPLICATE FROM DIFFERENT HEALTH PLANS	C	80	6,505
<i>Plan Total</i>				8,733

Preliminary Encounter Sanctions Error Summary

Preliminary Encounter Sanctions Error Summary

Quarter Ending: June, 2006

Plan ID: 079999 Plan Name: ADHS

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>Total</i>
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	1
N004	NDC CODE NOT ON FILE	C	1
N004	NDC CODE NOT ON FILE	C	5
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	4
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
V020	REVENUE CODE NOT ON FILE FOR DOS	I	1
V045	NO ACCOMMODATION BILLING - BILL IS I/P OR LTC	I	4
<i>Plan Total</i>			19

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Attachment 5

Preliminary Sanction Letter Sent to CRS Sites

[Date]

[Recipient]
[CRS Site]
[Address]
[City, State Zip]

Dear [Dr./Mr. or Ms.] [Recipient]:

The purpose of this letter is to inform you of the preliminary results of sanctionable pended encounters for the quarter ending [month, year]. According to your contract, [CRS Site] is required to resolve all pended encounters within 120 calendar days of the original processing date.

Enclosed is a diskette with a spreadsheet and the summary reports of your sanctionable pended encounters for the quarter ending [month, year] including preliminary sanction amounts. Please enter your responses to any items believed not to be sanctionable into the designated area of the spreadsheet. Return the diskette and any supporting documentation to the Office of Program Support Encounter Unit, attention Kevin Gibson. If we do not hear from you by [Month Day, Year], we will use the preliminary results as the final sanction amount. The Arizona Department of Health Services' Encounter Unit will evaluate and, if appropriate, submit a challenge to AHCCCS for final review.

Should you have any questions regarding this matter, please feel free to contact me at (602) 364-4727.

Sincerely,

[Name], Eligibility/Encounter Manager
Bureau of Financial Operations

Enclosures

c: [Name], Deputy Director, ADHS
[Name], Chief Financial Officer, ADHS
[Name], Program Support Manager, ADHS
Contract Compliance File

Error Summary Final

Error Summary Final

Quarter Ending: June, 2006

Plan ID: 079999 Plan Name: ADHS/

<i>Error Code</i>	<i>Error Description</i>	<i>Form Type</i>	<i>Total</i>
D010	PRIMARY DIAGNOSIS NOT ON FILE (FOR DOS)	A	1
D305	INAPPROPRIATE DIAGNOSIS SEQUENCE	A	2
N004	NDC CODE NOT ON FILE	C	6
R660	DHS MHS ENC RCP MUST BE ON MHS ENROLL	A	2
T005	PSYCH BED W/OUT PSYCH DX-INVALID	I	1
<i>Plan Total</i>			12

Final Sanction Summary

Final Sanction Summary Quarter Ending: June, 2006

Plan ID: 079999 **Plan Name:** ADHS/

TSN: 79

Age Category	Total Encounters	Sanction Amount
181-240 Days	1	\$10

TSN: 80

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	\$5
241-360 Days	2	\$30

TSN: 81

Age Category	Total Encounters	Sanction Amount
121-180 Days	4	\$20
181-240 Days	3	\$30

TSN: 84

Age Category	Total Encounters	Sanction Amount
121-180 Days	1	\$5

Plan Total	Total Encounters	Sanction Amount
	12	\$100

Final Sanction Letter Sent to CRS Sites

[Date]

[Recipient]
[CRS Site]
[Address]
[City, State Zip]

Dear [Dr./Mr./Ms.] [Name]:

The purpose of this letter is to inform you of the final results of sanctionable pended encounters for the quarter ending [Month, Year].

In a letter dated [Month Day, Year], [CRS Site] was provided an opportunity to review the preliminary results, and provide input to items believed to be sanctioned in error. AHCCCS has completed their review of the errors [Enter amount of sanction or amount waived] for all aged pended encounters for this quarter.

Please note that, when sanctions are waived, the CRS Site is still liable for correcting all pended encounters unless the error is due to an AHCCCS error.

Should you have any questions regarding this matter, please contact [Name], Encounter Unit Manager at (602) [phone number].

Sincerely,

[Name]
Chief Financial Officer

c: [Name], Deputy Director, ADHS
[Name], Program Support Manager, ADHS
Contract Compliance File, ADHS
OPS Representatives, ADHS

Office of Program Support Operations and Procedures Manual

Deletion/Override Log

Introduction:

ADHS/OPS requires each CRS Site to maintain and submit a quarterly reconciliation log of all encounters that have been overridden, deleted, or voided from the AHCCCS PMMIS system. The quarterly Deletion and Override logs are scored as part of each CRS Site's yearly Administrative Review.

Deletion and Override Log Contents:

The CRS Sites are required to maintain a log of all deleted, overridden, or voided encounters from the AHCCCS PMMIS system. The quarterly logs must be submitted in accordance with the following schedule.

Submitting Deletion and Override Logs:

The CRS Site is required to submit the Deletion/Override log to OPS no later than the 30th of the month following the end of the quarter. For example, for quarter ending March 31, 2007, the report is due by April 30, 2007. One week prior to the end of each quarter the OPS Representatives will send an email to each CRS Site stating that the Deletion and Override log is due to OPS. If the 30th of the month falls on a holiday or weekend, the OPS Representative will advise the Site of any extension. The CRS Site will submit the Deletion and Override log file to the FTP server according to the required Deletion and Override Logs File Layout (Attachment 1). The CRS Site will send an email to their OPS Representative and will copy the Encounter Supervisor when the logs have been placed on the FTP server. Once the OPS Representative receives the email from the CRS Site stating that the Deletion and Override log is available, it will be reviewed for accuracy.

Quarterly Deletion/Override Log Submission Schedule

<u>Review Quarter</u>	<u>Due Date At ADHS/OPS</u>
Ending March 31	April 30
Ending June 30	July 30
Ending September 30	October 30
Ending December 31	January 30

Comparing Deletion and Override Logs for Accuracy:

ADHS IT Department keeps a file of each CRS Site's voided or deleted encounters and will add in all override requests. This file is made available to the Office of Program Support to compare to the CRS Site's submitted log. The system will compare each encounter in the ADHS IT file to the Deletion/Override log submitted by the CRS Site. The system will use the following criteria to compare the logs.

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- **ICN/Line Number/CRN:** The CRS ICN, line number and CRN must match the ADHS Deletion and Override file's ICN, line number and CRN for each encounter.
- **Provider ID:** The Provider ID must match the record's Provider ID for each encounter if applicable. The identification number provided must match the original submission.
- **NPI:** The National Provider Identifier must match the record's National Provider Identifier for each encounter. The identification number provided must match the original submission.
- **Start/End Date:** The start date and end date must match the records start and end date for each encounter.
- **Error 1:** If the encounter originally pended at AHCCCS, the error should be reported and must match the record's Pended Encounter History Error 1 record for each encounter.
- **Client ID:** The Client ID must match the record's Client ID for each encounter.
- **Reason Code:** If there was a Reason Code submitted for the deletion or override of an encounter from AHCCCS, it must appear in the log and must match the record for each deleted encounter. CRS Sites must use one of the OPS approved reason codes. (Attachment 2)
- **Record Missing:** If a CRS Site's Deletion and Override log is missing encounter records, as compared to the ADHS Deletion and Override file, the number of missing records will be calculated.

Findings:

Upon completion of a CRS Site's Deletion and Override log review, the results will be provided to the OPS Representative. An e-mail will then be sent to the CRS Site, by the assigned representative, identifying any errors that have been discovered as well as a final score for that quarter's Deletion and Override log.

Administrative Review Scoring:

Submissions of Deletion/Override Logs are monitored as part of the CRS Site's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review Section of this manual.

Deletion and Override Log

File Name: Enc_Recon_log MMDDYY_CRS_ID

Format: comma quote delimited file

Claims and Encounters Deletion and Override Log Record Layout

Field Name	Type	Remarks
CRN	X(14)	
ICN Number	X(11)	
Line Number	X(2)	
Procedure NDC Revenue Code	X(11)	
Units	Number (7,1)	
CRS ID	X(2)	
Provider ID Number	X(6)	Must match original submission
National Provider Identifier (NPI)	X(10)	Must match original submission
Service Begin Date	DATE	MM/DD/YYYY
Service End Date	DATE	MM/DD/YYYY
Error Code 1	X(4)	
Error Code 2	X(4)	
Error Code 3	X(4)	
Error Code 4	X(4)	
Type	X(1)	V = Void Transaction D = Pend Delete O = Pend Override
Client ID	X(10)	
AHCCCS ID	X(9)	
Form Type	X(1)	A-HCFA, B-UB, C-DRUG
Deletion Override Reason	X(4)	
Deletion Override Description	X(200)	

CRS Sites must maintain a log containing the fields listed above for every encounter that is deleted, voided or overridden from the PMMIS system at AHCCCS.

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Attachment 2

Approved Override Code:

A001 Per CRS review, not a duplicate encounter

Approved Deletion Codes:

D012 Recipient not AHCCCS eligible/enrolled during dates of service (R410, R480)

D017 Recipient does not have MHS enrollment at AHCCCS during dates of service (R660)

D018 Encounter not eligible to adjust (H280)

D019 Drug not eligible for Medicaid coverage (N027)

DITS Per CRS request deleted by ITS

DOPS Per CRS request deleted by OPS

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OPS/CRS Workgroups

Introduction:

In an effort to maintain consistency throughout the Office of Program Support (OPS), the following meeting guidelines should be used for the CRS Site Encounter Workgroup Meetings.

Workgroup Meeting Scheduling:

CRS Workgroup meetings are to be held on a monthly basis with each CRS Site scheduled during a separate week from the other Sites but in conjunction with the CRS Site meeting for out of town sites

Agendas:

- The agenda should be completed using the **Meeting Agenda/Minutes Template** (Attachment 1)
- Research any agenda item submitted by the CRS Site as soon as it is presented. Accepting only a topic from the CRS Site and adding it to the agenda is insufficient, the OPS Representative should also document the specific questions the CRS Site has regarding the topic.
- When an edit reason is discussed the OPS Representative **must** include the description of the edit along with the edit number. Additionally, any time a number is used to identify an item the written description must be given.
- One week before the meeting, distribute the *final agenda* to the CRS Site.
- Workgroup agendas **must** be completed at least one day prior to the date the agenda is due to a CRS Site so that it may be reviewed and approved by a supervisor or manager.

Before the Workgroup Meeting:

Once a final Workgroup agenda has been sent to a CRS Site, the OPS Representative is responsible for hosting an internal meeting, known as a pre-briefing, to inform all ADHS parties that will be attending the Workgroup of all issues to be discussed. Any clarification of an issue should be made at this time.

Conducting the Workgroup Meeting:

- Before the Workgroup meeting begins, the OPS Representative shall have the OPS Administrative Assistant prepare enough copies of the following items for hand out to all persons attending the Workgroup:
 - ✓ Agenda
 - ✓ 210 Report
 - ✓ Aged Pends Report

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- ✓ *210 Report* – Provided to identify claims submitted by the CRS Site past the 210 day filing time requirement.
 - Print the 210 report for the month prior to the date of the Workgroup meeting.
 - Enter the report findings on the Workgroup meeting agenda. The agenda should display the findings from the current and previous report.
- ✓ *Aged Pends-Report* – Provided to advise the CRS Site of the number of pends they have that exceed or are getting close to the 120-day limit.
- ✓ *Intakes without Demographics Report* – Provided to advise CRS Site of the number of intakes currently in the system without a demographic.
- ✓ *Override/Delete Log Request* – Advise the CRS Site of upcoming due dates for the Override/Delete Log submission.
- ✓ *Data Validation Update* – Advise the CRS Site of any data validation results and of any upcoming due dates.
- ✓ *Training* – Inquire if any training has taken place since the last meeting. If the CRS Site has conducted training, request a summary of the training content and a copy of the sign-in sheet.

New Issues:

New Issues should be logged with the date presented and the person assigned to do the research/follow-up. These issues should be researched immediately after the meeting not just before the next scheduled meeting. If the issue/problem is resolved prior to the next meeting the OPS Representative should contact the CRS Site to advise and update the information on the next agenda. The issue can be closed at the next meeting if the CRS Site agrees.

Closed Issues:

Closed Issues may be removed immediately after both the CRS Site and OPS agree that the issue is resolved. Closed items should be moved to the Closed Items Log (Attachment 2) for the CRS Site. OPS Representatives must remember to bring at least one copy of the Closed Items Log to each Workgroup meeting.

Following the Workgroup:

Following a Workgroup meeting, OPS Representatives are to immediately begin documenting all discussions from the Workgroup, known as minutes, upon return to ADHS.

Minutes:

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Minutes shall be completed using the **Agenda/Meeting Minutes Template** (Attachment 1). Meeting minutes must be discussed the day of or the day after the Workgroup at a De-briefing meeting. The De-briefing is the forum that shall be used to clarify any discussions that took place during the Workgroup meeting. The OPS Representative is responsible for scheduling and hosting this meeting. Minutes should be typed by a OPS Representative immediately following the De-briefing so the information is still fresh in their mind. Typed minutes are due to the supervisor or manager two (2) business days after the Workgroup. Upon review and approval by a supervisor or manager, the meeting minutes are to be distributed to the attendees no later than three (3) business days from the date of the meeting.

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Attachment 1

**CRS Site /Office of Program Support
Meeting**

Enter Agenda or Minutes Above

Created Date:
Final Date:

Current Meeting Date
Place
Time

Attendees:

CRS Site

OPS:

Absent:

<i>Issue:</i>	<i>Date reported:</i>	<i>Discussion:</i>	<i>Action:</i>	<i>Assignment:</i>
Old Business:				
Standard Issues:				
Daily Submission Report				
210 Report				
Aged Pends				
Intakes w/o Demographics Report				
Submission Schedule				
Override/Delete Logs, Due Date				
Check Register, Due Date				
Data Validation Update				
Training				
NPI				
Encounter Withhold				
New Business				
Next Meeting:				

Next Meeting Date
Place
Time

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Edit Alert

Introduction:

An Edit Alert is the method used by the Office of Program Support (OPS) to notify the CRS Sites of system changes that may impact the CRS Site.

Notifying CRS Sites of System Changes:

Whenever possible the OPS will notify the CRS Site 90-days prior to the implementation of system modifications. There may be instances when the 90-day notification notice is not possible i.e. legislative requirements or emergency production corrections. If one of these situations occurs, the CRS Site will be notified as soon as possible. These notifications will be communicated thru Edit Alerts, and reiterated during Encounter Workgroup meetings.

Create and Distribute the Edit Alert:

Once an SSR is written for a system modification, and the originator has obtained all of the required signatures, the original yellow SSR will be delivered to the IT Department and a copy will be delivered to the OPS Encounters Unit Supervisor and the Testing Coordinator.

It is the responsibility of the Testing Coordinator to draft an Edit Alert. The Edit Alert will contain the following:

- The system change
- Scenarios (if applicable)
- The SSR number and description
- The expected implementation date

The completed Edit Alert is e-mailed to the CRS Sites and distributed to OPS and ITS staff. A second Edit Alert will be e-mailed to advise the CRS Site that testing of the change has been completed and the exact date production will be updated.

Edit Alert Database:

To view and/or modify an Edit Alert in the database (Attachment 1), the OPS Representative will need to take the following steps.

1. Open the "Edit Alert" database by double-clicking on the desktop shortcut. If the shortcut is not available, go to the following target location: M:\Program Support Staff\Edit Alert Database\Edit_Alert_db, then double-click on the Edit_Alert_db.mdb file.

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2. Select “New/Changed Edit Alert” from the Main menu.
3. To review an Edit Alert, you can either scroll through the Edit Alerts, which are tracked by number, or do a search with specific wording, creation date, or Edit Alert number.
4. To modify an Edit Alert, locate the Edit Alert that needs modification or revision and populate the Edit Alert with new text. No save option is available because the MS Access database immediately saves each entry.
5. To add an Edit Alert, go to the record beyond the last Edit Alert for a blank form. Populate all Edit Alert database fields, keeping in mind that the Edit Alert will be distributed to all CRS Sites and OPS staff. Information entered should be specific and match the SSR.
6. To create a snapshot of any Edit Alert, click on the box with the “camera and document”. A snapshot of the Edit Alert will be created in the OPS Representatives F:\ drive.
7. Anytime an Edit Alert is sent, whether internally for OPS/IT staff or out to the CRS Sites, it must be in the form of a snapshot.

Implementation

Once implementation takes place, an Edit Alert will be emailed to advise the CRS Site of the exact date production will be updated.

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Attachment 1

Edit Alerts Database

Microsoft Access - [Edit_Alert_FRM]

File Edit View Insert Format Records Tools Window Help

MS Sans Serif 8 B I U

Tracking Number: [] Reference Title: REVISED - Billing Limitation Override Capability

Notification Date: 10/13/2006 Implemented:

Expected Implementation Date: 10/6/2006

Change_Description

CIS has been updated to allow the use of an override to bypass billing limitations on procedure codes T1019, S5110, H2014, H2014 HQ and H2017 billed in conjunction with Foster Care codes S5140, S5145 as well as all accommodation revenue codes for dates of service after 6/30/06. A new valid value of "F" has been added to the override field for this function.

Scenarios (if Applicable)	Edit_Function
It is the expectation that therapeutic foster care services may be billed in conjunction with support services, based on behavioral health recipient needs. Persons who are in need of support services, for specific specialized needs that cannot be addressed through their therapeutic foster care, must have access to those identified services. In those circumstances override "F" should be used.	

Create Snapshot Print This Screen

Record: 14 of 59

Form View

Sample Edit Alert

New/Changed Edit Alert

Tracking Number: 69

Implemented:

Reference Title Demographic - AXISIII Field Change

Notification Date: May 25, 2007

Expected Implementation Date: July 1, 2007

ADHS will provide the RBHA's with 90 days notice when possible

Change Description: Establish a field that stores behavioral health recipient's current medical diagnoses. (SSR 2178)

The current data set submitted by the T/RBHA to BHS utilizes five 2-byte fields, which indicate a generic category of the recipient's current medical condition(s). ADHS must identify whether the behavioral health recipient reports as having any of 36 AHCCCS-specified diagnoses.

The new field will identify specified conditions of behavioral health recipients for which coordination of care should be provided. The Coordination of Care performance measure and other potential analysis will be extrapolated through examination of this data.

The existing AXISIII field(s) will remain in the data set, but field-specific edits for records with an intake date of MM/DD/YYYY (system change date) or later will be ignored/modified. Data submissions with an intake date of MM/DD/YYYY (system change date) or later will not require completion of the existing AXISIII field(s).

The new field will store up to three 2-byte codes. A maximum of three unique codes may be stored per individual record. Either Not Applicable (N/A) or a valid code must be entered. If N/A is entered as the first of the 3 possible entries, then N/A must also be entered for subsequent entries. Exact codes, other than N/A, cannot be repeated in an individual record. If more than one field is completed with any valid value other than N/A the codes must be unique.

This change will enable ADHS/DBHS to be more in sync with AHCCCS' system and will decrease the number of encounters pending at AHCCCS.

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Special Day Runs

Introduction:

The Office of Program Support recognizes that there may be occasions when a CRS Site will need to submit encounters separate from the normal submission. These types of submissions are considered special day runs and can be utilized to test changes made to the CRS Site's system or to isolate a specific group of encounters. In addition, encounter form type(s) that have been restricted to the test environment, special day runs will be the only form of submission until the test criteria has been satisfactorily met.

Request Process:

Special day runs will only be performed by ADHS on Wednesdays. The CRS Site must coordinate with their OPS Representative to schedule a special day run. The following are the procedures that must be performed:

- The CRS Site must submit an electronic request, by Noon on Tuesday, including encounter volumes and specific details of what is being submitted and why.
- The OPS Representative will review the request with the appropriate OPS management.
- The OPS Representative will notify the CRS Site electronically of the request approval or denial by COB Tuesday.
- If the request is approved the OPS Representative will copy the IT department to alert them that a special day run will be submitted the next day.

Processing the Special Run Day:

To successfully complete the special day run request the CRS Site must:

- Ensure files are not placed on the FTP server prior to Wednesday morning (files placed on the server prior to Wednesday morning risk being picked up by the nightly processing)
- Ensure the files are submitted to the FTP server by 10:00 a.m. on Wednesday

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Check Register Review

Introduction:

OPS requires all CRS Sites to submit check registers for all Fee-For-Service (FFS) paid claims on a quarterly basis to ensure a CRS Site is submitting timely and accurate encounter data. Check register reviews are scored as part of each Site's yearly Administrative Review.

Check Register Request:

On a quarterly basis, OPS Representatives send a request to each Site via email stating that the Site's check register from the previously ended quarter is due to ADHS/OPS (Attachment 1). The Site is given 10 business days from the date of the email to submit their check register.

Timeframes to be followed:

- The 1st business day of the month the OPS Representative will send an email to each CRS Site requesting the check register for the appropriate fiscal year quarter.
- The CRS Site will be given 10 business days to return the check register to their respective OPS Representative.
- Within 5 business days, the OPS Representative will submit a request to the CRS Site for copies of the checks, either the first paid claim on checks where a single claim was paid or the third paid claim on checks where multiple claims were paid.
- The CRS Site will be given 10 business days to submit the requested information to the appropriate OPS Representative.
- The OPS Representative will review the submitted information and provide the CRS Site with the outcome within 10 business days from the day the second request was received. CRS Sites will be sent a preliminary letter summarizing the findings along with a spreadsheet of the claims reviewed.

Check Register Received:

Once the OPS Representative receives a check register, the review will begin. Within 5 business days of receiving the check register, the OPS Representative will submit a second request (Attachment 2) and a Check Register Claim Request spreadsheet (attachment 3), via email, to the CRS Site for the FFS claims and copies of either the first paid claim on checks where a single claim was paid or the third paid claim on checks where multiple claims were paid. The CRS Site will be given 10 business days to submit the requested information to the OPS Representative. Upon receipt of the FFS claims request, the OPS Representative shall begin the sample selection process.

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Sample Selection Process:

The OPS Representatives have two weeks to research the submitted information by randomly selecting 20% (not to exceed 150) of the encounters to review for correctness, timeliness or omission errors. If the check register contains fewer than 30 check numbers associated with Fee-For-Service paid claims, the entire check register will be reviewed.

How to Determine Encounter Errors:

Correctness: The service dates, procedure code, modifier, units, dollar amounts, and diagnosis codes are compared against a copy of the providers' claim, which is supplied to the OPS Representative by the CRS Site. If what the CRS Site adjudicated in their system does not match what the provider billed, a correctness error will result. If both a correctness and timeliness error are found on a single encounter, only the correctness error is calculated into the score. CRS Sites must adjust all correctness errors found and resubmit to ADHS within 10 business days from the date the preliminary letter was sent to the Sites.

Timeliness: An encounter must reach the CIS system at ADHS within 210 calendar days from the end date of service billed, or the encounter is considered untimely, and will result in a timeliness error. Additionally, adjustments of an encounter must be completed and accepted into CIS within 210 calendar days from the end date of service billed to be considered timely.

Omissions: OPS representatives are to work closely with the CRS Sites before omission errors are cited because CRS Sites have 210 calendar days from the end date of service to submit a clean claim to ADHS. The following are the steps an OPS Representative should follow before calling an omission error:

- Contact the CRS Site's Claims department and request documentation of claim status.
- Determine the date the claim was adjudicated in the CRS Site's system. The CRS Site must provide a screen print to document that the claim is in their system.
- If the claim has been cleanly adjudicated in the CRS Site's system with a process date prior to the date the check was written, the encounter is not considered an omission. The CRS Site will be required to submit a screen print from their claim system demonstrating the above information.
- If a claim is older than 210 calendar days from the end date of service and has not yet been submitted to ADHS, the encounter is an omission.

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If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Scoring the Check Register Review:

Within two weeks of receiving the FFS claims from the CRS Site, ADHS/OPS will compute each CRS Site's score by dividing the number of correct claims by the total number of claims reviewed. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating. Score and compliance rating are then based on the following table. Corrective action will be requested as applicable.

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

Preliminary Findings:

Within 10 business days from receipt of the claims, the OPS Representative will prepare and issue the preliminary findings (Attachment 4) including a spreadsheet of the claims reviewed (Attachment 5).

Challenges:

The CRS Sites have 10 business days to challenge the preliminary findings of a Check Register Review from the date of the preliminary letter

Final Score:

OPS Representatives must take into consideration any challenges before calculating the final score of the quarterly Check Register Review. The final score must be determined within 5 business days from the due date provided in the preliminary letter, and a final letter sent to the CRS Site stating the number of errors and the final score (Attachment 6).

Correction of Errors:

It is the expectation of the Office of Program Support that all correctness and omission errors will be corrected and/or submitted within 30 days from the date of the final letter. The OPS Representative will monitor CRS to ensure corrections are made in a timely manner. If corrections have not occurred the issue will be discussed with the CRS Site at the Workgroup meetings.

Admin Review Scoring:

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The Check Register Review process is monitored as part of the CRS Site's yearly Administrative Review. Complete information regarding the scoring of Administrative Review standards can be found in the Administrative Review section of this manual.

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Check Register Request Template

Attachment 1

[Date of Request]

In accordance with the following schedule the Office of Program Support is beginning the [1st, 2nd, etc.] Quarter, fiscal year [2007], Check Register Review process. Please submit Fee-For-Service (FFS) check registers for the months of [i.e. October, November, and December] [Year], to the attention of [OPS Representative] by [10 Business Day's from Date of Request].

Quarterly Review Month

October 2006
January 2007
April 2007
July 2007

Check Register Requested

1st quarter, fiscal year 2007
2nd quarter, fiscal year 2007
3rd quarter, fiscal year 2007
4th quarter, fiscal year 2007

If you have any questions please do not hesitate to contact me.

[OPS Representative]

[Title]

[Phone]

[Fax]

[Email Address]

FFS Claims Request Template

Attachment 2

Subject: [FY07 – 2nd Quarter], FFS Claims Request

Dear [Recipient],

Thank you for your response to the previous check register request. ADHS/OPS has reviewed the check register for the quarter ending [December 2006], and has randomly selected a 20% sample of checks associated with the Fee-For Service paid claims. The next step in the review process will be to examine the paid FFS claims. Please submit the third paid claim from each of the checks listed on the attached spreadsheet. If the identified check contains less than three paid claims, please provide a copy of the first paid claim. This information should be sent to the attention of [RHBA Representative] by [End of Month].

Please feel free to contact me should you have any questions or require any additional information.

Thank you,
[RBHA Representative]
[Title]
[Phone]
[Fax]
[Email Address]

Check Register Review Preliminary Letter Template

[Date]

[Recipient]

[Site]

[Street Address]

[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Arizona Department of Health Services/Office of Program Support (ADHS/OPS) has concluded its preliminary findings of the [first, second, etc.] quarter, fiscal year [2007] Fee-For-Service (FFS) Check Register Review. The claims in the attached Check Register Review Summary have been researched to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions were identified during the course of the review, the score was automatically defaulted to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The preliminary score of this review is []%, which represents [Score Rating] Compliance. Any challenges must be presented to OPS within 10 business days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact me at (602) [Phone Number].

Sincerely,

[Name]

Encounters Unit Supervisor

Enclosures

- c: [Name, CFO/CEO], CRS
- [Name] OPS Manager, ADHS
- [Name] Office Chief, CRS
- [Name] Division Chief Compliance, CRS
- [Name] CFO, CRS
- [Name] Encounter Manager, ADHS

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Check Register Review Final Letter Template

Attachment 6

[Date]

[Recipient]

[Site]

[Street Address]

[City, State Zip]

Dear [Dr./Mr./Ms.] [Recipient],

The Arizona Department of Health Services/Office of Program Support (AHDS/OPS) has completed the [first, second, etc.] quarter, fiscal year 2007 Fee-For-Service (FFS) Check Register Review. The claims in the Check Register Review Summary were reviewed to determine if omission, correctness or timeliness errors exist. If a claim has both a correctness and timeliness error, only the correctness error has been calculated in the findings. If any omissions are identified during the course of the review, the score will automatically default to a 0% rating.

Type of Error	Encounters Reviewed	Number of Errors	Compliance Rate
Correctness			%
Omission			%
Timeliness			%
Total			%

Score Rating	
90-100%	Full Compliance
75-89%	Substantial Compliance
50-74%	Partial Compliance
0-49%	Non Compliance

The final score of this review is []%, which represents [Score Rating] Compliance. It is the expectation of OPS that all correctness errors will be corrected and submitted within 30 days from the date of this letter. If you have any questions regarding your score or the Check Register Review process, please do not hesitate to contact me at (602) [phone number].

Sincerely,

[Name]

Encounters Unit Supervisor

Enclosures

- c: [Name, CFO/CEO], CRS
 [Name] OPS Manager, ADHS
 [Name] Office Chief, CRS
 [Name] Division Chief Compliance, CRS
 [Name] CFO, CRS
 [Name] Encounter Manager, ADHS

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Coordination of Benefits

Introduction:

CRS Regional Contractors are required to take reasonable measures to determine the legal liability of third parties who are liable to pay for covered services.

Policy:

CRS Regional Contractors shall cost-avoid a claim if it establishes the probable existence of a third party or has information that establishes that third party liability exists. However, if the probable existence of third party liability cannot be established or third party liability benefits are not available to pay the claim at the time the claim is filed, the CRS Regional Contractor must process the claim. If a CRS Regional Contractor knows that the third party insurer will not pay the claim for a covered services due to untimely claim filing or as the result of the underlying insurance coverage (e.g., the service is not a covered benefit), the CRS Regional Contractor shall not deny the service, deny payment of the claim based on third party liability, or require a written denial letter if the service is medically necessary. The CRS Regional Contractor is required to reimburse providers for previously recouped monies if the provider was subsequently denied payment by the primary insurer based on untimely filing limits or lack of prior authorization and the member failed to disclose additional insurance coverage other than AHCCCS.

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AHCCCS Study

Introduction:

The Centers for Medicare and Medicaid Services (CMS) requires AHCCCS to oversee and submit progress reports on the encounter data collection process. AHCCCS performs yearly data validation studies to meet this requirement. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition to meeting the CMS requirement, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data.

Sample Selection Process:

The sample size for each contractor is re-calculated each year. The size is determined using the detailed "Random Sample Calculation" methodology documented in the *AHCCCS Encounter Data Validation Technical Document*. The sample size indicates the number of encounters/services AHCCCS intends to review for the data validation study.

Medical Record Collection Process:

AHCCCS creates a report for each CRS Site identifying the clients selected for review. The Data Validation Specialist will send the CRS Site the appropriate portion of the report and a computer disk that identifies the clients that are included in the data validation study. The CRS Site is responsible for identifying which provider/facility provided the services to the client and where the medical records are housed. The CRS Site must forward the list of providers/facilities to AHCCCS by the date specified. AHCCCS will prepare a letter to notify the provider about the data validation process and its requirements. The provider/facility must locate the medical records for each of the clients requested and must forward the medical records to AHCCCS by the date specified.

Type of Errors Examined:

AHCCCS will review the medical records to determine what services the clients received. The services received will be compared to the encounters submitted to determine what types of errors, if any, exist. To comply with CMS requirements three types of errors are examined.

- Correctness-an error is assessed when the dates of service, procedure code and or diagnosis code in the encounter were incorrectly coded according to the medical documentation
- Timeliness- an error is assessed when the encounter is received by AHCCCS more than 240 days from the end of the month in which the service was rendered, or the effective date of the enrollment
- Omission- an error is assessed when provider documentation indicates that medical services were rendered, but an encounter was never received at AHCCCS

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Preliminary Report Distribution, Review and Challenge

A preliminary report will be prepared and will be distributed to each CRS Site. This is the only opportunity that the CRS Site/provider has to challenge the errors identified by AHCCCS. The CRS Site is responsible for identifying any errors that they want to challenge in the AHCCCS preliminary report. The CRS Site should review the preliminary error report and perform a comparison to data from the client's medical records and/or the CRS Site's system. Each challenge must be supported by additional documentation. Types of additional documentation include, but are not limited to:

- PMMIS screen prints
- CRS screen prints
- Screen prints from the CRS Site's internal system

All documentation required to support the challenge including the *Data Validation Challenge Form* (Attachment 1) must be submitted to OPS by the date specified. If the documentation does not support the challenge, the challenge will not be processed and forwarded to AHCCCS.

Methods for Challenging Errors:

The type of evidence that is required to successfully challenge an error is dependent on the type of error identified. This section describes some the techniques that may be useful in challenging data validation errors.

Remember: This is the ONLY opportunity for the CRS Site to challenge the errors identified by AHCCCS.

Correctness Errors-The CRS Site or the provider must:

- Submit documentation outside of the medical record supporting that the code or date on the encounter is the clinically correct code or date
- Show that the ICD9 diagnosis code in question did not require a 4th or 5th digit at the time the service was provided

Timeliness Errors-The CRS Site or the provider must:

- Document that the encounter could not be submitted in a timely fashion at AHCCCS because of system problems at AHCCCS during the relevant timeframe.
- Show that the encounter referenced is an adjustment and that the original encounter and the adjustment were both submitted in the correct time frame.

Omission Errors-The CRS Site or the provider must document that the encounter should never have been sent to AHCCCS because:

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- The client was not eligible for Title XIX or XXI services
- The service was not covered by AHCCCS
- The provider was not eligible to bill for Title XIX or XXI services

Challenge Received:

The Data Validation Unit will review the preliminary report and the challenges submitted by the CRS Sites. The Data Validation Unit will create one unified challenge response containing all documented challenges noted by the CRS Site. This along with all the supporting documentation submitted by the CRS Sites, will be forwarded to AHCCCS.

Final Report:

AHCCCS will review the challenges and documentation submitted. This review will result in a final report that is distributed to the appropriate CRS Site. Included with the final report is the sanction assessed by AHCCCS. The AHCCCS sanction calculation process is a complex, multi-step process. Details regarding the AHCCCS sanction calculation process can be found in the *AHCCCS Encounter Data Validation Technical Document*. The ADHS/DBHS process for passing the AHCCCS Sanction on to the CRS Site is as follow, ADHS/DBHS takes the total sanction dollar amount and divides it by the total number of errors from AHCCCS, which results in a sanction amount per error. The sanction amount per error is then multiplied by the number of errors for each CRS Site resulting in a final sanction amount per CRS Site. This process is valid for both the “A” and “B” Study.

Collection of Sanction:

ADHS/DBHS will withhold the final sanction amount from the capitation paid to the CRS Site each month.

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Attachment 1



Division of Behavioral Health Services
Office of Program Support Services
2122 East Highland, Suite 100
Phoenix, Arizona 85016
Phone: (602) 381-8991
Fax: (602) 553-9023

DBHS Received Date

Data Validation Challenge

Preliminary Results are the RBHAs Only Opportunity to Challenge the AHCCCS Data Validation Findings

CRS Site: Phoenix Flagstaff Tucson Yuma
CRS Representative: _____ **Phone:** _____

Client Information:

Client Name: _____
CIS Client ID: _____ AHCCCS Client ID: _____

Challenged Error:

Omission Correctness Timeliness

AHCCCS Tracking #: _____
CIS ICN: _____ AHCCCS CRN: _____

Explanation of Challenge: _____

Please note: Without proper and legible documentation attached the challenge will not be forwarded to AHCCCS and the challenge will be considered unsubstantiated.

Required Documentation:

CIS Screen Print PMMIS Screen Print RBHA Internal Screen Print Other Information as Needed to Support Claim

For ADHS Use Only:	ADHS Reviewer: _____
<input type="checkbox"/> Challenge Referred to AHCCCS	Date: _____
<input type="checkbox"/> Challenge Determined to be BHS Responsibility	
<input type="checkbox"/> Challenge Determined to be RBHA Responsibility	
Comment:	

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OPS/CRS Contractor Data Validation Review

Introduction:

The purpose of the data validation Site Review is to evaluate the process of the CRS Contractor to ensure they are accurately, thoroughly and timely reporting their encounters. Additionally, it is an opportunity for ADHS/OPS to perform a data validation study with the Sites similar to the yearly AHCCCS study.

A Data Validation Representative will perform one site review per quarter per Site. It is the CRS Site's responsibility to select the members to be reviewed.

Sample Selection Process:

ADHS/OPS will review fifty (50) medical record charts per review. The Site is responsible for randomly selecting the medical records to be reviewed and making sure the records are available at the time of the review.

The CRS Contractor is required to provide OPS a complete schedule of available dates for the review at least **30** business days prior to the beginning of the review quarter.

Quarterly Data Validation Review Schedule

<u>Review Quarter</u>	<u>Dates of Service Reviewed</u>
Ending March 31	July, August & September of previous year
Ending June 30	October, November & December of previous year
Ending September 30	January, February & March of current year
Ending December 31	April, May & June of current year

Example: In June 2006 the quarterly review will be for services provided in October, November and December of 2005.

Site Review:

OPS will review the medical records pulled by the Site, each medical service will be reviewed and coded by the OPS Data Validation Representative. The service code, place of service, modifier, number of units, and diagnosis code will be documented on the *ADHS/OPS Data Validation Site Review Summary* spreadsheet (Attachment 1) as the appropriate code for the services documented by the provider. OPS will review medical record findings with the Site prior to completing the Review. In addition

After the on-site visit, the Data Validation Unit will review the encounters on file in the CRS system to determine if the claims have been submitted and verify that there are no discrepancies between the service codes, place of service, modifier, number of units, and diagnosis codes documented in the medical record and the encounter data.

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- Omission, an omission error will be called when a service is identified in the medical record but is not found in CRS.
- Timeliness, a timeliness error will be called when the received date in CRS is greater than 210 days from the last day of the month in which the service was rendered.
- Correctness/Service Code, a service code correctness error will be called when the service code from the medical record does not match the service code in CRS. A correctness error on the service code includes the modifier and place of service.
- Correctness/Diagnosis, a diagnosis code correctness error will be called when the diagnosis code does not match the diagnosis code in CRS.
- Correctness/Units, a units error will be called when the do not match the units in CRS.
- Non-billable, a non-billable error will be called when documentation is found in the chart that does not substantiate a billable service or when an encounter is found in CRS but documentation was not found in the chart.
- Comments, the comments section will be used to further explain any errors or additional findings from the review. The comments will also indicate if the error is also in the CRS system.

After the Site Review:

Within five business days after the Site Review, the Data Validation Unit will prepare and issue a summary of the Site Review, which will include the number of records reviewed, the number of errors found, the review score, any training issues identified, and if required, requests for corrective action. DBHS will give the CRS a date by which the omission errors must be submitted. The CRS will also be required to correct and resubmit the correctness errors by that same date. The Data Validation Representative will copy the CRS Representatives on all correspondence.

Type of Error	Number Reviewed	Number of Errors	Error Rate
Correctness: Service Code			
Correctness: Modifier			
Correctness: Place of Service			
Correctness: Units			
Correctness: Diagnosis Code			
A single encounter may have more than one correctness error, however the encounter will only be counted once in the total calculation			
Timeliness			
Omission			
	Encounter Total	Encounters w/Errors	Error Rate
Total			

The CRS has two weeks to review the response and either challenge the findings or provide information on when ADHS can expect all corrections to be completed. The Data Validation unit will review the response submitted by the CRS who will then be notified, within 2 business days, if the plan is accepted. If the response is a challenge, the Data Validation Representative reviewing the challenge must provide a response to the CRS within 5 business days.

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Providing Information:

Monthly, the Data Validation Representative will provide the OPS Representative with an update. It will be the responsibility of the OPS Representative to copy the Data Validation Representative on the “call for agenda items” that is sent to the CRS Site prior to the monthly meeting. At that time it will be the Data Validation Representatives responsibility to provide the update, which will include any outstanding responses due from the CRS Sites as well as a status on any ADHS deliverables. In addition, the Data Validation Representative will advise the CRS of any AHCCCS activity.

If fraud is suspected at any time during the ADHS/OPS Site Review, the suspected fraud will be reported to the Corporate Compliance Officer at ADHS.

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Correct Reporting of Ancillary Charges

Incorrect Billing

UBs submitted in this manner will fail CIS pre-processor edit, N228 UB ancillary line with zero/blank units or dollars.

Line	Rev Cd	Units	Billed	NonCovChg	Paid	Description
01	134	5	2960.00	000.00		Psych/3&4 Bed
02	251	1	0.00	000.00		Drugs/Generic
03	301	32	0.00	000.00		Lab/Chemistry
04	302	1	0.00	000.00		Lab/Immunology
05	305	1	0.00	000.00		Lab/Hematology
Total			2960.00		2960.00	

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00			Psych/3&4 Bed
02	251	1	450.00			Drugs/Generic
03	301	32	400.00			Lab/Chemistry
04	302	1	150.00			Lab/Immunology
05	305	1	150.00			Lab/Hematology
Total			4800.00		2960.00	Total paid for entire claim

Correct Billing

The providers should bill UBs to the RBHAs exactly as they would bill any private insurance carrier. Ancillary revenue codes, units, and amounts must be reported on all inpatient UBs. The rates reported should not be the contracted amount or the amount the RBHA is expected to pay but the actual amount of the service. The RBHAs will report their contracted amount for the service in the paid field.

Line	Rev Cd	Units	Billed	NonCov Chg	Paid	Description
01	134	5	3650.00	690.00		Psych/3&4 Bed
02	251	1	450.00	450.00		Drugs/Generic
03	301	32	400.00	400.00		Lab/Chemistry
04	302	1	150.00	150.00		Lab/Immunology
05	305	1	150.00	150.00		Lab/Hematology
Total			4800.00		2960.00	Total paid for entire claim

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Correct Reporting of Same Day Admit/Discharge Encounters

Inpatient encounters for clients who are admitted and discharged on the same date will be allowed for ancillary services only. These UB92/UB04 inpatient encounters with the same start and end date must be submitted as follows:

Line	Rev CD	Units	Billed	NonCov Chg	Paid	Description
01	134	1	1200.00	1200.00	0.00	Psych/3&r Bed
02	251	1	450.00	0.00	450.00	Drugs/Generic
03	301	32	400.00	0.00	400.00	Lab/Chemistry
04	302	1	150.00	0.00	150.00	Lab/Immunology
05	305	1	150.00	0.00	150.00	Lab/Hematology
		Total	2350.00		1150.00	Total paid for claim

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CRS Resync Requests

Introduction:

The Office of Program Support recognizes that there may be occasions when a CRS Site will need to have a file of all data as reflected in the ADHS computer system. This type of request is called a “resync” and may be utilized by the CRS Site for the purpose of performing a reconciliation or due to processing problems.

Request Process:

The CRS Site must coordinate with their OPS Representative to schedule a “resync”. The CRS Site will send an e-mail to their OPS Representative and will copy the Encounter Manager with a request for a “resync”. The Request must contain the following information:

- CRS Site name
- Type of resync(s) requested:
 - ✓ AHCCCS Eligibility
 - ✓ Encounter
- Date range:
 - ✓ Fiscal year (July 1 – June 30)
 - ✓ Calendar year (January 1 – December 31)
 - ✓ Any other time increment (quarter, month, etc.)

The OPS Representative will forward the e-mail notification to the identified IT contact and will copy BHS/ITS Management.

Request received prior to 2:00 p.m. should be completed in approximately 2 – 4 hours. Requests received after 2:00 p.m., files will not be made available until the next day.

The OPS Representative will be notified by BHS/ITS when the files are available on the FTP Server. The OPS Representative will then notify the CRS Site via e-mail with the file names.

Duplicate Encounter Logic

Introduction:

ADHS/OPS has system edits in place to prevent exact duplicate encounters from being accepted into CIS. In addition ADHS/OPS has potential duplicate edits that require review and intervention on the part of the CRS Site. Duplicate logic is applied to an encounter when another encounter exists in the database or on the file being submitted by the CRS Site. The following are the logic used in these edits for each form type

Exact Duplicate Logic:

UB92/UB04 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Dates of service
- First 2 digits of bill type

1500 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Service/Procedure Code
- Date of service
- Modifier
- Place of service

Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- Provider ID
- NDC
- Dispense date

Potential Duplicate Logic:

Two additional edits exist that use similar logic to the duplicate logic and when failed will require review and intervention by the CRS Site. There are no override capabilities available for these edits.

1500 will reject when the fields listed below are the same

- Client ID
- Provider ID
- Service/Procedure Code
- Modifier
- Place of service

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However, dates of service are overlapping

- Fail N254-overlapping dupe in file
- Fail N255-overlapping dupe in database

Pharmacy/NCPDP will reject when the fields listed below are the same

- Client ID
- NDC
- Dispense date

However, provider is different

- Fail N256-NDC/different provider in file for date of service
- Fail N257-NDC/different provider in database for date of service

CRS Administrative Review

Introduction:

Annually the ADHS/DBHS/OPS conducts an Administrative review of each CRS Site. Monitoring and Scoring of the Administrative Review Standards is performed throughout the review year based on the following established policies/procedures.

Standard:

The CRS Site has developed and maintained a system that meets claims/encounter data processing requirements defined by ADHS.

Scoring:

There are four elements that apply when evaluating the final score for meeting claims/encounter data processing requirements defined by ADHS: Meeting a 90% Acceptance Rate, meeting performance measured by the 210 Report, meeting the CRS Site's submission schedule and meeting performance measured by the Aged Pends Report. Here is how each element is rated:

- **90% Acceptance**

The total number of all encounters accepted / the total amount of all encounters submitted = passing/failing percentage

- If the final percentage is 90% or above Score = 100%
- If the final percentage is below 90% Score = 0%

- **210 Report**

The total amount 210 PD / the total amount of encounters accepted = percentage

Take the percentage and subtract by 100 to receive the final score

- **Submission Schedule**

Each CRS Site should have 12 months worth of submission data to review for the Admin Review period (7/1/06 – 6/30/07). If a CRS Site does not meet it's predetermined submission schedule, for any one of the three form types, within a month, it will be determined that the CRS Site has not met the requirements of it's submission schedule.

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There are 12 possible points a CRS Site can obtain. Each month the CRS Site meets its submission schedule requirements; 1 point will be awarded. Each month the CRS Site fails to meet its submission schedule requirements; 0 points will be awarded.

The total points awarded / total months = percentage

(12/12) =	100%
(11/12) =	92%
(10/12) =	83%
(9/12) =	75%
(8/12) =	67%
(7/12) =	58%
(6/12) =	50%
(5/12) =	42%
(4/12) =	33%
(3/12) =	25%
(2/12) =	17%
(1/12) =	8%
(0/12) =	0%

- **Aged Pends**

The total number of pends > 120 days / the total number of pends = percentage

Take the percentage and subtract from 100 to receive the final percentage for this element

Each element should now have its own percentage. Add all acquired percentages together and then divide by 4 (the sum of all the elements). This will result in the final percentage, for this standard, which should be scored against the standard Admin Review scale:

90 – 100%	Full Compliance
75 – 89%	Substantial Compliance
50 – 74%	Partial Compliance
0 – 49%	Non-Compliance

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Standard:

The CRS Site submits an accurate and timely override/deletion log from providers to the CRS Site and for encounters from the CRS Site to ADHS/DBHS in accordance with OPS submission schedule.

There are two elements applied to the evaluation of the final scoring of the Administrative Review standard: timeliness and accuracy. The CRS Site must submit the override/deletion log by the OPS requested deadline and the file must be formatted according to specifications of the file layout. Each CRS Site should have submitted four override/deletion logs during the review period.

- The CRS Site submitted all four Override/Deletion logs timely and accurately – 100% (Full Compliance)
- The CRS Site submitted three out of the four Override/Deletion logs timely and accurately – 89% (Substantial Compliance)
- The CRS Site submitted two out of the four O/D logs timely and accurately – 74% (Partial Compliance)
- The CRS Site submitted one out of the four O/D logs timely and accurately – 49% (Non-Compliance)
- None of the O/D logs submitted by the CRS Site were timely and accurate – 0% (Non-Compliance)

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AHCCCS Operational and Financial Review

Annually, AHCCCS will conduct an Operational and Financial Review (OFR) of ADHS/DBHS/CRS in order to determine if there are organization, management and administrative systems in place capable of fulfilling all contract requirements including those areas related to encounter submission and data validation.

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Provider Registration

Introduction:

All providers are required to register with the AHCCCS Administration and obtain an AHCCCS provider identification number.

Providers are required to:

- Complete an application
- Sign a provider agreement
- Sign all applicable forms, and
- Submit documentation of their applicable licenses and/or certificates

Information may be obtained by calling the AHCCCS Provider Registration Unit at:

Phoenix area: (602) 417-7670 (Option 5)
In-state: 1-800-794-6862 (Option 5)
Out of state: 1-800-523-0231, Ext. 77670

AHCCCS Provider Registration materials are available on the AHCCCS Web site at www.ahcccs.state.az.us.

National Provider Identifier (NPI)

Effective January 23, 2004, the final rule regarding the National Provider Identifier (NPI) was published. CMS started assigning NPI numbers to providers last May, and beginning in May 2007 NPIs are required. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Health Care Providers *must* communicate their National Provider Identifier's [NPIs] directly to the AHCCCS Administration,

The following outlines 3 Options for getting the required NPI information to the AHCCCS Administration.

Option 1: An electronic mailbox has been established for providers to forward a copy of their NPI notification via email. This email address can only accept copies of the statement emailed to the provider from the NPI enumerator. Please note that the Provider AHCCCS ID number also needs to be included in the email for identification purposes. This email address is NationalProviderID@azahcccs.gov.

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Option 2: Providers may submit a copy of the NPI notification received from the NPI enumerator, either via mail or fax. Again, the provider's name and AHCCCS ID number need to be included on the document. The information should be mailed or faxed to:

AHCCCS
Provider Registration Unit
P.O. Box 25520
Phoenix, AZ 85002
Mail Drop 8100
FAX: (602) 256-1474

Option 3: NPI numbers will also be accepted via written notification. Notification must include the provider's name, AHCCCS ID number, NPI number and signature of the provider or an authorized signor.

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System Service Requests

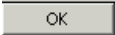
Introduction:

A System Service Request (SSR) is the method used by the Office of Program Support (OPS) to notify DBHS/ITS of system changes/modifications needed in the Client Information System (CIS). In addition an SSR can be used to request research of encounter issues or to request reports.

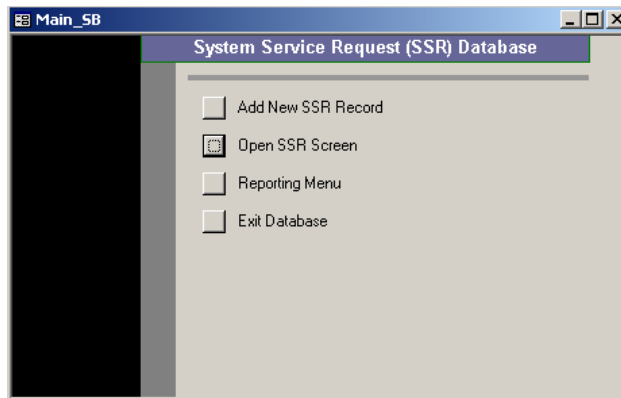
Create an SSR:

OPS staff can access the SSR database using the following icon found on their desktop. The user ID and Password will then be entered.



- 1) Type in your **User ID** and **Password**. (*Note: User IDs and passwords are case sensitive*)
- 2) Press the **OK** button. 

SSR Main Menu



- **Add New SSR Record** – Open SSR Input Screen to enter a new SSR
- **Open SSR Screen** – Open SSR Input Screen to view all existing SSRs
- **Reporting Menu** – Go to Report Menu
- **Exit Database** – Exit system

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Adding a New SSR Record

The following information is to be completed to add a new or change an existing SSR.

SSR INFO TAB

SSR FORM TABLE2 : Form

SYSTEM SERVICE REQUEST (SSR) INPUT FORM
* Required fields in yellow *

SSR ID: 0003 SSR TITLE: UB-92 Unit Validation Edit

SSR INFO INFO2/REVISIONS ITS BHS/TESTING SIGNATURES

REQUESTED BY: Ruth Bateman REQ DATE: 2/9/2002
CONTACT:

DIVISION REQUESTED BY: OPS CLASSIFICATION: Production Fix
COMPLETION BY: PRIORITY: High
REQUESTED IMPLEMENT: PRIORITY ORDER:
RBHAS NOTIFIED: STATUS: Completed - Implemented
DOCUMENTATION ATTACHED: Yes COMPLETED: 5/20/2002

SSR DESCRIPTION:
Add revenue-codes starting with 15 to edit. Add acceptable bill-types that go with patient-status 20 to edit.

Record: 3 of 810

Note: Required fields are in yellow.

- **SSR ID** – Number automatically generated by SSR database
- **SSR TITLE** – Brief description of request
- **REQUESTED BY** - Name of requester + **DATE** - Date request was created
- **CONTACT** – Contact for questions regarding the request, if different from the Requester
- **DIVISION REQUESTED BY** - Requester's Division (pull down list)
- **COMPLETION BY** - If applicable, date the request needs to be completed
- **REQUESTED IMPLEMENTATION** - If applicable, requested date for implementation
- **RBHA/CRS NOTIFIED** - If applicable, date RBHA/CRS were notified of change
- **DOCUMENTATION ATTACHED** - Yes/No (default = "No")
- **CLASSIFICATION** - Type of request (pull down list, default = "Enhancement")
- **PRIORITY** - Requester's priority for request (pull down list, default = "Normal")
 - ❖ *Emergency*: Agency services immediately negatively affected
 - ❖ *High*: Important to Agency/Division - Complete after any emergencies
 - ❖ *Normal*: Change request will increase production - Complete as scheduled
- **PRIORITY ORDER** - Order in which requests will be prioritized and worked
- **STATUS** - Status of request (read-only, see ITS Tab to edit this field)
- **COMPLETED** - Date request was completed (read-only, see ITS Tab to edit this field)
- **SSR DESCRIPTION** - Detailed description of request

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INFO2/REVISIONS TAB

SSR FORM TABLE2: Form

SYSTEM SERVICE REQUEST (SSR) INPUT FORM

* Required fields in yellow *

HELP! SAVE PRINT Print UA Signoff

SSR ID: 0003 SSR TITLE: UB-92 Unit Validation Edit

SSR INFO INFO2/REVISIONS ITS BHS/TESTING SIGNATURES

SCENARIO:

BENEFITS:
It will include revenue codes starting with 15 in the edit check. It will ensure that discharge bill-types are used with patient status 20 (client deceased).

REVISION DATE: 6/6/2002

SSR REVISION:
If revenue code starts with 11, 12, 13 or 15, then
if it the last day of the month (all Ubs) or
If it is a provider type 78, B1 B2 or B3 and it is the first day of the month or
If it is a provider type 78, B1, B2 or B3 and the revenue code is 18x, or
if ((patient-status = 30 AND
bill-type = '112' or '113' or '122' or '123') OR
(patient-status = 20 AND
bill-type = '111' or '114' or '121' or '124') OR
(patient-status is '02' thru '06' AND
bill-type = 111))

Record: 3 of 810

- **SCENARIO** - A descriptive example of the problem or change
- **BENEFITS** - A description of any/all benefits of the request
- **REVISION DATE** - Date of revision (*Note: If there are multiple revisions, note the revision date for each one in the SSR Revision description field*).
- **SSR REVISION** - If applicable, a description of change to original request

After the SSR form has been completed it must be signed by the OPS Manager or the DBHS CFO.

Distribution of an SSR:

After an SSR is written and the originator has obtained all of the required signatures the SSR is placed in the designated Administrative Staff's In-Basket. The Administrative Staff will then:

- Make 2 copies of the SSR including any attached documentation
- Hand deliver the original SSR including all attached documentation to the IT department
- Deliver one copy including documentation to the SSR Originator
- The remaining copy will be used to create a testing folder which will be delivered to the Testing Unit.

It is the responsibility of the SSR Originator to follow-up on the progress/completion of the SSR request

Office of Program Support

Operations and Procedures Manual

System Access Requests

Introduction:

Some T/RBHA/CRS employees will need access to the DBHS/CIS or ADHS/CRS and AHCCCS/PMMIS claim systems to perform their job duties. The procedures to obtain a CIS/CRS and/or PMMIS ID are as follows:

CIS/CRS

Two forms must be completed to request a CIS/CRS user ID. The employee requesting the login ID must complete and sign both forms. To obtain copies of the CIS forms the RBHA/CRS Site should contact the ADHS/DBHS Corporate Compliance Office.

- ADHS Computer User Registration Request Form (Attachment 1)
- ADHS User Affirmation Statement (Attachment 2)

The T/RBHA/CRS should fax both signed forms to the ADHS/DBHS Corporate Compliance Office at fax number (602) 364-4736. The Corporate compliance Officer will review the forms to ensure they are complete and will forward the request to the IT department. ADHS/DBHS ITS will assign an appropriate login ID and password for the new user.

PMMIS

Two forms must be completed to request a PMMIS user ID. The employee requesting the login ID must complete and sign both forms. The RBHA/CRS Site may obtain copies of the AHCCCS security forms at the following website:

<http://www.ahcccs.state.az.us/Publications/Forms/PlansProviders/02-001F.doc>

- AHCCCS User Access Request Form (Attachment 3)
- AHCCCS User Affirmation Statement (Attachment 4)

The T/RBHA/CRS Site should fax both signed forms to the ADHS/DBHS Corporate Compliance Office at fax number (602) 364-4736. The Corporate compliance Officer will review the forms to ensure they are complete and will forward the request to AHCCCS. AHCCCS will assign an appropriate login ID and password for the new user.

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ADHS COMPUTER USER REGISTRATION REQUEST FORM INSTRUCTIONS

- I. Fill out the top part of the form per the following instructions:
 - Add/Remove/Change - Check one of the boxes to indicate which action is needed. *{Required Field}*
 - Request Date - Enter the date this form is being filled out. (i.e. NOW) *{Required Field}*
 - Effective Date - If request is NOT to be done within 2 days, enter the date the requested action is needed. If blank, the request will be done within 2 days.
 - User Name - PRINT the complete name. (Last Name, First Name, and Middle Initial) User Name
 - Work Title - Enter the working title of user. If the user is an outside consultant, write CONSULTANT in this space. *{Required Field}*
 - Office/Section - Enter the name of the office AND section where the user works. *{Required Field}*
 - Physical Location - User's work location. *{Required Field}*
 - Phone# - Enter the phone number of the user. *{Required Field}*
 - Appl./Systems - If this form is being filled out for a client user (i.e. non-ITS employee) check off only the particular application(s) (i.e. BDR, CLAS, USAS), into which the user needs to be added or removed.

If this form is being filled out for ITS personnel who need general access to a computer system, also check those systems.
 - Other Instr - Write any other specific instructions the Security Administrator will need to know
 - Supvr. Name - PRINTED Supervisor Name. *{Required Field}*
 - Supvr. Signature - Supervisor's signature ONLY! Forms with any other signature will not be processed. *{Required Field}*
 - Phone# - Enter the phone number where the Supervisor can be reached if there are any questions. *{Required Field}*
 - Data Owner Sign. - Signature of the Person, or their designee, responsible for the data for which access is being requested
 - Phone# - Enter the phone number where the Data Owner can be reached if there are any questions
 - Office - Enter the name of the office where the Data Owner works.
- II. Mail, hand deliver, E-MAIL, or FAX this request to the Security Administrator. (The mail address, E-MAIL name, and FAX # are at the top of the request form.) The request will be processed within 48 hours after being received.
(EXCEPTION: If a user needs to be immediately removed from the system, call the Security Administrator to facilitate special processing requirements.)
- III. When the request has been processed, a copy of the completed form showing the login name and Internet ID, (if applicable), will be returned to the requestor by Inter-office Mail. Each new user added will also receive in a sealed envelope, their own unique USERID and INITIAL password.

**ARIZONA DEPARTMENT OF HEALTH SERVICES
 USER AFFIRMATION STATEMENT**

I have been made aware and understand that all personnel who have access to the Arizona Department of Health Services (DHS) data are bound by applicable laws, rules and DHS directives and are responsible for DHS data.

I agree to abide by all applicable laws, rules and DHS directives, and I pledge to refrain from any and all of the following:

1. Revealing DHS data to any person or persons outside or within DHS who have not been specifically authorized to receive such data.
2. Attempting or achieving access to DHS data not germane to my mandated job duties.
3. Entering/altering/erasing DHS data for direct or indirect personal gain or advantage.
4. Entering/altering/erasing DHS data maliciously or in retribution for real or imagined abuse, or for personal amusement.
5. Using DHS workstations, printers, and/or other equipment for other than work related purposes.
6. Using another person(s) personal logon ID and password.
7. Revealing my personal logon ID and password to another person.
8. Asking another person to reveal his/her personal DHS logon ID and password.

In relation to my responsibilities regarding the proprietary rights of the authors of computer software utilized by DHS, I recognize that:

1. DHS licenses the use of computer software from a variety of outside companies. DHS does not own this software or its related documentation and, unless authorized by the software developer, does not have the right to reproduce it.
2. When used on a local area network or on multiple machines, employees/contractors shall use the software in accordance with the license agreement.
3. Employees/contractors who know of any misuse of software or related documentation within the agency shall notify their manager/supervisor, or the department security administrator.
4. Employees/contractors making, acquiring or using unauthorized copies of computer software, or using personal non-DHS software are subject to punitive action in accordance with agency guidelines as appropriate to the circumstances.
5. According to U. S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to \$250,000 and/or up to 5 years imprisonment.
6. In the event that an employee is sued or prosecuted for the illegal reproduction of software, he/she will not be represented by the Department of the Attorney General.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedures occurring pursuant to this policy or misuse of department property including computer programs, equipment, and/or data, may result in disciplinary action including dismissal, and/or prosecution in accordance with any applicable provision of law including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and accept responsibility for adhering to all applicable laws, rules, and DHS directives. Failure to sign this statement will mean that I will be denied access to DHS data, computer equipment, and software.

NAME (Last, First, MI.) PRINT OR TYPE	SIGNATURE	PHONE	DATE
NAME OF SUPERVISOR (Last, First, MI.)	SIGNATURE	PHONE	DATE

Routing: Original to Security Administrator; Copy 1-Originator

Office of Program Support Operations and Procedures Manual

Instructions for User Access Request Form

Date: Enter the effective date in format mm/dd/yy.

Section I, Security Access Requirements:

Security Action: Check box(s) for action required. All three may be checked if multiple actions are to be made to multiple systems.

System Access: Check box(s) for system to be accessed or changed. For Mainframe, complete sections II and IV. For Network, complete sections III and IV. For Other, indicate which region(s) (PRODCICS/AFIS, CICS/PROD/HRMS, etc) or systems to modify/Add, and complete section IV and any other related sections.

Note: Do not use this form for Oracle requests. Oracle forms can be found on the Infonet.

Section II, Mainframe Access Requirements:

OPID: Leave blank.

Group#: See the PMMIS naming standards for correct Group Number values.

****Long Term Care****

-Printer: Leave blank unless defining a default PMMIS printer.

-Worker ID: If required, enter either the valid case number provided by the supervisor, or the users first and last initial and the last four digits of the user SSN.

-Type: If required, enter the correct two-digit Type code from the PMMIS Type Code Table.

-Site: If required, enter the correct three-digit Site code from the PMMIS Site Code Table.

Authorized by Group Owner: Signature of new user's PMMIS group owner.

E/C Adjudication Level: If required, enter the valid two digit code (01-99)

Health Plan ID: If required, enter the valid six digit Health Plan ID.

Claims Administrator Signature: The Claims Administrator must sign here if Adjudication Code and/or Health Plan ID is assigned.

Mainframe Userid: Will be entered by Security Administration if a new id is being created. If the logon is going to be Changed or Deleted, the requester should enter the user's logon id.

Section III, Network Access Requirements:

Path(s) or Applications: If yes, enter a valid path name that shows the location of the protected directory to be accessed, or enter the name of the application to be accessed. Indicate via the check boxes if the access should be read or write. (I.e. HomerDir\Share\Orange\Red\Blue\ or DADITS, ECS, ERVS, HRTS, HEIS, PARIS, PATS, etc.)

Protected Directory Owner Signature: Signature of the Directory or Application Owner authorized to grant access to the protected Directory or Application. Call Security for information on Directory and Application Owners.

Copy network logon profile from this user: Enter the name or ID of an existing user who has access to resources (directories, files, or applications) that this account should have access to.
Note: This information is used to aid in the general definition of the new user. Access to protected directories or application will not be granted based on the field. The appropriate authorization signature is always required for access to protected resources.

Network/NT Userid: Will be entered by Security Administration if a new id is being created. If the logon is going to be Changed or Deleted, the requester should enter the user's logon id.

Section IV, User Information Requirements:

User Information: Enter Name, Title, Division, Department and location of user. For Network signon ids, your middle initial is required.

Authorized By: Signature, date, title, mail drop, and extension of Security Representative or Supervisor.

Section V, Security Administration:

Security Administration section to be completed by the Security Administrator.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

USER AFFIRMATION STATEMENT

I have been made aware and understand that all personnel who have access to AHCCCS data are bound by applicable laws, rules and AHCCCS directives. I agree to abide by all applicable laws, rules and AHCCCS directives, and I pledge to:

1. Reveal AHCCCS data only to those persons, whether outside or within AHCCCS, who have been specifically authorized to receive such data.
2. Only access AHCCCS data germane to my assigned job duties.
3. Never enter/alter/erase AHCCCS data for direct or indirect personal gain or advantage.
4. Never enter/alter/erase AHCCCS data maliciously or in retribution for real or imagined abuse, or for personal amusement.
5. Use AHCCCS computer programs, e-mail, terminals, printers, and/or other equipment only for work-related purposes.
6. Never use another employee's AHCCCS Logon ID and password or ask another employee to reveal his/her personal AHCCCS Logon ID and password.
7. Never reveal my AHCCCS Logon ID and password except to the Assistant Director of my division, the Agency Director or Deputy Director, upon request.

In addition, I recognize that:

1. AHCCCS licenses the use of computer software from a variety of outside companies. Neither AHCCCS nor its employees own this software or its related documentation and, unless authorized by the software developer, do not have the right to reproduce or alter the software or the documentation.
2. AHCCCS employees should not acquire or use unauthorized copies of computer software.
3. When used on a local area network or on multiple machines, AHCCCS employees shall use the software in accordance with the license agreement.
4. AHCCCS employees who know of any misuse of software or related documentation within the agency shall promptly notify their manager/supervisor or Assistant Director.
5. According to U.S. Copyright Law, 17 USC Sections 101 and 506, illegal reproduction of software can be subject to criminal damages up to \$250,000 and/or up to five (5) years imprisonment.
6. The Arizona Attorney General's Office will not represent and the agency will not provide legal representation to an employee who is sued or prosecuted for the illegal reproduction of software.

Appropriate action will be taken to ensure that applicable federal and state laws, regulations, and directives governing confidentiality and security are enforced. A breach of procedure occurring pursuant to this policy or misuse of AHCCCS property including computer programs, e-mail, equipment and/or data may result in disciplinary action up to and including dismissal, and/or prosecution in accordance with any applicable provision of law, including Arizona Revised Statutes, Section 13-2316.

My signature below confirms that I have read this form and understand it. I accept responsibility for adhering to all applicable laws, rules, and AHCCCS directives. Failure to sign this statement will mean that I will be denied access to AHCCCS data, computer equipment, and software.

NAME OF EMPLOYEE (Last, First, M.I.) Print or Type	SIGNATURE	MAIL DROP	DATE

Routing: Pink (original) - Employee Personnel File; Canary - ISD; Green - Employee.



Office of Program Support Operations and Procedures Manual

Training Requirements

Introduction:

CRS Sites are required to provide on-going training to their providers for submission of claim/encounter data.

Encounter Related Training:

The OPS Encounter Unit requires the CRS Site to provide evidence of on-going training that has been provided to their providers. The following evidence will be submitted at the OPS/RBHA Workgroup Meeting:

- Sign-in sheets for any training that took place in the previous month
- A brief description of the training provided

Data Validation Related Training:

The OPS Data Validation Unit requires the CRS Site to provide training to any provider with a data validation review error rate greater than 10%. The following evidence will be submitted at the OPS/RBHA Workgroup Meeting:

- Sign-in sheets for any training that took place in the previous quarter
- A brief description of the training provided

OPS Training Available

The Office of Program Support has a Trainer available to provide training at the CRS Sites. Any Site that would like to arrange training should contact their assigned OPS Representative.

Office of Program Support

Operations and Procedures Manual

Operations and Procedures Manual Updates and Revisions

The OPS Operations and Procedures Manual will be reviewed and updated as needed. The OPS Manager is responsible for maintaining this manual and should coordinate with all functional areas of DBHS/CRS when there are proposed changes. All functional areas of DBHS/CRS should coordinate with the OPS Manager regarding any changes in their policies, procedures, contracts or reference documents that may affect this manual.

Tidbits

Introduction

The Office of Program Support (OPS) produces a monthly newsletter called *Tidbits* that is posted on the ADHS/DBHS website at <http://www.azdhs.gov/bhs/tidbits.htm> . The purpose of the *Tidbits* is to keep the RBHAs and the CRS up to date with OPS changes, Edit Alerts and Encounter processing information. The following is an example of the first page of a *Tidbits* issue.



Special Day Runs and Testing

As discussed in the RBHA/IT and Encounter Workgroup meetings, DBHS will only be accepting special day runs every Wednesday. This is being done to ensure DBHS/IT can focus on other projects through the remainder of the week.

If a RBHA wishes to perform a special day run, they must coordinate it through their designated RBHA Representative by doing the following:

- √ Provide an electronic request, by Noon on Tuesday, including encounter volumes and specific details of what is being submitted and why. OPS will either approve or deny the request per an electronic response that will be sent out by COB on Tuesday.
- √ Ensure that files are submitted to the FTP server by 10:00am on Wednesday. Please do not post files to the server, for a day run, prior to Wednesday as they may be picked up in the nightly process.

NPI Testing

As you all know, DBHS officially started the NPI testing process on March 1, 2007. The May 1, 2007, CIS NPI implementation is now here. The Office of Program Support (OPS) would like to express appreciation to all the RBHAs for their dedication and hard work in making the NPI Testing process a success over the past two months!

OPS urges the RBHAs to ensure providers are obtaining NPIs and submitting them to AHCCCS in the proper fashion.

NPI Taxonomy codes

Confused about Taxonomy Codes? Go to:
http://www.wpc-edi.com/taxonomy/more_information

Need to see a list of Taxonomy Codes? Go to:
<http://www.wpc-edi.com/content/view/515/229>

Submission of Form CMS-1500 (08-05)

CMS is instructing contractors to reject Form CMS-1500 (12-90) claims received starting July 2, 2007. Providers will now be required to begin submitting the Form CMS-1500 (08-05) beginning July 2, 2007. For more information on this matter, please click on the following link:
<http://www.cms.hhs.gov/transmittals/downloads/R1274CP.pdf>

Coding Q & A

- Q** Can a provider bill Individual counseling and Level I Residential on the same day?
- A** Yes. Based on the B2 and B5 Matrixes, as well as the Covered Services Guide. There are no billing limitations, which would prevent those two codes being billed together on the same day. As always, documentation is key when billing any service.

- Q** Where should one encounter the Diagnosis Code for a client?
- A** The Diagnosis Code should be encountered from the most recent assessment. If however, during the course of an audit, the assessment falls after the date range in question the Diagnosis Code should then be taken from the most current assessment for the date range in question. Please note that if a Diagnosis Code is present, it must be signed and dated by an individual who meets the applicable requirements A.A.C. R9-20-209 (i.e. a Psychiatrist or a Behavioral Health Medical Practitioner).