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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PROVIDER NOTIFICATION

DATE: September 10, 2010

TO: AHCCCS Providers

FROM: Marc Leib, M.D., J.D.
Chief Medical Officer

SUBJECT: Copayment Requirements Effective 10/1/2010

As a result of changes in Federal and State laws and regulations, including provisions of the Deficit Reduction Act of 2005, AHCCCS will expand member copayment requirements effective October 1, 2010. The expanded copayment requirements, which are described in AHCCCS Final Rule A.A.C. R9-22-711, include mandatory copayments for certain populations, higher optional (nominal) copayment amounts for certain populations, and clarification of the services and populations which are exempt from both mandatory and optional copayments. The expanded copayment requirements will result in a modest cost savings to the State. This memorandum provides general information regarding copayment requirements that will become effective October 1, 2010.

Mandatory Copayments:

AHCCCS members who will have mandatory copayments for certain services beginning October 1, 2010 are:

- Transitional Medical Assistance (TMA) members
- Childless Adults
- MED (Medical Expense Deduction) members

("Childless Adults" and MED members are also referred to collectively as the "AHCCCS Expansion Population" or the "TWG (Title XIX Waiver Group) Population.")

Mandatory copayments **permit** providers to **deny** services to members who do not pay the copayment. However, certain services (such as emergency services) are exempt from mandatory copayments, and specific members (such as individuals under the age of 19) are also exempt from copayments. The copayment amounts for Childless Adults and MED members are higher than those applicable to the TMA population. In addition, TMA members are not responsible for making additional copayments in a quarter when the total aggregate amount of copayments that have been made exceeds 5% of the family's income. (The 5% limit does not apply to Childless Adults and MED members; therefore, these individuals *are required* to pay each copayment irrespective of the total aggregate amount of copayments that these members have paid.) Please be aware that payments to providers have been reduced by the amount of a member's copayment obligation *regardless of whether or not the provider successfully collects the mandatory copayment.*

Optional (Nominal) Copayments:

Optional (also known as nominal) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment. The optional copayment amounts have been updated to reflect slightly higher amounts beginning October 1, 2010. Members who are subject to the nominal copayments are not responsible for making additional copayments in a quarter when the total aggregate amount of copayments that have been made exceeds 5% of the family's income.

Copayment Tracking

The AHCCCS Administration will track each member's specific copayment levels by service type, and this information will also identify those members who have reached the 5% copayment limit. AHCCCS will further identify whether the member is subject to a mandatory or a nominal copayment and when copayments cannot be charged, i.e. the service or member is exempt from copayments. This information will be communicated to providers through the various verification systems: EVS, IVR, the web, and HIPAA transactions 270 and 271. Refer to the sample chart attached.

For additional information regarding the October 1, 2010 copayment requirements, please visit the AHCCCS website at: www.azahcccs.gov/commercial/ProviderBilling/copayments.aspx

Member CoPays - Effective 10/1/2010

Member Co-Pay Level	Description	Mandatory, Optional or Exempt	CoPay Service(s)	CoPay Amount	Services Identified as:
00	Exempt from CoPays	Exempt - No CoPays for any services	None	None	None
20	Nominal - Traditional	Optional - Services cannot be denied for failure to pay a CoPay	Office Visits	\$3.40	Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Pharmacy	\$2.30	Pharmacy Form type; Any NDC Code not indicated as Family Planning.
			Outpatient Professional Therapies	\$2.30	Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.

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21	Nominal - HIFA Parents	Optional - Services cannot be denied for failure to pay a CoPay	Office Visits	\$3.40	Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Pharmacy	\$2.30	Pharmacy Form type; Any NDC Code not indicated as Family Planning.
			Outpatient Professional Therapies	\$2.30	Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
40	TWG (MED; Non-MED; AHCCCS Care)	Mandatory - Services may be denied for failure to pay a CoPay	Office Visits	\$5.00	Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Generic Pharmacy	\$4.00	Pharmacy Form type; Any NDC Code not indicated as Family Planning and w/ Brand Indicator of "N".

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			Brand Pharmacy	\$10.00	Pharmacy Form type; Any NDC Code not indicated as Family Planning and w/ Brand Indicator of "Y".
			Non-Emergency Use of the ER	\$30.00	Facility Form type (OP); ER Revenue Code 045X Billed with an Admit Type of 2 or 3 OR a HCPCS/CPT Code of 99281; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
50	TMA (Transitional Medical Assistance)	Mandatory - Services may be denied for failure to pay a CoPay	Office Visits	\$4.00	Professional Form type (1500); HCPCS/CPT Codes = 99201 thru 99205; 99213 thru 99215; 99241 thru 99245; 99385 thru 99387; or 99395 thru 99396 w/ any Place of Service; and w/ any Diagnosis not equal to - 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
			Pharmacy	\$2.30	Pharmacy Form type; Any NDC Code not indicated as Family Planning.
			Outpatient Professional Therapies	\$3.00	Professional Form type (1500); HCPCS/CPT Codes = 97001 thru 97535 w/ a Place of Service equal to 11-office; 12-home; 20-urgent care; 22-outpatient; or 72-RHC; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.

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			Surgeries (In Office; Outpatient non-emergent; ASC's)	\$3.00	Professional Form type (1500); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
					OR
					Facility Form type (OP); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.
					OR
					Provider Type ASC (43); Professional Form type (1500); HCPCS/CPT Codes = 10000 thru 69999 (excluding 36415 and 36416) w/ a Place of Service equal 11-office; w/ any Diagnosis not equal to 640 thru 643.99; 644.2 thru 676.99; V22 thru V24.99; or V27 thru V27.99; OR w/ any Diagnosis not indicated as Family Planning.