AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

March 2022

DD Tribal Health Plan (THP)

Effective October 1, 2021, formerly named DD-AIHP will now be referred to as DD-THP.
Effective April 1, 2022, DD-THP enrolled members will be transitioned to AHCCCS FFS for behavioral and physical services. This change will improve care coordination and increase system transparency for members and providers. Additional information regarding this transition and training resources may be found on the AHCCCS Website.

Office of the Inspector General (OIG) Provider Participation Agreement

AHCCCS has revised the provider participation agreement and the group biller participation agreement. The new agreements are available for review on the AHCCCS website. Changes to the agreements are generally deemed accepted by providers and group billers 30 days after the date of publishing. More details on this and other terms of the agreement are set forth in the application form.

Participating Provider Reporting Requirements

Effective for dates of service on or after June 1, 2022, Participating Provider Reporting Requirements will also apply to the following provider types and claim forms. To retain information related to the actual professional practitioner that is participating in or performing services associated with the clinic visit, this information must be reported on the claim.

Claim Form Types:

- CMS 1500 claim form, Field 19 Field Title: Additional Claim Information
- ADA claim form, Field 35 Field Title: Remarks

Provider Types:

- 05 – Clinic
- 77 - Outpatient Behavioral Health Clinic
- IC – Integrated Clinic

Denial Edit Code H482 “NPI Missing or Invalid” will append to the claim if the participating provider information is not entered or is in the incorrect format.

Payment Error Rate Measurement (PERM) Audit

What is Payment Error Rate Measurement (PERM) Audit

The PERM Audit is designed to measure improper payments in the Medicaid and CHIP programs, as required by the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Improvement Act or IPERA, and the Improper Payments Elimination and Recovery Improvement Act of 2012 IPERIA). The improper payment rates are based on reviews of the Fee-for-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the year under review.

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ANNOUNCEMENTS

IMPORTANT: For Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address of servicedesk@azahcccs.gov

TRAINING AND CONTACTS

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page on the AHCCCS website at: https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

The DFSM Provider Training Team’s First Quarter Training Schedule is posted on the DFSM Provider Training web page.

For provider training questions and technical assistance with the online web portal please outreach the Provider Training Division of DFSM through email at ProviderTrainingFFS@azahcccs.gov

- Prior Authorization Questions FFS PA Line (602) 417-4400
- Claims Customer Service Billing Questions (602) 417-7670 - Option 4
- Provider Registration Process Questions (602) 417-7670 - Option 5

Prior Authorization Questions FFS PA Line (602) 417-4400

Claims Customer Service Billing Questions (602) 417-7670 - Option 4

Provider Registration Process Questions (602) 417-7670 - Option 5

Provider Registration – Fax Applications (602) 256-1474

Electronic Payment Sign Up (Remittance Advice Sign Up/835)

ELECTRONIC PAYMENT SIGN UP

(Remittance Advice Sign Up/835) Contact: ISDCustomerSupport@azahcccs.gov
–OR- call (602) 417-4451

COVID FAQ

FAQs COVID Fact Sheet.

Please note that these materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional

Provider Billing Reminders:

It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement. For each claim submitted, you must be sure to include the correct member's name and AHCCCS ID number, date(s) of service, revenue, procedure codes, units, and charge amounts (etc). Claims should adhere to standard coding practices to also include modifiers if applicable. Providers should utilize the respective state and federal billing & coding resources to ensure claims meet the appropriate billing guidelines.

Responding to PERM Documentation Requests:

Providers must submit the requested information by the due date noted on the request. Please note that it will be the responsibility of the provider identified on the claim to ensure that all supporting medical records, from the provider who rendered an AHCCCS covered service for which the claim payment under review was requested, is submitted in a timely manner. Training Resources

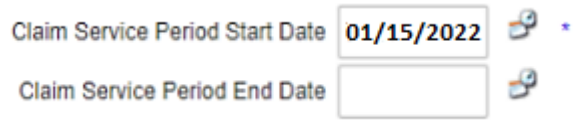
Transaction Insight Portal- Important Information for Users Reporting the Date of Service and Provider Address Fields

To ensure the successful linking of documentation to a claim we have outlined the following information on the most common errors found when entering information into the Transaction Insight Portal. We have also included some tips and tricks for providers to keep in mind when submitting documentation using the Transaction Insight Portal.

Dates of Service Fields:

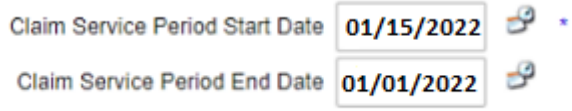
The **Claim Service Period Start Date** is a required/mandatory field, while the End Date field is not. Providers may submit documentation using only the Start Date field.

The Claim Service Start Date (required): Providers can enter the date manually using a **MM/DD/YYYY** format or use the Date icon and select the date from the calendar.



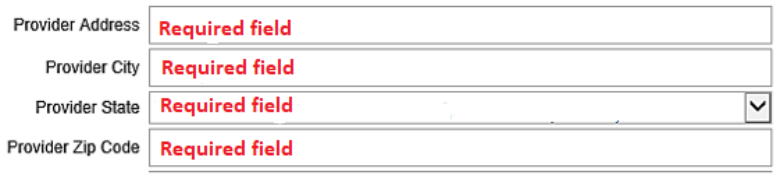
The Claim Service End Date (optional): It is recommended that Providers leave the Claim Service End Date field blank. Providers who choose to enter a Service End Date must make sure the begin date is not later than the end date of service. If the begin date is later than the end date, then documentation may fail to link up to the claim.

Incorrect: The service begin date is after the service end date.



Provider Address Fields:

The Provider Address, city, state and zip code are required fields. Incorrect address information may cause the documentation to not link to the claim.



Transaction Insight Portal - PWK Using the AHCCCS 12 Digit Claim Reference Number(CRN)

The AHCCCS Online Claims Submission (Attachment Tab) Control Number or Claims 837 Submission Loop 2300/PWK06 must be the same data/value entered in the Transaction Insight Payer Claim Control Number or Provider Attachment Control Number.

If you received a letter that states the claim is denied due to missing documentation, please note that a replacement claim is not required if there are no changes to be made to the original claim submission.

If the only action required is to attach the requested documentation to the claim, this step can be completed using the Transaction Insight Portal upload process. In this scenario, providers can use the AHCCCS twelve (12) digit claim reference number assigned to the claim in lieu of creating a PWK number.

Please note the last three digits associated with the CRN are a line number only and not part of the actual 12- digit claim reference number.

Transaction Insight Payer Claim Control Number or Provider Attachment Control Number field.

Example 1. Valid Format Using the CRN: 220400000999

Example 2. Invalid Format Using the CRN and Line number: 212640001234001. If this format is used, the document will not link to the claim and will be denied for missing documentation.

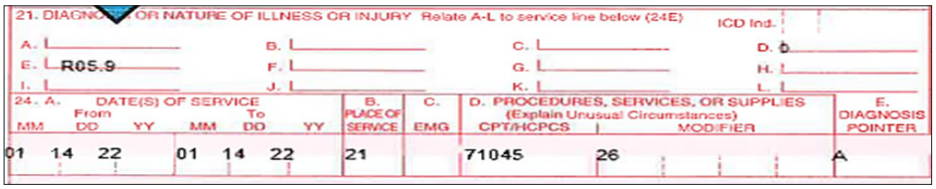
Important Billing Information for Providers - Common Billing Errors on Paper Claim Submissions

AHCCCS has identified an increase in multiple errors on paper claim submissions. If the paper claim submission contains incomplete, invalid information or misaligned data fields, the claim may be returned to the provider.

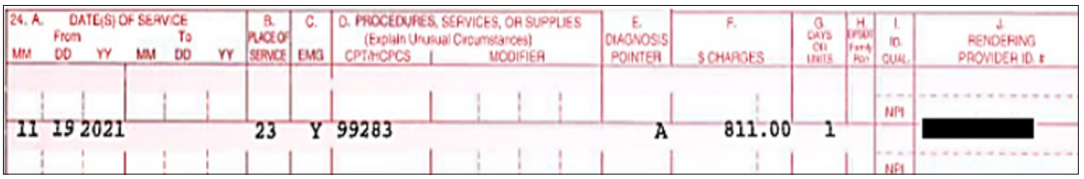
Paper claim submissions must be submitted on the standard Red and White CMS 1500 or UB-04 claim form. Reproductions and copies to include black and white copies of the CMS 1500 and UB-04 claim forms are not accepted. AHCCCS will accept the standard Black and White American Dental Association (ADA) claim form only.

Examples:

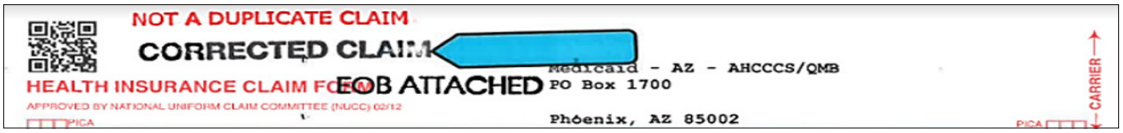
Example 1. Offline/Misaligned Data Fields: In these examples, the data must be aligned within the appropriate block fields. The diagnosis code, ICD-10 Indicator and dates of service are not properly aligned in each field.



Example 2. The submitter must complete the fields in sequence/ order. Skipping line one and entering billing information on line two is incorrect.



Example 3. Labels and stamps on claim forms will not be accepted. The only exception to this is in the signature field, where a stamped signature will be accepted.



When submitting paper claim forms to AHCCCS, the following are the general rules that apply to the CMS-1500 claim forms:

1) The preferred font for claim submission is Lucinda Console and the preferred font size is 10.
2) ICD-10 codes are required on all claim forms.
3) Any behavioral health service billed with a DSM-4 diagnosis code will be denied.
4) The following should not be included on the claim form:
   - White Out paper correction fluid,
   - Correction tape,
   - Labels and stamps except for stamped signatures are allowed.
5) Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system, so should not be used.
6) Handwriting is not permitted on any part of the claim form. The only exception to this is the signature field, where a written signature will be accepted.

Transportation Requests

Transportation requests should not be included in the meals and lodging requests, since doing so will delay the authorization. They need to be submitted separately. Transportation should be arranged as soon as the scheduled appointment has been made. The member and/or the treating facility should arrange transportation with an AHCCCS registered transport provider.

Prior authorization is required for non-emergency transportation more than 100 miles one way or roundtrip. AHCCCS requires a referral with a letter of medical necessity from the referring facility if services are not available or there is a medical reason for the member to receive services beyond the closest facility.

- The referral can be submitted to AHCCCS PA via fax at 602 254-2431.
- The information should be sent using the AHCCCS Fee For Service Prior Authorization Medical Documentation Form.