ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

February 2025

Provider Quick Tip Guide - Submitting A Surgery PA Request

Prior authorization of an AHCCCS covered procedure is the responsibility of the performing provider. Surgeons must obtain a separate and distinct PA from that of the facility. Assistant surgeons and anesthesiologists do not require separate prior authorizations.

Requirements for Surgery PA Request:

- Elective or non-emergency surgery will require a prior authorization,
- Both the primary surgical procedure and any surgical procedure designated in the CPT Manual as a separate procedure;
- Surgeries scheduled more than 72 hours after initial emergency admission of a continuous hospitalization;

Tips for Submitting the Surgery PA Request: On the Event List page the authorized date for the request should be filled in as a single date for the surgery procedure. A surgery PA request ***should not be entered with a date range.***

Correct entry: (Service Begin Date 1/26/2025 - Service End Date 1/26/2025).
Incorrect entry: (Service Begin Date 11/10/2024 - Service End date 12/31/2024).

If the PA has been approved and for some unexpected reason, the surgery has to be rescheduled and the same surgeon will perform the surgery, providers should complete The ***Prior Authorization Correction Form*** to request changes to the existing PA to include CPT codes.

Important Note: If a different surgeon is scheduled, the provider must submit a New PA case under the new surgeon's National Provider Identification (NPI).

Any additional medical documentation, for example, the operative report and discharge summary, should be uploaded with the PA correction form. The form must be completed in its entirety.

Prior Authorization Correction Form
DD-THP Tribal Health Program Authorization Correction Form

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

To upload documents to the new EDI Solutions portal ServiceNow, users will need to have access. If you do not have an account, please follow the instructions outlined in the EDI Portal Provider Signup and Login Guide.

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ServiceDesk@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

Provider Claims Dispute Education: Claims Disputes Cannot Be Filed With An Invalid Claim Number (1/25/2025)

The Office of the General Counsel (OGC) has experienced an increase in dispute requests that cite or refer to a claim reference number (CRN or ICN) that is in a *Void* status.

A void claim is a claim that has been canceled in the AHCCCS processing system based on the actions of the submitter and no longer exists as an active claim.

The AHCCCS Online Provider Portal allows users to log in and view a list of their submitted claims with their current status.

When submitting a valid claims dispute, the submitter is required to specify the accurate claim reference number associated with the *disputed claim.* Should an incorrect or void claim number be referenced; the dispute will be returned to the submitter.

Claim Submission Requirements for Paper Claims

When a paper claim is submitted please ensure that the printed information is aligned correctly within the appropriate section/box on the claim form. If a claim is not aligned correctly, it may cause the Optical Character Recognition (OCR) system to read the data incorrectly and the claim will be rejected.

Providers are required to use the ***Original National Standard Form*** for paper submissions (CMS 1500 and (CMS 1450) printed in red OCR ink. Reproductions and download copies are not accepted and will be returned to the provider.

The ***mandatory font style and size*** for ALL claims submission is **Lucinda Console** and the **Font size is ten (10)**. This must be consistent across all data fields on the claim submission for the OCR to capture the information. AHCCCS Medicaid does not provide claim forms

Date of Service From – To Fields (Mandatory):

The CMS 1500 and ADA 2024 dental claim forms must contain a "From - To" date. Enter the appropriate date of service in month, day, and year sequence *(MMDDYYYY) without the slash* on each service line billed.

The UB-04 claim form must have a begin date on each line of service billed. Information on the claim form needs to be in the exact field and cannot crossover into incorrect fields.

Paper Claim Resubmissions

To submit a correction claim, it is required to clearly indicate that it's a resubmission by using the original or subsequent claim number and specify that it's a replacement claim. Resubmissions must be filed within 12 months of the date of service if the original claim met the six month requirement.

Requirement	CMS 1500	Field 22 - Resubmission Code is required, Code = "7" (Replacement) Include the AHCCCS 12-digit CRN/ICN number to be corrected.
Requirement	UB-04	In field 4, use the Type of Bill with a Frequency Code ending in "XX7" to indicate "replacement claim". In field 64, enter the AHCCCS 12-digit CRN/ICN number to be corrected.
Requirement	Dental	The 2024 ADA form specifically added the "Payer ID" section to provide a dedicated space for claim numbers.

Tips For Checking Claim Status

Providers are encouraged to access AHCCCS Online Provider Portal for real-time claim and prior authorization updates, and information, including eligibility verification, claims status, prior authorization status, and more.

Provider Claim Research Tips

To research a claim denial online, navigate to the "claims" inquiry section, and then filter to view only the claims for the member and date span.

Review Claim Denial Details:

Once you select a claim, the portal should display the reason for the action taken on the claim. This will usually provide details about the reason for the denial, including specific policy codes and explanations for why the claim was not approved.

Identify the Claim Issue:

1. **Exceeded timely filing limit** – This occurs when claims are filed outside the initial 6- months from the date of service period and or if the provider failed to include the original or subsequent claim reference number from the prior claim submission as proof of timely filing.
2. **Prior authorization:** In the event that prior authorization is not obtained prior to the service being performed, a claim may be denied. Mismatch in service details will cause a claim to be denied.
3. **Submitting Unnecessary Prior Authorization requests:** When providers submit prior authorizations for services that do not require a prior authorization creates unnecessary burdens for both the provider and the prior authorization staff.
4. ***Verify patient information:*** Many denial codes for claims sent to the wrong payer will show the name of the health plan responsible for the claim and the member, based on the service date. For instance, "L050.1" indicates that the recipient was enrolled in the Mercy Care Plan for the entire service date, while" L050.3" means the recipient was enrolled in a plan that does not permit payment, like AHCCCS SLMB-Part B Buy-In. The health plan enrollment can be easily verified using the online provider portal.
5. Missing or incorrect information: This may include various elements such as a member identification number, a place of service code, a missing modifier, a provider who was not active on the date of service or the National Provider Identifier (NPI). NPI was approved after receipt of the claim.
6. Frequency of service denials: Service denials can occur for various reasons. For instance, the code "V002.1" means that the service has a lifetime limit of one and has already been paid. Another example is "V004.2," which relates to pricing issues; this may occur when the service dates fall into two different rate periods. In this case, the first date of service is 9/25/2024, and the service ends on 10/5/2024, which marks the beginning of a new fee-for-service rate period (10/1) HCPCS - CPT Procedures Daily Limits

   Provider Denial Resolution Guide (01/23/2025)
   - The Edit Resolution Guide is a tool that was created to help providers understand the denial edits, descriptions, and actionable next steps. New denial edits will be added periodically to the guide. Providers maintain the responsibility to ensure all claims are billed appropriately.
7. **Duplicate Claims** – Claims submitted for a single encounter on the same day by the same provider for the same patient. Before submitting a new claim, check the remittance advice or the online portal for the previously processed claim. Verify the reason the initial claim did not allow payment. Review the actual copy of the claim submission. Providers must submit one claim to include all lines of services for the same date of service. Multiple Claims submitted for CPT services on the same date of service may be denied as duplicate.
8. **Check For Accuracy Of Claim Coding Details:** Verify that all information on the denial notice is correct, including patient details, procedure codes, and dates of service.