

REVISION DATES: 10/1/2018; 10/01/2015

## General Information

All claims submitted to the AHCCCS Administration are extensively edited by the AHCCCS claims system. When a claim fails an edit, an error record is created for that claim. All failed edits related to the claim denial are displayed on the Remittance Advice with an edit number, decimal point, and a single digit that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice.

## Status Checks Online

AHCCCS has a web application that allows AHCCCS registered providers to check the status of claims using the Internet. To create an account and begin using the application, providers must go to the following web address:

<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>

There is no charge for creating an account and there is no transaction charge.

**Note:** When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the **master account holder**. For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration.

Providers can check the status of a claim using the member's AHCCCS ID number and the date of service. The Claim Status page allows providers to view the claim status history, edit history, and accounting summary.

Other services available at AHCCCS Online are:

- Online Claim Submissions
- Checking Online Claim Status
- Member Eligibility and Enrollment Verification
- Newborn Notifications
- Prior Authorization Inquiry
- Prior Authorization Submission
- Provider Information Updates (such as correspondence address updating)

## Understanding Common Billing Errors

A relatively small number of errors account for the vast majority of pended and denied claims. It is important to understand the nature of these errors and the actions to be taken to resolve them. This section presents a summary of common denial or disallowance edits, including the

error number, error message, a brief description of the error, and a brief statement of the action required. This summary is not all-inclusive.

L099 Recipient Eligibility/Enrollment (CMS 1500) and  
H216 Recipient Eligibility/Enrollment (UB-04 claims)

These edits relate to the member's eligibility for the services billed on the CMS 1500 (L099) or the UB-04 (H216) claim forms.

L099.1 Recipient Not Elig/Enrl For Entire DOS; Invalid Eligibility

H216.1 Recipient Not Elig/Enrl For Entire DOS; Invalid Eligibility

A claim has been received for a member who was not AHCCCS eligible on the date(s) of service.

Verify the member's AHCCCS ID number on the Remittance Advice and on the claim that you submitted. If the AHCCCS ID is correct, verify the member's dates of eligibility.

Bill only for services rendered on the dates the member was AHCCCS eligible. The member may have been enrolled in the American Indian Health Program (AIHP) for dates of service billed on the claim. However, enrollment in the American Indian Health Program does not guarantee AHCCCS payment.

The services may need to be split, billing only for the dates the member was AHCCCS eligible. For example, assume that services were from March 28 through April 5. The patient's AHCCCS eligibility began April 1. Only bill AHCCCS for services provided April 1 – 5. If the entire date span is billed (March 28 – April 5), the claim will fail edit L099.1.

Verify the member's AHCCCS ID number and eligibility standing with the AHCCCS Division of Member Services (DMS). See Chapter 2, Eligibility.

H002 Recipient ID Test

H002.3 Recipient ID; Field Is Not On File

The member ID number on the claim is not a valid ID number in the AHCCCS system.

Verify the member's AHCCCS ID number using AHCCCS Online.

Enter the correct member AHCCCS ID on your claim and refile the claim.

L077 Service Provider Status Test (CMS 1500 claims) and  
H200 Service Provider Status Test (UB-04claims)

This edit relates to the service provider's ability to bill for the service indicated on a CMS 1500 claim (L077) or on a UB-04 claim (H200)

- L077.1 Service Provider Status Not Active; Not Authorized to Bill for Service
- H200.1 Service Provider Status Not Active; Not Authorized to Bill for Service

Either the service provider was not enrolled as an active provider with AHCCCS on the date of service, the service provider was not licensed/certified to provide the specific service on the date of service, or the procedure may not be billed by the service provider's provider type. Providers should contact AHCCCS Provider Registration for assistance. (Please see the references section at the bottom of the chapter for contact information.)

#### L078 Billing Provider Status Test (CMS 1500 claims)

This edit relates to the billing provider's ability to bill for the service indicated on a CMS 1500.

- L078.1 Billing Provider Status Not Active; Not Authorized To Bill For Service

The billing provider's AHCCCS ID was terminated prior to or during the claim dates of service.

#### H211 Billing To Service Provider Relationship

This edit relates to the billing provider's ability to bill on behalf of the service provider identified on the claim.

- H211.1 Billing Provider Not Valid Group ID - Invalid Combination Of Codes

The provider submitted a claim with both a service provider ID and a group billing ID. If a group billing ID is present on the claim, the AHCCCS system will check for a provider authorized affiliation.

**For that affiliation to be valid, the provider must have notified Provider Registration in writing that a specific group is authorized to bill for the provider's services.**

Contact Provider Registration to determine if the necessary authorization has been made. If not, Provider Registration will send the provider a form to complete and return. The affiliation may be retroactively established at the provider's request.

#### L016 Category Of Service (CMS 1500)

This edit relates to the provider's ability to perform a service based on AHCCCS policy.

- L016.1 Category of Service - Not Found For Provider

L016.3 Category of Service - Provider Is Not Authorized

For both category of service edits, verify that the correct procedure was billed. If there is no error in the procedure billed on the claim and the provider believes that the service was billed correctly, the provider should contact the AHCCCS Provider Registration.

L076 Timeliness Test (CMS 1500 claims) and the H199 Timeliness Test (UB-04 claims)

L076.4 Claim - Received Past 6 Month Limit

H199.4 Claim - Received Past 6 Month Limit

The initial claim for services was received by AHCCCS more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. For hospital claims, the end date of service is the date of discharge. If the claim was originally submitted within the six-month time frame, resubmit the claim with the CRN of the previously denied claim.

L076.2 Claim Received - Past 12 Month Limit, Deny

H199.2 Claim Received - Past 12 Month Limit, Deny

A resubmission of a denied claim was received by AHCCCS more than 12 months from the end date of service or date of retro-eligibility posting. For hospitals, the end date of service is the date of discharge. Verify the From and Through dates of service entered on your claim.

Note: Refer to the section on “Resubmissions, Replacements, and Voids” in Chapter 4, General Billing Rules, for the AHCCCS required fields. If information is missing (failure to complete specific claim form fields) the resubmission/replacement won’t link to the original claim causing the resubmission/replacement to be denied as a duplicate or for timely filing.

L081 Duplicate Check

L081.2 Duplicate Check Failed; Duplicate Claim

A claim for the same provider, same member, and same date of service has already been billed and paid.

L067 Medicare Crossovers (CMS 1500 claims)

L067.1 Recipient Has Part B; Medicare Must Be Indicated, Is Missing

If an AHCCCS member has Medicare coverage, the provider must bill Medicare first. Medicare will automatically cross the claim over to AHCCCS for payment of coinsurance and deductible.

Please refer to Chapter 7, Medicare/Other Insurance Liability for information on Medicare and other insurance.

### L001 Procedure Code Test

This edit relates to the validity of the procedure code entered on the CMS 1500 claim form. The following further describe the edits related to the procedure code.

- L001.1 Procedure Code - Field Is Missing
- L001.2 Procedure Code - Field Is Invalid Format
- L001.3 Procedure Code - Field Is Not On File

For all of the procedure code edits, verify that the procedure code was entered on the claim, that the code was entered in the correct format, and that the code is a valid five-digit CPT or HCPCS code.

### L032 Recipient Age/Gender Test For Procedure

- L032.1 Procedure Code Is Invalid For Recipient Age and Gender
- L032.2 Procedure Code Is Invalid For Recipient Age
- L032.3 Procedure Code Is Invalid For Recipient Gender

For all of the edits, determine if the correct procedure code was billed for the member. If the procedure code is incorrect, enter the correct code and resubmit the claim. If the procedure code is correct, contact Claims Customer Service and request a review of the age and/or gender limits for the procedure code.

### L060 Procedure Modifier #1

This edit relates to the validity of the first procedure modifier entered on a line of the CMS 1500 claim form. The following further describe the edits related to the procedure modifier.

- L060.1 Procedure Modifier #1 - Field Is Missing
- L060.2 Procedure Modifier #1 - Field Is Invalid Format
- L060.3 Procedure Modifier #1 - Field Is Not On File

For all of the edits, verify that the first procedure modifier was entered on the CMS 1500 claim line, that the modifier was entered in the correct format, and that the modifier is valid for the procedure code billed on that line. To determine if a modifier is

valid, contact the AHCCCS Claims Customer Service Unit. If the modifier is not appropriate for the procedure, providers may request a review.

#### H094 UB-04 Primary Diagnosis

This edit relates to the validity of the diagnosis code entered on the UB-04 claim form. The following further describe the edits related to the diagnosis code.

- H094.1 Primary Diagnosis Code - Field Is Missing
- H094.2 Primary Diagnosis Code - Field Is Invalid Format
- H094.3 Primary Diagnosis Code - Field Is Not On File

For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD diagnosis code and entered correctly on the UB-04 claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

#### L019 Diagnosis Code #1 Test

- L019.1 Diagnosis Code #1 Has Missing Reference Code
- L019.2 Diagnosis Code #1 Has Invalid Reference Code
- L019.3 Diagnosis Code #1 Is Missing
- L019.4 Diagnosis Code #1 Has Invalid Format
- L019.5 Diagnosis Code #1 Is Not On File

For all of the diagnosis edits, determine if the primary diagnosis code is a valid ICD diagnosis code and entered correctly on the CMS 1500 claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

#### L023 Age/Gender Test for Diagnosis Code #1

This edit relates to the validity of the diagnosis code entered on the CMS 1500 claim form as it relates to the member's age and/or gender. The following further describe the edits.

- L023.1 Diagnosis Code #1 - Invalid For Recipient Age and Gender
- L023.2 Diagnosis Code #1 - Invalid For Recipient Age
- L023.3 Diagnosis Code #1 - Invalid For Recipient Gender

For all of the edits, determine if the correct diagnosis code was used for the member. If the diagnosis code is incorrect, enter the correct diagnosis code and resubmit the claim following the instructions in Chapter 4. If the diagnosis is correct, contact Claims

Customer Service and request a review of the age and/or gender limits for the diagnosis code.

As other edits are encountered, providers should contact the AHCCCS Claims Customer Service Unit for assistance.

## References

For additional information on the **PA process** and for contact information for **the Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU)**, which does prior authorization, please visit:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html>

### To outreach Provider Registration:

In Maricopa County: 602-417-7670 and select option 5  
Outside Maricopa County: 1-800-794-6862  
Out-of-State: 1-800-523-0231

### To outreach the Division of Member Services (DMS):

Providers may call the Interactive Voice Response (IVR) within Maricopa County at (602) 417-7200 and all other counties at 1-800-331-5090. There is no charge for this service.

A provider may use their National Provider ID (NPI) to verify a member's eligibility, enrollment via the provider IVR. The provider's IVR allows unlimited verification information by entering demographic information or the member's AHCCCS ID Number, without having to wait in the phone queue.

This allows providers access to the AHCCCS Prepaid Medical Management Information System (PMMIS) for up-to-date eligibility and enrollment. Verification can be made for a single day or for a date range within the two years of the placed phone call.

Providers may also request a faxed copy of eligibility for their records via the IVR.

Provider may also use the AHCCCS Online Portal to verify eligibility and claim information at:



<https://azweb.statedicaid.us/Account/Login.aspx?ReturnUrl=%2f>

## Revision History

Date	Description of changes	Page(s)
10/1/2018	Link to AHCCCS Online was updated (Master Account Holder information added) The following was added to the Status Checks Online section: “Note: When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the <b>master account holder</b> . For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration.” Checking Online Claim Submission and Prior Authorization Submission were both added to the “Other services available at AHCCCS Online” bullet pointed list.	1 1  1 1-7
	The Understanding Common Billing Areas section was comprehensively updated. The edits had more detail added to provide additional clarification for providers. Clarifications were added to the following edits: <ul style="list-style-type: none"> <li>• L099</li> <li>• H216</li> <li>• H002</li> <li>• L077</li> <li>• H200</li> <li>• L078</li> <li>• H211</li> <li>• L016</li> <li>• L076</li> <li>• H199</li> <li>• L081</li> <li>• L067</li> <li>• L001</li> <li>• L032</li> <li>• L060</li> <li>• H094</li> <li>• L019</li> <li>• L023</li> </ul>	
	L067.2 edit removed as it has not been utilized in over 5 years. A References Section with contact information for DFSM’s CMSU (the PA area), Provider Registration, and the Division of Member	4 7



	Services (DMS) was added  Changed "recipient" to member"  Formatting	Throughout (except edits) All
10/01/2015	New format "ICD-9" replaced with "ICD	All