Welcome To Today's Presentation!

We will begin shortly. All lines have been automatically muted.

Before we begin, please make sure your phones and computer microphones are muted. Please do not place your call on hold during today's presentation.

Please use the chat feature for questions or raise your hand.

Thank You.

Behavioral Health Residential Facility (PT B8) Claim Submission Training

DFSM Provider Training
Updated November 21, 2023

AHCCCS
Arizona Health Care Cost Containment System

About This Training

These materials are designed for the AHCCCS Fee-For-Service (FFS) programs, including American Indian Health Program (AIHP), DD-Tribal Health Program (DD THP),Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

This training presentation will cover How to submit a Behavioral Health Residential Facility (BHRF) claim using the AHCCCS Online Provider Portal. The claim form type is the CMS 1500 (Professional)/837P format.

If you have any questions about this training presentation, email: **ProviderTrainingffs@azahcccs.gov**




Welcome to the AHCCCS Online Provider Portal

AHCCCS Online Provider Portal

Submitting claims electronically is the fastest and most efficient way to submit claims to a payer. The AHCCCS Online Provider Portal is a free application offered to registered FFS providers to submit claims directly to the Fee-for-Service (FFS) program.

- Registered providers must have a valid ***Username and Password.***
- Providers must keep your login information safe and secure.
- It is prohibited to share your account information.

AHCCCS Online Provider Portal Functions

The AHCCCS Online Provider Portal is a free website that allows providers to initiate many service functions to include:

Member eligibility verification (Medicare/Third Party Liability (TPL),
Claim Submission and Status,
Prior Authorization Submission and Status,
Electronic Fund Transfer (EFT),
Provider Verification
Behavioral Health Site Assignment
Provider Billing Affiliations
EFT Enrollment,
Provider Verifications, category of services and more.

Helpful Information

Submitting a clean claim is critical to avoid denial errors and delays receiving reimbursement. A clean claim is a claim that has no errors and can be processed without additional information from the provider. The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process and will provide notification when additional information is required for review.

The **AHCCCS Online Provider Portal** provides claim updates in real time. This is a great tool to utilize to stay on top of claims submissions, prior authorizations requests and more; even if the claim was submitted via EDI or a clearing house.

The **Transaction Insight Portal** (275) is another free application that providers can use to attach necessary documentation to the claim submission. ***If you only need to submit additional documents for review, it is not necessary to resubmit the claim.***

AHCCCS Online Provider Portal Quick Guide

Not yet registered? Under **New Account**, click **Register for an AHCCCS Online account** and complete the request form.

https://ao.azahcccs.gov/Account/Register.aspx

URL **Sign In to the AHCCCS Online Portal.**
https://ao.azahcccs.gov/Account/Login.aspx




Getting Started

CMS 1500 Claim *(Professional)* Form Submission

Required Billing Information

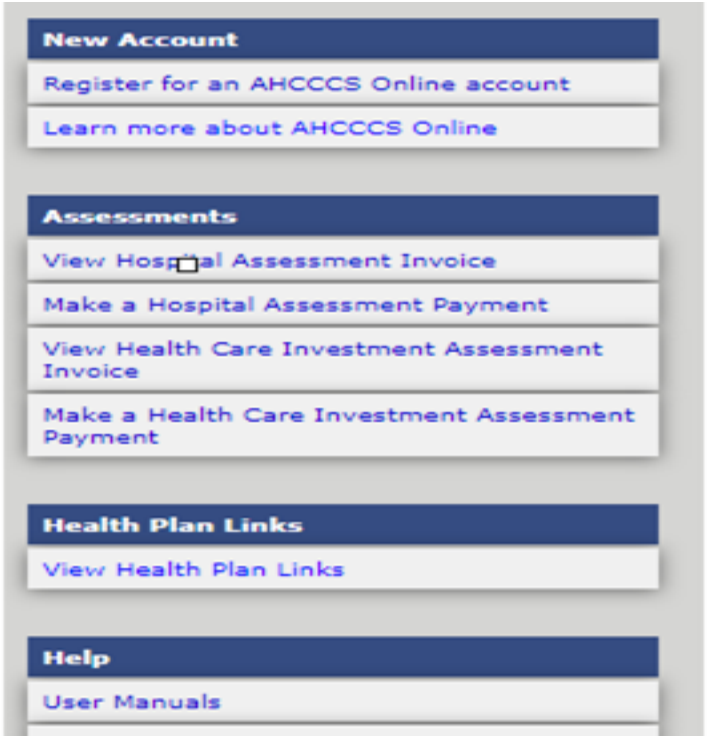
- Verify the member's eligibility and enrollment,
- The prior authorization must be in an approved status before the claim can be submitted for processing,
- Have all the billing information available at the time of submission:
  - Member ID,
  - Date of birth,
  - Date span (cannot exceed 7 days per service line),
  - Billing code H0018 –
  - **Effective 12/1/2023 the new Place of Service Code is 56.**
  - ICD-10 Behavioral health diagnosis code,
  - Total units must match the dates of service billed on the claim,
  - Charge amount (multiple the per diem rate times the number of days billed),
  - National Provider Identification(NPI).

BHRF Per Diem Code (H0018)

- The BHRF per diem code (H0018) is the only code approved for BHRF providers to bill for covered services. The services must be identified in the member's treatment plan and require a prior authorization ***before the member is admitted***.
- H0018 does not include "room and board".

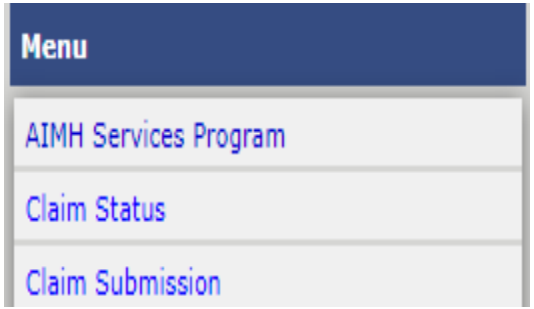
Sign In to the AHCCCS Online Portal.

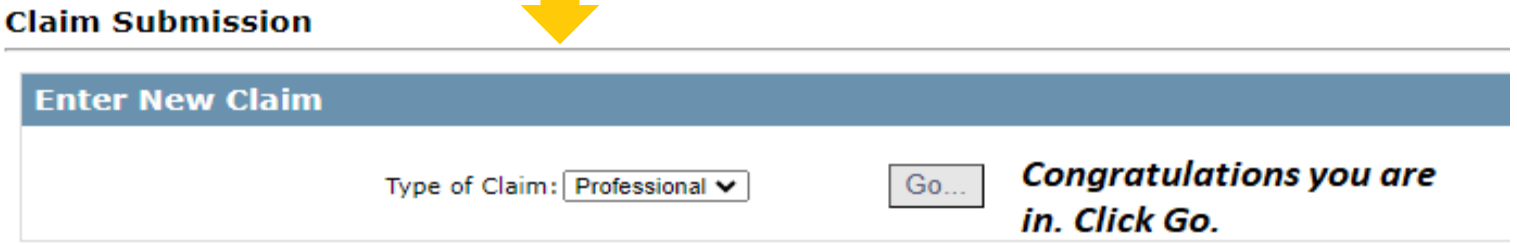
AHCCCS Online Provider Portal



Let’s Submit The Claim

Click Claim Submission

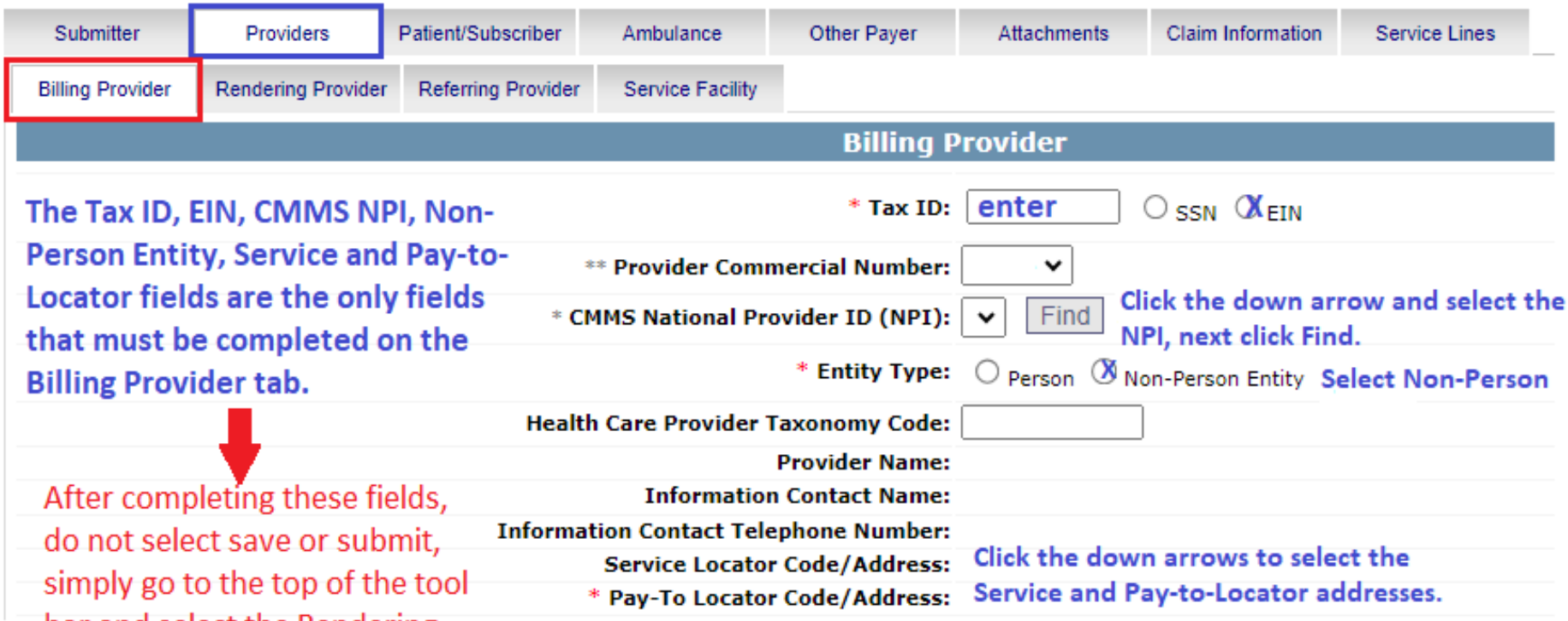




General Notes:

- **Service Line Tab** – Submitters can enter multiple diagnosis codes (Dx). Omit the decimal point (for example F10.34 would be entered as F1034).
- **Diagnosis code pointer** - you will need to check a box for every diagnosis code that is entered (for example, if 2 diagnosis codes are entered, you must check Diagnosis code pointers 1 and 2.
- **Payer Responsibility** - If the member does not have any other insurance, select (P) for Primary. If the member has a primary payer other than AHCCCS, select (S) for secondary payer, etc.
- Providers must include a copy of the primary payer's explanation of benefits with each claim submission *(when applicable).*

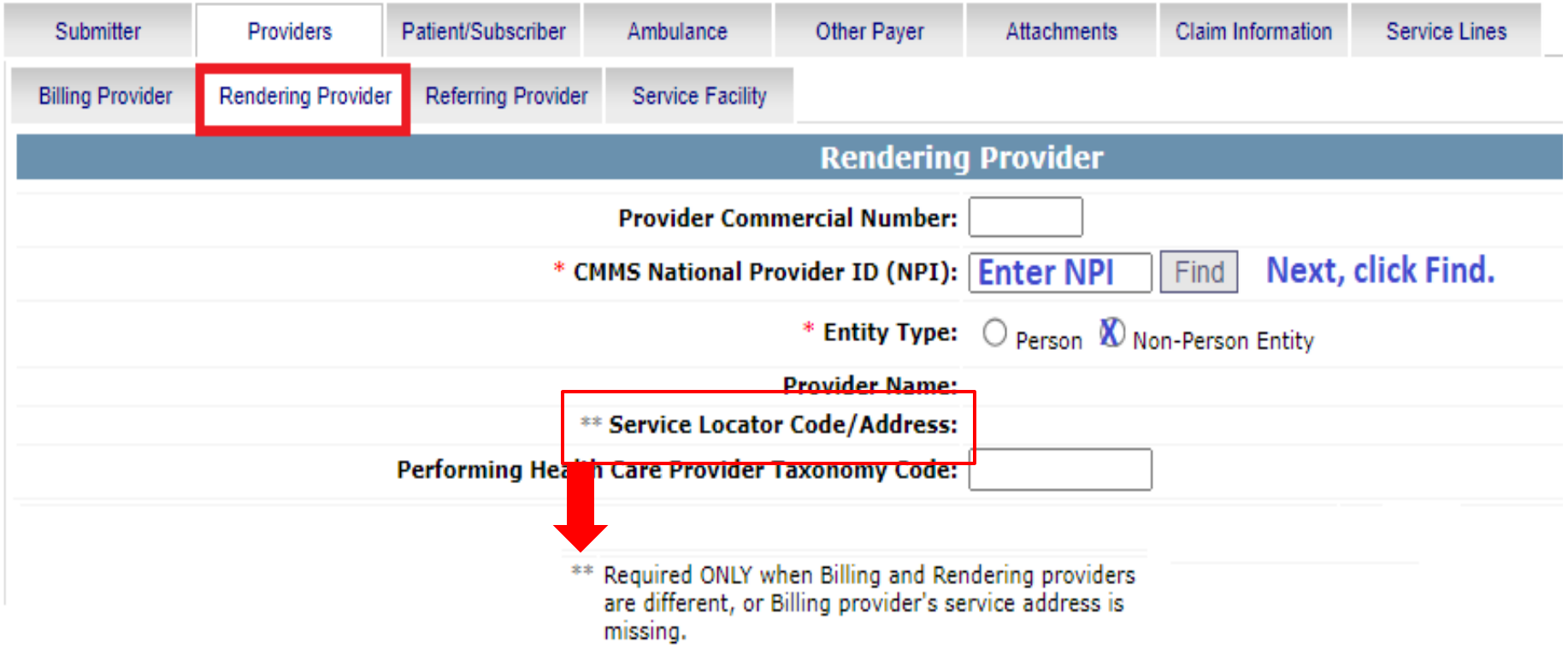
Completing the Billing Provider Tab



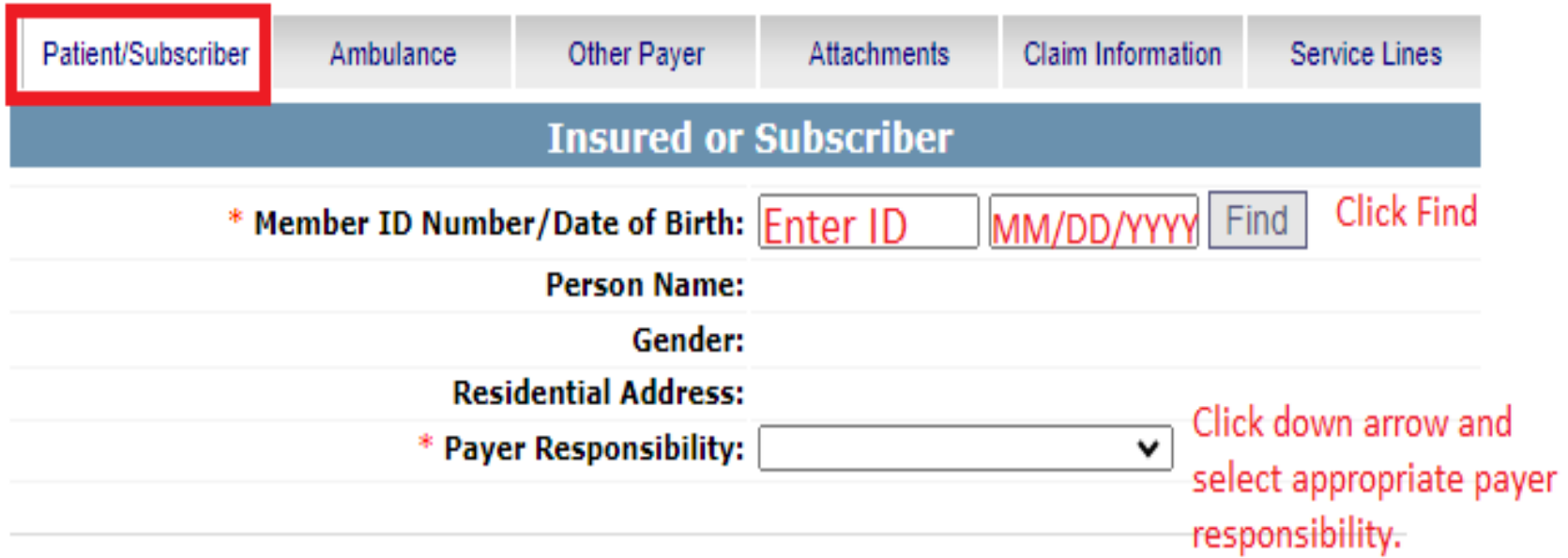
The Tax ID, EIN, CMMS NPI, Non-Person Entity, Service and Pay-to-Locator fields are the only fields that must be completed on the Billing Provider tab.

After completing these fields, do not select save or submit, simply go to the top of the tool bar and select the Rendering Provider Tab.

Completing the Rendering Provider Tab



Completing The Patient Subscriber Tab



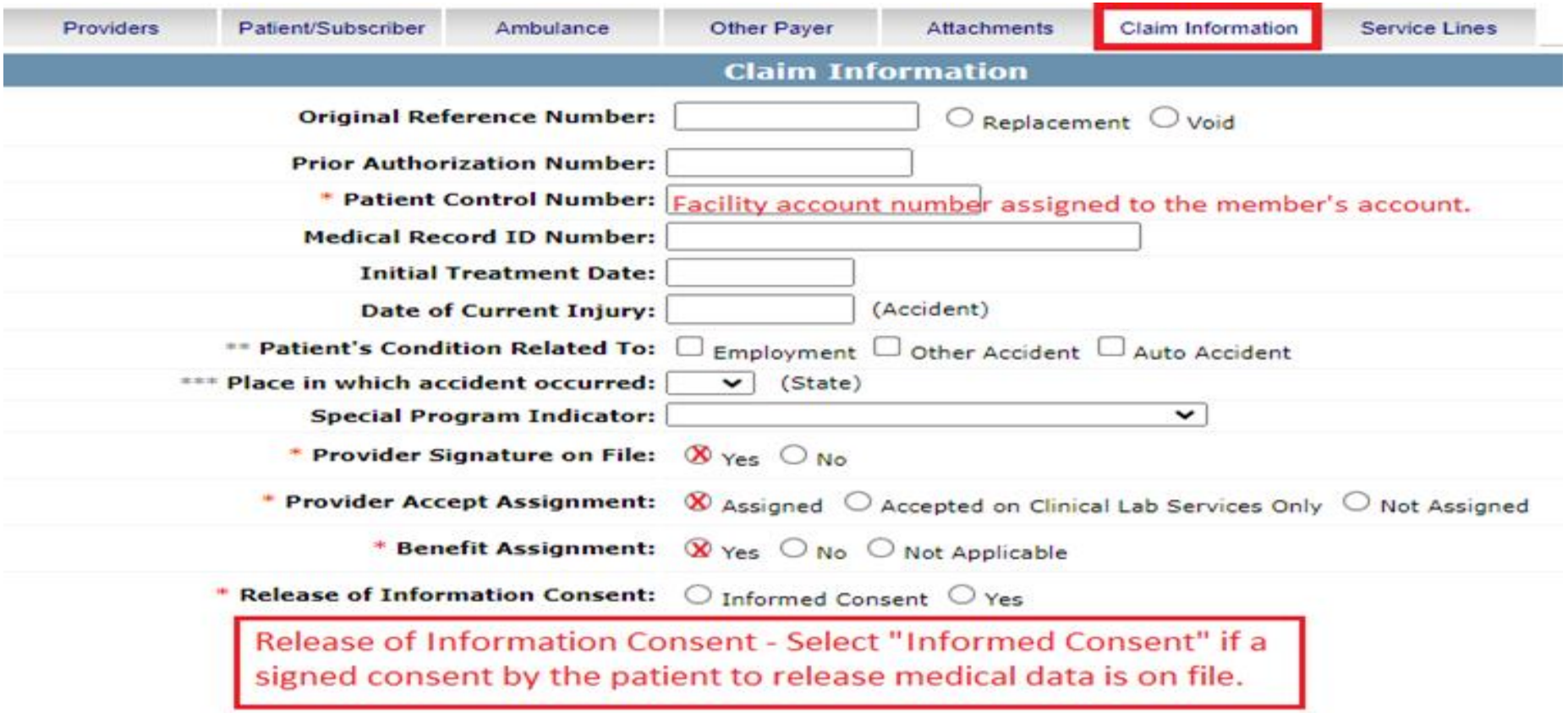
Other Claim Tabs

- BHRF providers will not complete the **Ambulance** and **Other Payer** tabs (skip these tabs).
- The **Attachment tab** is only required if the provider is attaching documentation with the claim for consideration. If no documentation is required, skip this tab.
- For example, if the member has a primary payer other than AHCCCS and you are attaching a copy of the explanation of benefits (EOB) with the claim submission.

Attachments Tab

- **Report Type** – Click the drop down and select **B4** "Referral Form".
- **Report Transmission** – Click the drop down and select **"EL – Electronically Only"**
- **Control Number** – In this column you will create the unique PWK number. The recommended format is the member's **AHCCCS ID** and the **Date of Service with no spacing or special characters**, (**A12345678070120 23**).
- The **"A"** in the AHCCCS ID must be **"capitalized"** on the attachment tab and in the Transaction Insight Portal.

Claim Information Tab



Quick Note - Submitting a Replacement Claim

- When a correction or replacement claim is submitted, the original AHCCCS Claim Reference Number(CRN) must be included on the replacement claim to enable the AHCCCS system to identify the claim that you are replacing.
- This task is completed on the **Claim Information Tab**, enter the CRN in the "Original Reference Number field Claim and select the appropriate action.
- A replacement can be used to adjust a paid or denied claim, and it can also be used to recoup previously paid lines. A replacement will allow individual lines to be recouped, rather than the entire claim to be recouped.
- A void is a straight recoupment of a claim, with the entire claim being recouped, for example, the member has a primary payer that paid the claim in full, or the claim was billed under the incorrect member.

Service Lines Tab

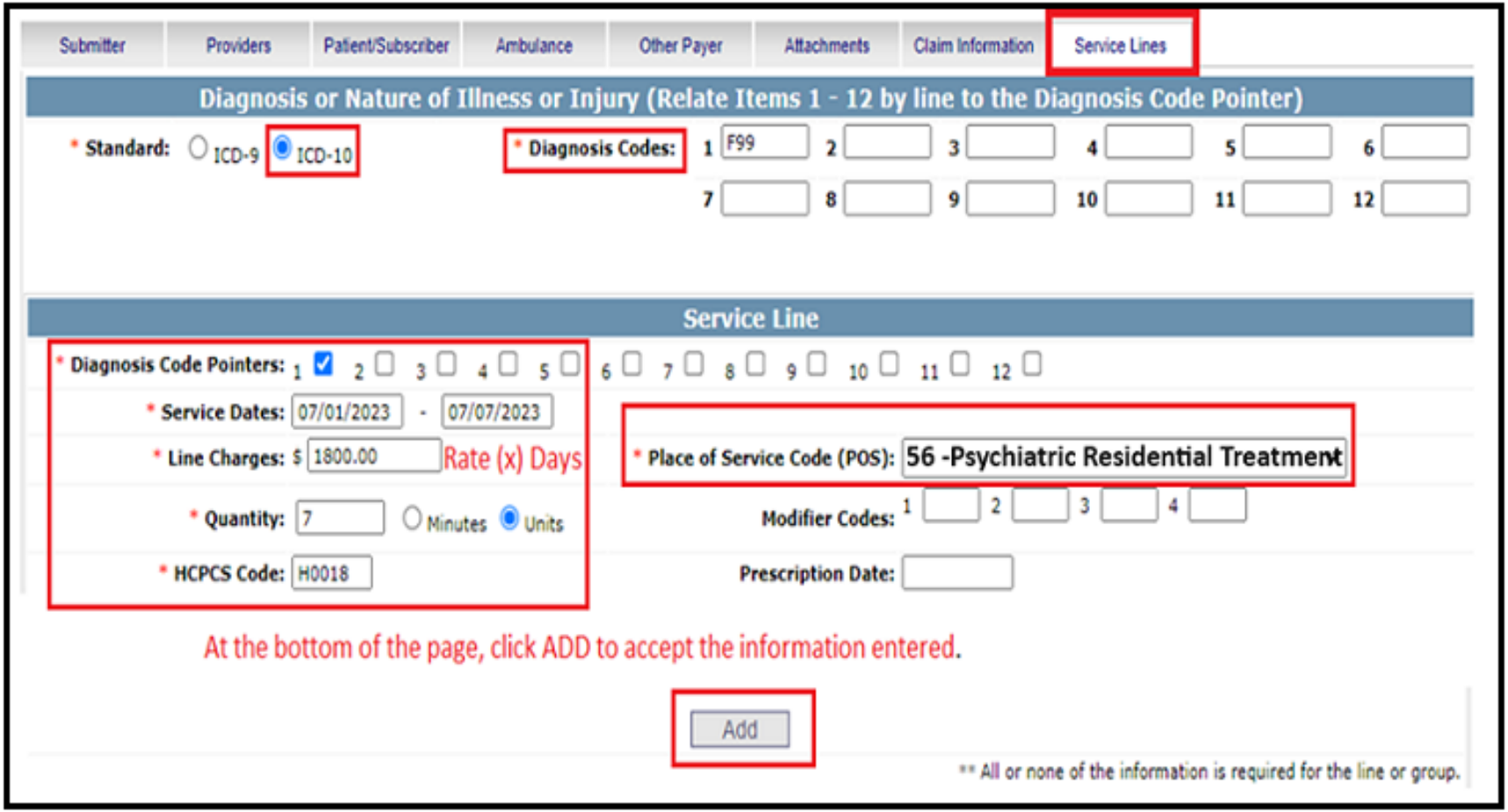
- The PA must be approved before submission of the claim.
- HCPCS Code - H0018
- Place of Service Code – 56 (effective with dates of services 12/1/2023)
- Total Days billed cannot exceed seven (7) days per service line.
- Service dates cannot overlap multiple months.

Examples of correct and incorrect billing date spans

- Correct billing: 7/1/2023 - 7/7/2023 (7 days).
- *Incorrect billing:* 7/1/2023 - 7/22/2023 (22 days).
- *Incorrect billing:* 6/20/2023 - 7/10/2023 (overlap multiple months).

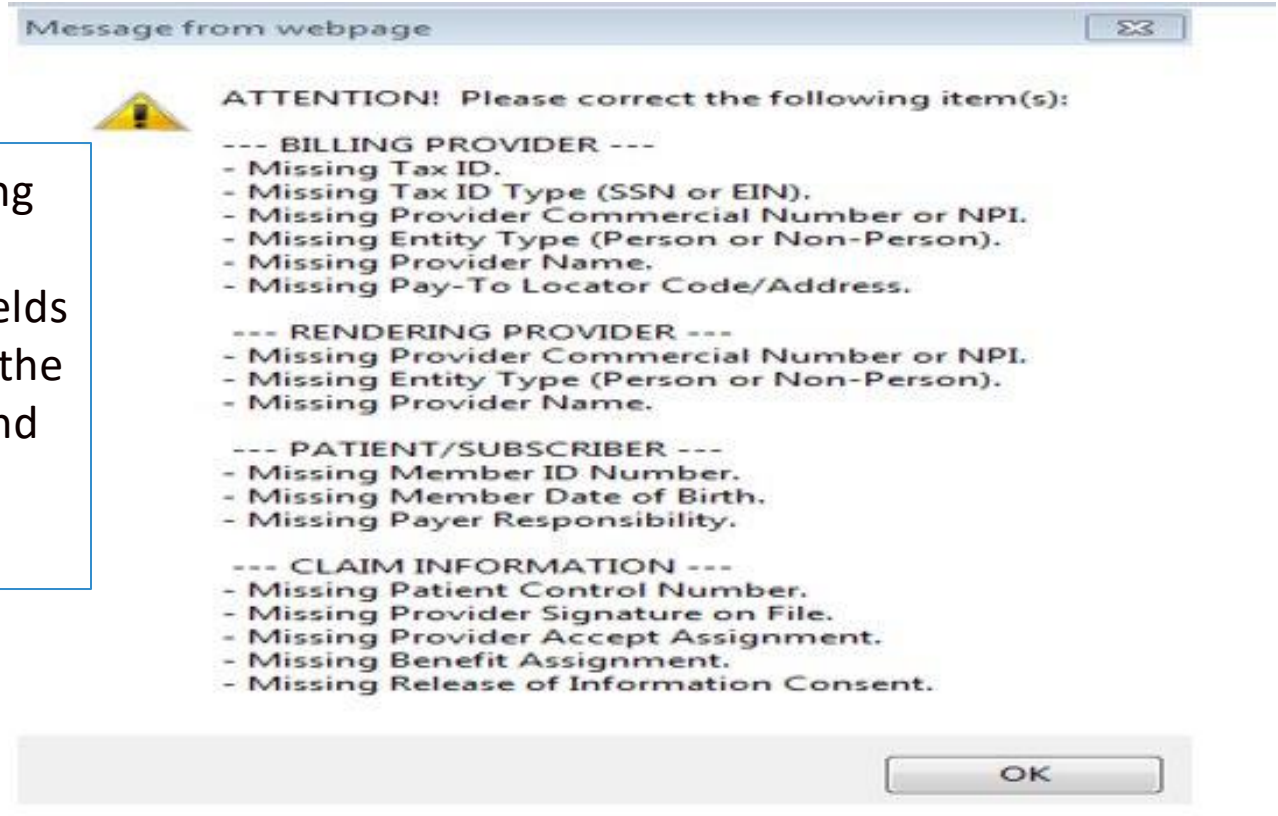
Required Fields Service Lines Tab

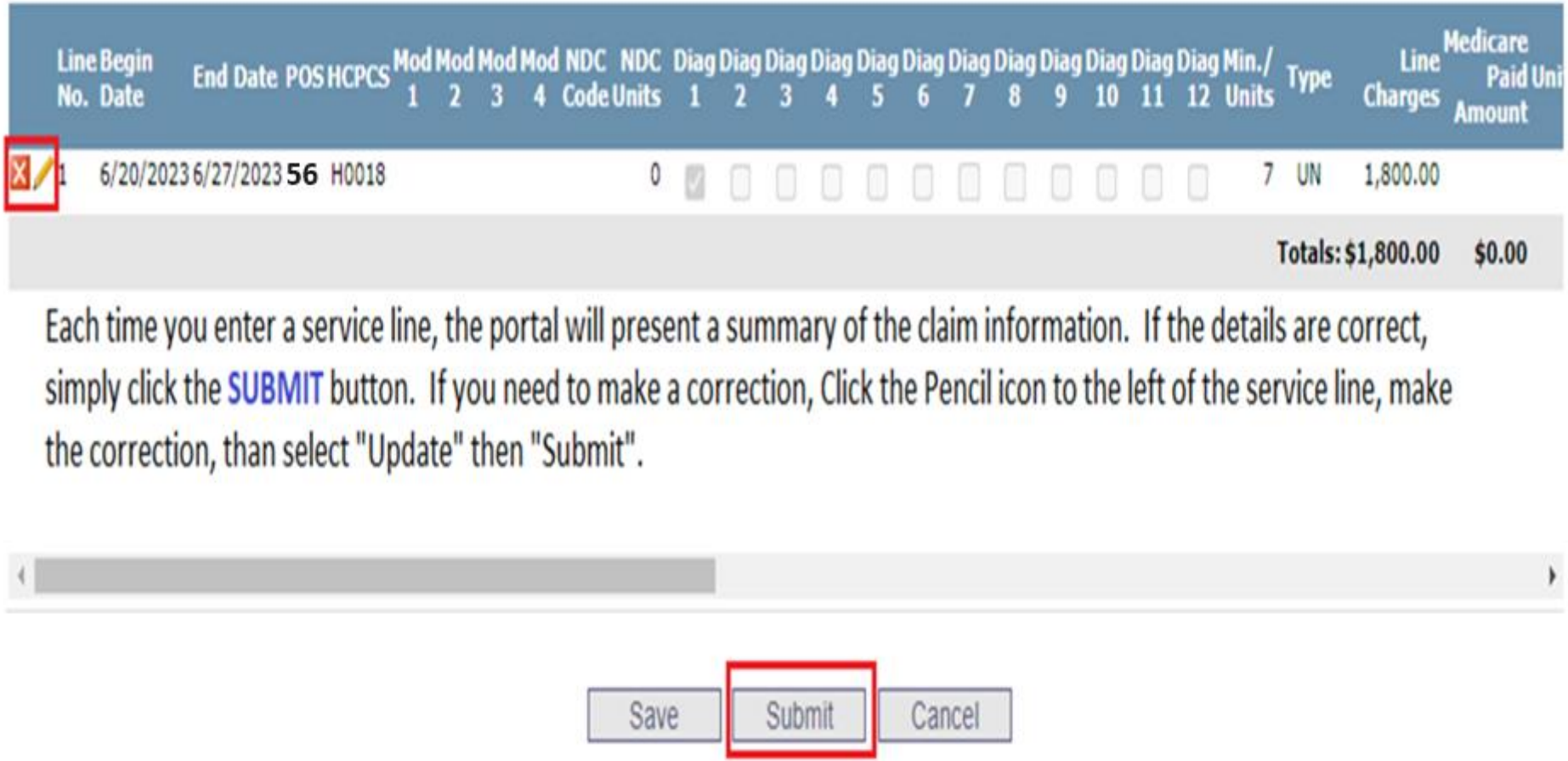
- ICD-10 (button),
- Behavioral health diagnosis code,
- Diagnosis code pointer,
- Service date span,
- Line charges (rate multiplied by the number of days billed),
- Quantity (number of days billed cannot exceed 7 days per service line,
- Units (button),
- HCPCS (H0018),
- Place of service code (56),
- *Note: POS 56 is effective with dates of services beginning 12/1/2023*


Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Diagnosis Codes: 1 F99 2 3 4 5 6
7 8 9 10 11 12
Service Line
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8 9 10 11 12
* Service Dates: 07/01/2023 - 07/07/2023
* Line Charges: $ 1800.00 Rate (x) Days
* Quantity: 7 Minutes Units
* HCPCS Code: H0018
* Place of Service Code (POS): 56 -Psychiatric Residential Treatment
Modifier Codes: 1 2 3 4
Prescription Date:
At the bottom of the page, click ADD to accept the information entered.
Add
** All or none of the information is required for the line or group.

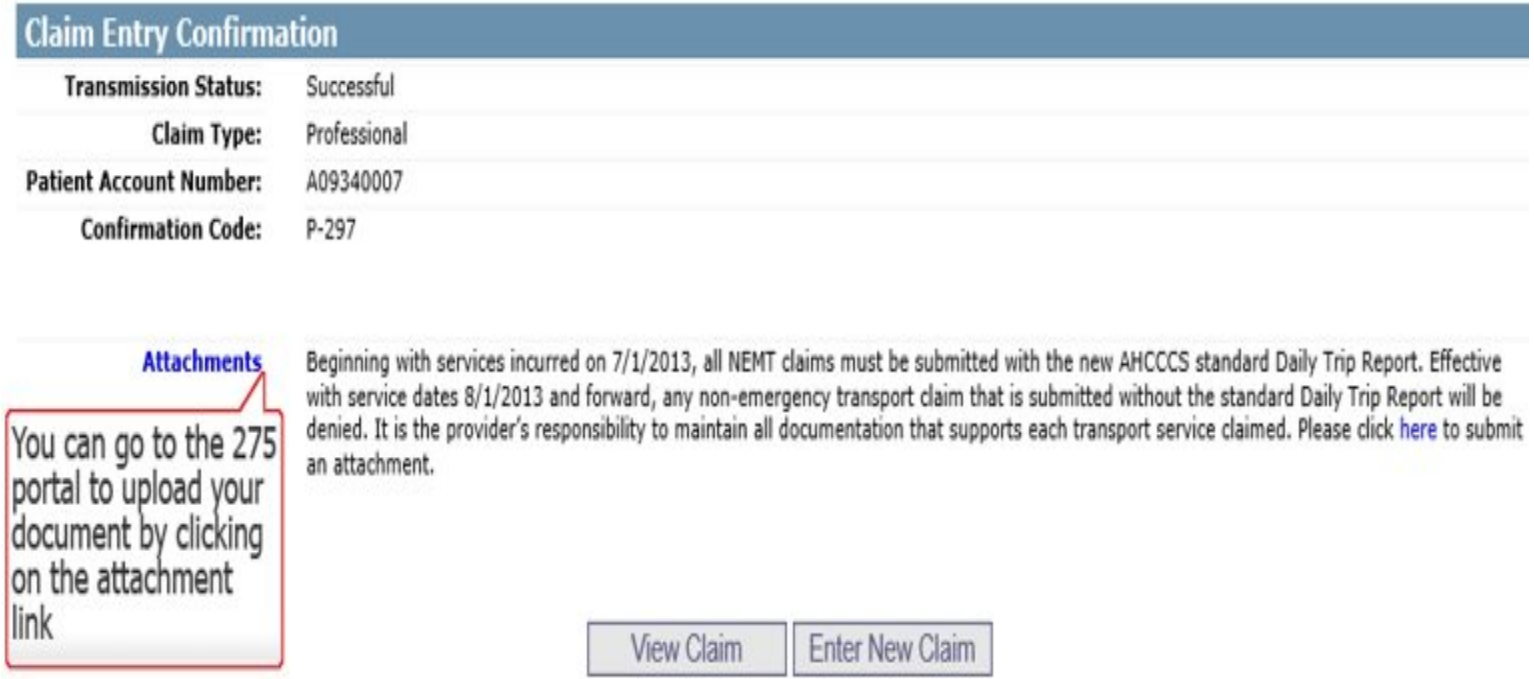
Missing Claim Fields

If a required field is missing information, the Online system will identify the fields that have an error. Make the necessary correction(s) and proceed with the claim submission.




Line No.
Begin Date
End Date
POS
HCPCS
Mod 1
Mod 2
Mod 3
Mod 4
NDC Code
NDC Units
Diag 1
Diag 2
Diag 3
Diag 4
Diag 5
Diag 6
Diag 7
Diag 8
Diag 9
Diag 10
Diag 11
Diag 12
Min./ Units
Type
Line Charges
Medicare Paid Amount
1
6/20/2023
6/27/2023
56
H0018
0
7
UN
1,800.00
Totals: $1,800.00
$0.00
Each time you enter a service line, the portal will present a summary of the claim information. If the details are correct, simply click the SUBMIT button. If you need to make a correction, Click the Pencil icon to the left of the service line, make the correction, than select "Update" then "Submit".
Save
Submit
Cancel

Claim Submission Confirmation Page



Claim Submission Confirmation Page

- **Claim View Tab**
  - select this tab to view the complete details of the current claim submission.
- **Enter New claim Tab**
  - select this tab to enter a new claim.



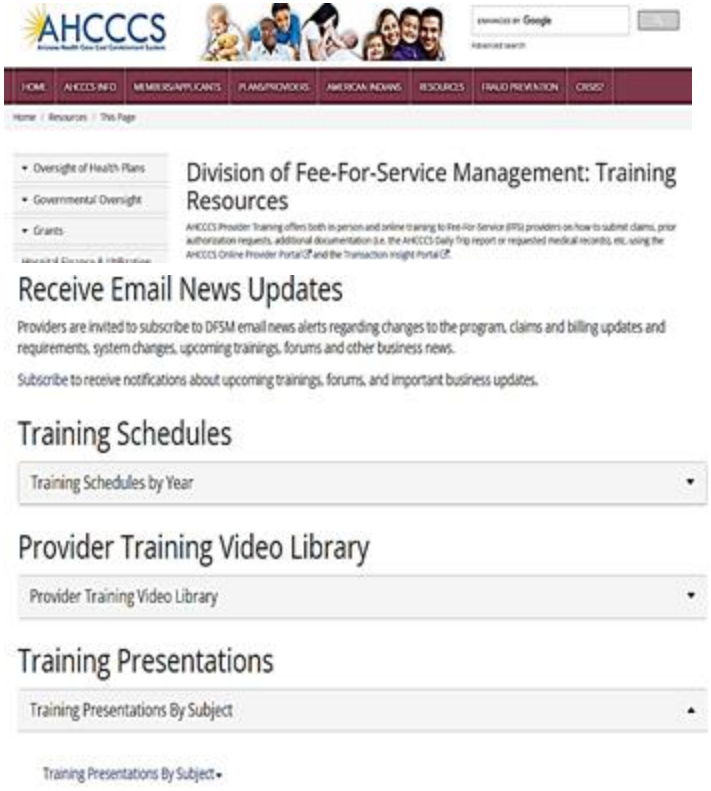
Division of Fee-for-Service Management (DFSM) Provider Education and Training Unit

Provider Education And Training

- The DFSM provider training team offers training webinars and videos on many topics including how to submit and status claims and prior authorization requests, using the AHCCCS Online Provider Portal for the FFS programs including AIHP, TRBHA and Tribal ALTCS.
- The training team also provides training on the Transaction Insight Portal application that is used to submit supporting claims documentation i.e., the AHCCCS Daily Trip report, explanations of benefits, medical records and more.
- We also offer updates to program changes, system updates, and changes to the AHCCCS policies, guides, and manuals.

Provider Education And Training Schedule

- The provider training schedules are posted quarterly. Providers can also view any of the learning materials that are available on the training webpage.
- To attend a live webinar, registration is required. Go to the Training Resources web page, select **Training Schedules, current year and quarter.** Select the training of your choice and complete the registration form and submit.
- All trainings are held via Zoom.
- In addition to offering live webinars, the Provider Education team is available to assist providers with one-on-one training needs.
- Division of Fee-For-Service Management Training Resources



Education And Training Questions

- **Rates** - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- **Coding** - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
- **ACC Plan Claims** - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.
- Note: The Provider Training and the Medical Coding teams cannot advise or instruct providers on how to code or bill for a service. Providers should direct coding questions to your professional coder or biller.

For training requests or questions about this presentation email:
providertrainingffs@azahcccs.gov

Need Help!

If you need assistance with the following:

Questions about warrants, paper EOBs, or EFTs please contact the Division of Business & Finance (DBF) at ahcccswarrantinquiries@azahcccs.gov or call **(602) 417-5500. Hours: 10:00 AM – 4:00 PM Arizona Time.**

To check the status of your EFT, please email the Division of Business & Finance (DBF) at ahcccsfinanceeft@azahcccs.gov

Questions related to electronic transactions or to request an ERA transaction setup email servicedesk@azahcccs.gov or contact **(602) 417-4451. Hours: 7:00 AM – 5:00 PM Arizona Time.**

Providers should use the AHCCCS Online website as the first step in checking the status of the prior authorizations and claims. Our Provider Services representatives are skilled to provide help to many *basic* prior authorization and claims questions. To reach **Provider Services call (602) 417-7670.**

Provider Services Call Center Operation Hours: **Monday-Friday from 7:30 A.M. - 5:00 P.M.**

Providers should not call the Provider Services if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims. Providers should refer to the AHCCCS Website Plans/Providers for more information.

Questions?

Thank You.