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.







AHCCCS Office of the General Counsel (OGC)

Claims Dispute Overview

DFSM Provider Training Team

June 2023

AHCCCS
Arizona Health Care Cost Containment System




Please note these materials are designed for Fee-for-service programs, including American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

AHCCCS Office of the General Counsel Claims Dispute Process

Effective August 16, 2018, the AHCCCS Office of the General Counsel (OGC) implemented an online process for submission of claim disputes.

The claim dispute process however should not be used for claim denials that are a result of:

- Provider billing or coding error;
- Untimely submission of a claim;
- Not submitting the appropriate documents to support the facts of the case;
- Prior authorization that may require a corrective action by the provider (e.g. change in CPT code, date of service, units, etc.).

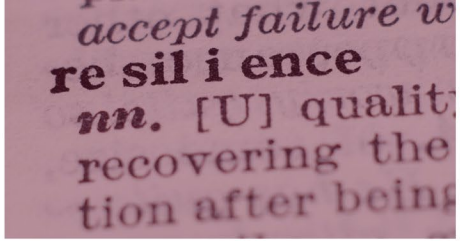
Office of the General Counsel
Claims Dispute Process

A claim dispute must state in detail the factual and legal basis for the claim dispute and the relief requested (i.e. payment, specific claim denial reason(s), quick pay discount, etc.).

The dispute must include any documentation which supports the facts of the case. Claim disputes that lack specificity will be denied.

The claims dispute process cannot be used as a substitute for failure to follow normal claim submission processes.





When NOT to File a Claims Dispute

Office of the General Counsel
Claims Dispute Process

The claims dispute process cannot be used to:

- Submit claims corrections.
- Provide documentation requested by the Prior Authorization unit.
- Provide medical documentation to the Medical Review team.
- File a claim Resubmission or Reconsideration request.

Providers should refer to the AHCCCS Fee-for-Service Provider Billing Manual, Chapter 28 Claims Dispute, and the AHCCCS IHS/Tribal Provider Billing Manual, Chapter 19 Claims Disputes, for additional information regarding the claim dispute process.

When NOT to File a Claim Dispute

Do not file a claim dispute if:

- The Remittance Advice has not been received;
- The claim is still pending in the AHCCCS claims processing system;
- The provider needs to submit additional or requested documentation;
- The provider needs to submit a corrected claim;
- The provider needs to reprocess a claim due to a provider update (i.e. group biller affiliation, tax ID, category of service added, etc.); or
- The provider needs to request a prior authorization or an update to an existing prior authorization.

The claim dispute process is used to resolve disputes regarding post-service payment denials and payment disputes.

It is the provider's responsibility to ensure adherence to timely filing deadlines.

Invalid Appeal / Dispute Requests

Other Invalid Appeal and Dispute reasons include errors such as:

- Service(s) not covered under the member's plan.
- Incorrect CPT/HCPCS code billed for the service.
- Incomplete information for review.
- Wrong Member Identification Number.

Important Note: A corrected claim submission including medical documentation should be submitted to the AHCCCS Claims department for reconsideration.

When NOT to File a Claim Dispute - Remittance Advice Is Not Received

The AHCCCS Fee-for-Service Remittance Advice provides information about claims adjudicated by the AHCCCS Division of Fee For Service Management (DFSM), including claims paid or voided, claims which were denied, and in process and adjusted claims.

The Remittance Advice provides the provider with Denial Reason Codes and Pricing Explanation Codes. It provides the provider information needed to resubmit the claim with corrections, and lets the provider know what caused the claim to deny (if it denied).

It is the provider's responsibility to follow the guidance from the Remittance Advice to correct the claim, when possible.

When NOT to File a Claim Dispute
The Remittance Advice

If the provider received the Remittance Advice from AHCCCS and still believes that a claim was denied inappropriately or paid incorrectly, the provider can contact Provider Services.

- The provider must provide the representative with the following:
  - Provider ID number and/or Provider NPI
  - Member's AHCCCS ID number
  - Date(s) of service in question
  - Claim Reference Number (CRN)
  - Denial reason

NOTE: This process does not extend the claim dispute filing deadlines and it does NOT change timely filing deadlines for claims.

When NOT to File a Claim Dispute - Remittance Advice Not Yet Received

- Claim Denials - The explanation of benefits (EOB) or Remittance Advice details the reason a claim is approved, denied or not adjudicated status.
- The EOB will also provide “remark codes” to provide further detail regarding the denial reason and what additional information may be required for review.

When NOT to File a Claim Dispute
The Claim is Still Pended

If a claim is pending in the AHCCCS claims processing system, a claim dispute will not be investigated ***until the claim is paid or denied.***

Pended claims have neither been approved or denied. The review of a claim must be complete prior to a claim being eligible for dispute. Even then, a provider may be able to make corrections to a claim or a previously approved prior authorization request to ensure payment.

- Note: A delay in processing a claim by the AHCCCS Administration may be cause for OGC to consider a claim dispute on a Pended claim, provided all claim dispute deadlines are met.

When NOT to File a Claim Dispute Additional Documentation is Needed

There are times when the AHCCCS Administration may request additional documentation for the processing of a claim. If this is not received, or if the documentation received is not sufficient to substantiate medical necessity of the service, then the claim may be denied.

The AHCCCS Remittance Advice will provide the Denial Code indicating this. A provider may also determine this by using the AHCCCS Online Provider Portal *or* by calling the Call Center Support.

It is the provider's responsibility to maintain and submit any requested documentation.

When NOT to File a Claim Dispute – Additional Documentation is Needed

If the provider is still within the timely filing deadline, the provider should submit the additional documentation to AHCCCS. (Do not void and replace.)

- If this is done via the Transaction Insight Portal, the documents will automatically link so long as the same PWK number as the claim is used.
- If this is done by mailing the documents in, the process will take longer as the documents will need to be manually linked to the claim. Please note, that when done this way the CRN number of the original claim must be marked on the front page of the medical documentation, or AHCCCS will be unable to link the documentation to the original claim.

When NOT to File a Claim Dispute – Additional Documentation is Needed

Once additional documentation is received, the claim will be re-reviewed by the claims system and AHCCCS, and it will be either approved or denied.

REMINDER: Requests for additional documentation, no documentation having been submitted with the initial claim, or medical documentation that did not initially substantiate medical necessity are not reasons to file a claim dispute.

When NOT to File a Claim Dispute – Claims in Need of Correction

If the provider is still within the timely filing deadline and there is an error on the submitted claim, the provider should follow steps outlined in the Fee-for-Service Provider Billing Manual (for FFS providers) or the IHS/Tribal Provider Billing Manual (for IHS and 638 providers).

- i.e. If the provider ID on a claim is illegible, the claim will deny. The provider will need to void and replace that claim with a legible provider ID.
- i.e. If other errors are made on the claim, claim corrections at times can be submitted, rather than voiding and replacing. See the billing manual for details.

How to Fix: Measures to correct the claim should be taken, as outlined in the Provider Billing Manuals, when possible, prior to submitting a Claim Dispute.

When NOT to File a Claim Dispute – Corrected or Updated Prior Authorization Requests

When there is an active PA on file, the AHCCCS claims system will automatically match the claim information against established PA files and choose the correct one.

However, the information entered on the claim form must ***exactly match*** what has been prior authorized and listed on the PA confirmation letter. If there are any discrepancies the system will not find the appropriate PA and the claim will be denied.

- This can result in denied claims due to no PA on file. This will be reflected on the AHCCCS Remittance Advice.

How to Fix: When this occurs, the provider must submit a PA correction request with supporting documentation, via the AHCCCS Online Provider Portal.

When NOT to File a Claim Dispute – Prior Authorization Questions

Prior Authorizations can be updated on the AHCCCS Online Provider Portal.

- Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

Additionally, Prior Authorization Forms can be found on the DFSM Prior Authorization Forms Web Page at:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

When NOT to File a Claim Dispute – Prior Authorization Questions

For prior authorization questions, please visit the AHCCCS Online Provider Portal or the AHCCCS website at:

- AHCCCS Online Provider Portal:
  - https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/
- DFSM Prior Authorization Web Page:
  - https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html

REMINDER: Providers can check the status of a submitted authorization request online and view messages from PA staff under the Prior Authorization Inquiry link.

When NOT to File a Claim Dispute – Prior Authorization Questions

Providers can check the status of their prior authorization using the AHCCCS Online Provider Portal. Also, comments regarding the status of the PA are available for viewing under the inquiry link.

For questions that cannot be resolved on the portal, please outreach the Provider Services Call Center Phone Line at 602-417-7670.

When NOT to File a Claims Disputes
Claims Questions

Most provider claims questions can be answered on the AHCCCS Online Provider Portal at:

- https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/

On the AHCCCS Online Provider Portal, a provider can:

- Check Member Eligibility
- Submit a Prior Authorization (PA) Request
- Check on the Status of PA Request and View Notes from the Team Reviewing the PA
- Submit a Claim
- Check the Status of a Claim
- Submit Documentation
- And more!

When NOT to File a Claims Disputes
Claims Questions

For claims questions that cannot be resolved on the portal, please outreach Provider Services at:

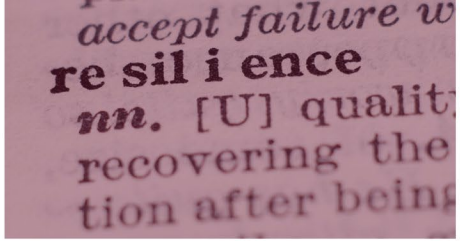
- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

Provider Services can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call 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.





Remittance Advice

How to Avoid a Claims Dispute

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Division of Business Finance

At the end of each financial cycle the Division of Business Finance issues a document called the **Remittance Advice (RA).**

- The RA is also available in electronic format (known as the **835 Transaction**).

The Remittance Advice, or notice of payment, is sent to each provider that had a claim adjudicate during the current week's financial cycle.

The Remittance Advice is separated into individual reports based on the status of the claim.

Each report provides details for claims that are **Approved, Denied, Hold, Void, Un-adjudicated** including **Secondary Payer** claims (Medicare/Other Insurance).

AHCCCS Division of Business Finance

Providers who would like to request a duplicate paper copy of the remittance advice may contact the Division of Business and Finance (DBF) at:

- Metro Phoenix (602, 480, & 623 area codes): 602-417-5500
- Toll Free: 877-500-7010
- Please note that there is a charge for a duplicate remittance advice of $4.00 per page.
- Duplicate paper copies are only available to providers receiving paper remittances, and not to providers receiving electronic 835s.

Providers receiving the electronic 835 remittance, who would like to request a duplicate 835, must contact the help desk at 602- 417-4451 for assistance.

What is the Remittance Advice?

The AHCCCS Fee-for-Service Remittance Advice (RA) provides information about claims adjudicated by the AHCCCS Division of Fee For Service Management (DFSM), including claims paid or voided, claims which were denied, claims that are in process, and adjusted claims.

The Remittance Advice is generated weekly.

- The paper Remittance Advice is mailed to the billing provider.
    - If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each service provider.

What is the Remittance Advice?

The Remittance Advice (RA), including the 835 Transaction, communicates the reason(s) why billed services are paid or denied to the claim submitter.

Both the current paper Remittance Advice (RA) used by AHCCCS and the electronic 835 RA Transaction have many adjudication code values and messages that serve this purpose.

The AHCCCS Remittance Advice will show the payer's claim reference numbers (CRN), EFT/ check number, service codes, description of services, denial reason codes, and remark explanations.

Why is the Remittance Advice Important?

Providers can leverage the information contained within the Remittance Advice/835 Transaction, so they can make corrections to claims, initiate a void or replacement of a claim in a timely manner.

Careful review of the Remittance Advice helps a provider to have successful claims.

Using the Remittance Advice can help a provider avoid having to file a Claims Dispute.

Remittance Advice Training

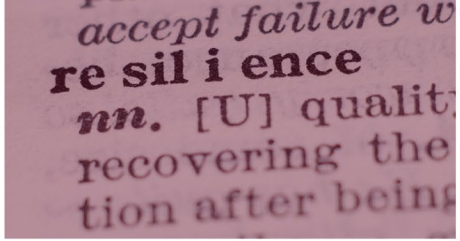
The AHCCCS Division of Fee-for-Service Management (DFSM) offers periodic trainings on how to read the Remittance Advice.

- The quarterly provider training schedule and these trainings are also available 24/7 on the FFS Provider Training Web Page at:
  - https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

The Fee-for-Service Provider Billing Manual also has a chapter dedicated to explaining the Remittance Advice and has exhibits with actual scrubbed copies of Remits for providers to review as examples.

  - https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html





Claims Overpayments

Claims Overpayment

Occasionally there may be an overpayment of a claim.

- A provider must notify AHCCCS of any overpayments to a claim.
- The provider can notify AHCCCS by submitting a replacement claim, which will allow recoupment of the overpayment to occur.

If an adjustment is needed then providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third-party payer.

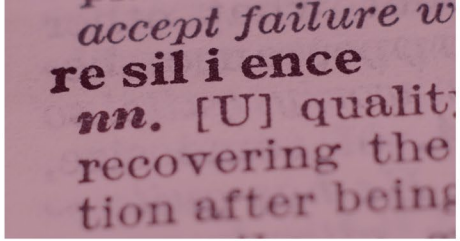
If the entire claim payment is to be recouped, providers may initiate a Void of the claim and no documentation is required.

Claims Overpayment

How does an Overpayment show on the Remittance Advice?

- The claim will appear on the Remittance Advice showing the original allowed amount and the new (adjusted) allowed amount.
- **Do Not** send a check for the overpayment amount. The claim must be adjusted and the overpaid amount will be recouped.





Timely Filing Deadlines

What Is A Clean Claim

As defined by ARS §36-2904 (G)(1) a “clean claim” is:

- A claim that may be processed without obtaining additional information from the provider of service or from a third-party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

FFS Providers: Timely Filing of Claims

The initial claim must be received by AHCCCS within:

- 6 months of the date of service (even if payment from Medicare or Other Insurance Liability has not yet been received); or
- 6 months from the retro-eligibility posting date; or
- 6 months from the date of discharge for an Inpatient hospital claim.

NOTE: The provider has up to **12 months** from the date of service to correctly resubmit the claim with the Medicare/Other Insurance payment Remit/EOB/EOMB, or to correct any errors on the claim. This must occur within 12 months of the date of service, which is the clean claim time frame.

IHS/638 Providers: Timely Filing of Claims

Title XIX Members

The initial claim must be received by AHCCCS within:

- 12 months of the date of service (even if payment from Medicare or Other Insurance Liability has not yet been received); or
- 12 months from the retro-eligibility posting date; or
- 12 months from the date of discharge for an Inpatient hospital claim.

IHS/638 Providers: Timely Filing of Claims

Title XXI (KidsCare) Members

The initial claim must be received by AHCCCS within:

- 6 months of the date of service (even if payment from Medicare or Other Insurance Liability has not yet been received); or
- 6 months from the retro-eligibility posting date; or
- 6 months from the date of discharge for an Inpatient hospital claim.

IHS/638 Providers: Timely Filing of Claims

Clean Claim Time Frame for Title XIX and XXI (KidsCare) Members

- The IHS/638 provider has up to 12 months from the date of service to correctly resubmit a claim for services provided to a Title XIX/XXI member with the Medicare/Other Insurance payment Remit/EOB.
- They have 12 months from the date of service to submit a corrected claim with no errors.
- This all must occur within 12-months of the date of service, which is the clean claim time frame.

Time Limits for Filing a Dispute

To file a dispute, the initial claim **must** have met timely filing for the claim submission.

Time Limits for Filing a Dispute

A provider must initiate any claim dispute challenging the claim denial or adjudication within 12 months from:

- The ending date of service; or
- The date of a member's eligibility posting; or,
- For a hospital inpatient claim, within 12 months from the date of discharge; or
- Within 60 days after the date of the denial of a timely claim submission, whichever is later.

Time Limits for Filing a Dispute

A clarification regarding ***"Within 60 days after the date of the denial of a timely claim submission, whichever is later. "***

- i.e. The Date of Service (DOS) of a claim is 1/1/2020.
- The provider submits the claim on 12/1/2020.
- The provider receives the denial on 12/31/2020.
- The provider then has 60 days ***from*** 12/31/2020 (the date they received the denial) to file their claims dispute, even though that is outside the initial window of the 12 months for a clean claim to be submitted.

Time Limits for Filing a Dispute

The date that a dispute is received by the OGC is considered the date that the claim dispute is filed.

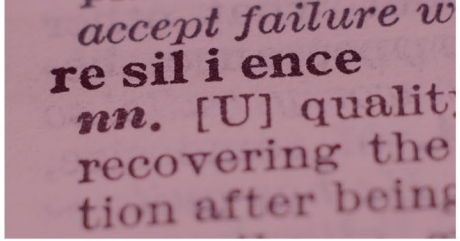
- i.e. A provider mails a dispute on 12/1/2020.

  OGC receives the dispute on 12/4/2020.

  The date 12/4/2020 is considered the date of receipt.

Keeping track of this date is important if a provider is nearing the end of their time limit for filing a dispute. Just because a dispute is post-marked within the time limit, does not mean it will be received within the time limit if it is sent last minute.





Resolving Claims Disputes

Recap - What to do Prior to Submitting a Claims Dispute

- Review the denial reasons listed on the Explanation of Benefits (EOB) and Remittance Advice or view the denials on the AHCCCS Online Provider Portal.
- Make appropriate corrections and resubmit the claim (within timely) to the claims department.
- Provide the requested documentation (take care to use the same PWK number if using the Transaction Insight Portal, or to list the CRN on the documentation submitted if mailing in).
  - EDI submissions reduce delay times.
  - Upload Medical Records (EDI) via the Transaction Insight Portal.
- Ensure the claim is coded correctly.
- Ensure the PA on file, if needed, is correct.

Useful Resources for Claims Disputes and Claim Submission/Corrections

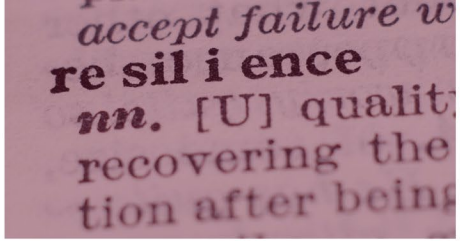
The Fee-for-Service and IHS/Tribal Provider Billing Manuals have individual chapters on Claims Disputes, how to submit individual claim types (professional, institutional, and dental), on reading the Remittance Advice, on correcting common claims errors, and on requirements for individual provider types (i.e. NEMT, FQHCs, etc.):

- Fee-for-Service Provider Billing Manual
- IHS/Tribal Provider Billing Manual

Filing a Claim Dispute

If the provider has exhausted ***all authorized processing procedures*** and still has a disputed claim, the provider has the right to file a claim dispute with the Office of the General Counsel.





Claims for Emergency Services and the Federal Emergency Services Program (FESP)

AHCCCS
Arizona Health Care Cost Containment System

Emergency Medical Treatment & Labor Act (EMTALA)

In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay.

- Citing EMTALA as the reason for the dispute does not override AHCCCS requirements for coverage, medical review or approval of a claim.
- Services that may be deemed “Medically Necessary” may not meet the Federal definition for ‘Emergency” care.

Federal Emergency Service Program

AHCCCS provides emergency health care services through the Federal Emergency Services Program (FESP) for qualified and nonqualified aliens, as specified in 8 USC 1611 et seq., who meet all requirements for Title XIX eligibility, as specified in the State Plan, except for citizenship.

Federal Emergency Services Program Guidelines

In accordance with the Balanced Budget Act, prior authorization cannot be required for emergency services.

Each time emergency services are delivered to a Federal Emergency Service program member, “the Federal criteria for an emergency medical condition must be met in order for the claim to be considered for payment”.

Federal Emergency Service Program Guidelines

Any services billed must meet the federal definition of emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement.

IMPORTANT: Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary but may not meet this definition of emergency for the FES Program.

Emergency Definitions

An "**Emergency medical or behavioral health condition**" for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:"

- Placing the member's health in serious jeopardy (this includes serious harm to self for purposes of behavioral health);
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Serious physical harm to self or another person (for behavioral health conditions).

FES Program Guidelines

Services rendered through the FES program are subject to all exclusions and limitations on services in Arizona Revised Statute R9-22-217.

This includes, but is not limited to, the limitations on inpatient hospital services as described in R9-22-204 and AHCCCS Medical Policy Manual, (AMPM) Chapter 300, Policy 310-K, Hospital Inpatient Services.

FES Program Guidelines

Under the FES program, all emergency services in any setting, are subject to retrospective review, so as to determine if an emergency did exist at the time of service.

If AHCCCS determines that the service did not meet the definition of an emergency medical or behavioral health condition then the following actions may occur:

- Denial or recoupment of payments, and/or
- Feedback and education to the provider, and/or
- Referral for investigation, if there appears to be a pattern of inappropriate billing.

Claims Submission & Documentation Requirements for FES Claims

- FES program members are not enrolled in an AHCCCS Complete Care(ACC) health plan.
- FES members do not have a primary care physician.
- Claims for services are reimbursed by the AHCCCS Administration on a Fee-For-Service basis if services meet the Federal definition of emergency services.
- For professional claims submitted on a CMS 1500 claim form, field 24C must be labeled as Emergency.
- For facility claims submitted on a UB-04 claim form, field 14 should be admit type 1: Emergency.

Claims Submission & Documentation Requirements for FES Claims (continued)

All claims for services provided to members eligible under the FES and FFS program will be reviewed by the AHCCCS Administration on a case-by-case basis.

All claims must be submitted to AHCCCS FFS with documentation that supports the emergent nature of the services provided or AHCCCS must have remote access to the medical records.

The emergency field must be indicated on claim forms for FES claims.

Important Billing Rules for FES Claims

The appropriate emergency indicator and Admission Type code must be included on each claim submission for an FESP/FFS member.

- Claims may not be marked urgent. They must be marked as emergency.

CMS 1500 /837P	**Field 24C (EMG) must be completed with a 'Y' or 'X'.**
UB-04 / 837I	**The Admit Type Field 14 identifies the type of visit. Per AHCCCS guidelines Admit Type "1" identifies the service as an "EMERGENCY' and must be included on the UB-04 for Inpatient and Outpatient services.**

Important Billing Rules for FES Claims

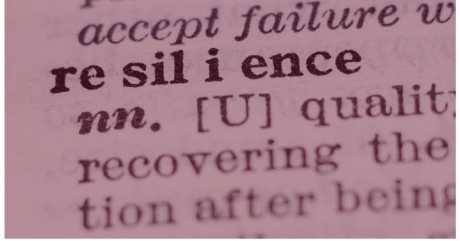
If the data fields on the claim submission are not completed correctly, it will result in a denial of the claim and the biller must submit a corrected claim with the appropriate fields completed for consideration.

- Important: Filing an appeal for an improperly completed claim form is not a valid claim dispute and is not accepted.

Common Edit Denial Reasons for FES Claims

Edit Code	Description	Action
MD034	Emergency Criteria Not Met	Medical review denial. Option to contact CS for reviewer comments.
H140.3	Primary Diagnosis not covered for contract type	Review claim data, make correction if appropriate.
L028.3	Diagnosis not covered for contract type	Review claim data, make correction if appropriate.
L076.4	Claim received past 6 month limit.	Did not meet the time frame for claim submission.
H218.4	Service not covered for ESP recipient must be emergency or PA.	Review the Admit type field. (UB-04)
L101.4	Service not covered for ESP recipient; must be emergency.	Review the EMG Field 24C on the CMS 1500.





Miscellaneous Errors Resulting in Claim Denials

Surgeon and Hospital Prior Authorizations

A common error resulting in claim denials, is that a surgeon must obtain a separate authorization.

- The hospital prior authorization is not sufficient for the surgeon.

Surgeons must obtain a separate and distinct PA from that of the facility for:

- Elective or non-emergency surgery, except voluntary sterilization;
- 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; and
- Organ transplantation not covered by Medicare.

The facility's PA number is separate from the surgeon's PA number and PA requirements may differ for these providers.

- **Note:** Assistant surgeons and anesthesiologists do not require separate PAs.

Blank Referring/Ordering Provider Fields

A common error resulting in claim denials, that is therefore not a cause for a claims dispute, is a blank ordering/referring provider field within a claim.

Another cause for denial of a claim would be a referring/ordering/prescribing/attending provider who is not registered with AHCCCS.

Referring, Ordering, Prescribing and Attending (ROPA) Providers

Per 42 CFR 455.410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) **must require all ordering or referring physicians, or other professionals providing services** under the State plan or under a waiver of the plan, to be enrolled as participating providers.

- This means that referring, ordering, prescribing and attending (ROPA) providers must be AHCCCS-registered providers. Providers must be registered with AHCCCS to ensure payment of items and/or services.

Referring, Ordering, Prescribing and Attending (ROPA) Providers

Even if a provider does not intend to submit claims to Medicaid, providers who are not registered with AHCCCS, but who may be the Referring, Ordering, Prescribing, or Attending **(ROPA)** provider, **may keep members from getting needed health care, *unless they enroll with AHCCCS.***

For additional information on ROPA and 42 CFR 455.410 please visit the AHCCCS website, and review the ROPA flier.

Charges To Members R9-22-702

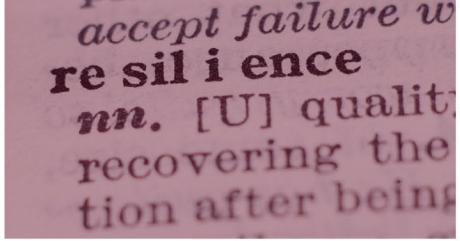
Per Arizona Revised Statute §36-2903.01(K) providers are prohibited from billing AHCCCS members, including QMB Only members, for AHCCCS-covered services.

- Upon oral or written notice from the patient, that the patient believes the claims to be covered by the system [AHCCCS], a provider or non-provider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or non-provider has verified through the Administration that the person has been determined ineligible, has not yet been determined eligible, or was not, at the time services were rendered, eligible or enrolled:

Charges To Members R9-22-702

1. Charge, submit a claim to, and/or demand or otherwise collect payment from a member or person who has been determined eligible, unless specifically authorized by this article or rules adopted pursuant to this article.
2. Refer or report a member or person, who has been determined eligible, to a collection agency or credit reporting agency for the failure of the member or person, who has been determined eligible, to pay charges for system covered care or services, unless specifically authorized by this article or rules adopted pursuant to this article.





DFSM Provider Training Team

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- 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
  - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- 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.

The DFSM Provider Training Team can be reached at 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.