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Edit Denial Resolution Guide Workshop

2-6-2025

Agenda

- Overview of the Edit Denial Resolution Guide
- Submitting Behavioral Health Documentation
- Top 5 behavioral health edit denials
- Top 5 AD edit denials
- Top 5 medical denial (MD) edits

Overview of the Edit Denial Resolution Guide

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What is the Edit Denial Resolution Guide?

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.

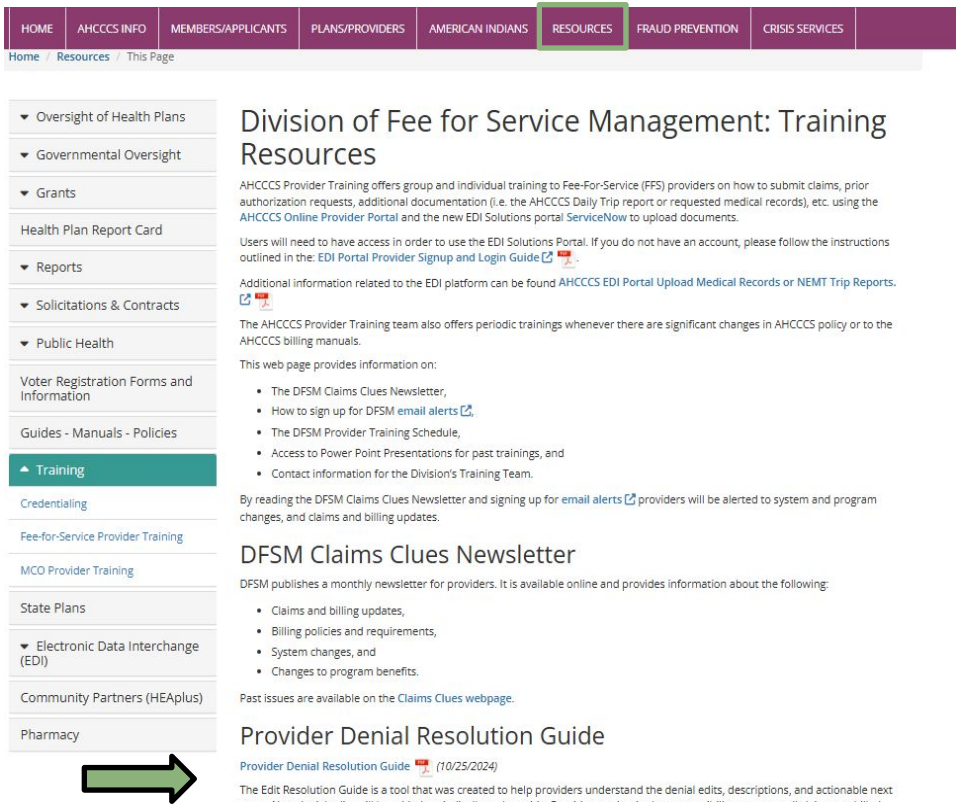
We recommend providers review the claim denial edits in the Edit Resolution Guide ***prior*** to submitting a ticket to the Service Desk.

Where is the Edit Denial Resolution Guide Located?

The Edit Resolution Guide can be found on the DFSM Training Resources webpage and is updated regularly.

To navigate to the DFSM Training Resources webpage:

- Click on the *Resources* tab on the AHCCCS website.
- Select *Fee-for-Service Provider Training* on the right-hand side.



Submitting Behavioral Health Documentation

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The Importance of Submitting Complete Documentation For Review

Accurate and complete medical documentation is the foundation of efficient claims processing.

- Missing or incomplete documentation can result in delays and denials.
- Proper documentation encompasses only the complete written records pertaining to the claim billed with respect to member's care, services and necessity.
- Complete and legible documentation is crucial for accurate claims processing.
- Detailed records support the medical necessity of billed services,
- Documentation facilitates accurate coding of services performed.
- Incomplete claims trigger requests for additional information and delays processing.

EDI Solutions Portal

The EDI Solutions portal ServiceNow is used to upload documents to a claim submission.

Users will need to have access in order to use the EDI Solutions Portal. If you do not have an account, please follow the instructions outlined in the: EDI Portal Provider Signup and Login Guide.

Additional information related to the EDI platform, including how to upload documentation, can be found AHCCCS EDI Portal Upload Medical Records or NEMT Trip Reports.

Top Behavioral Health Edit Denials

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Top Behavioral Health Denials

- AD075-Documentation Does Not Support Services/Charges
- AD281-Invalid Provider Signature AMPM 940 (III)(A)(3); ARS18-106
- H001.X-SERVICE PROVIDER ID TEST - NOT VALID FOR PROVIDER
- H482.1-PARTICIPATING PROVIDER - FIELD IS MISSING
- H482.7-PARTICIPATING PROVIDER - NOT VALID FOR PROVIDER

AD075 Documentation Does Not Support Services/Charges

This edit will present when information in the documentation does not match the claim.

Common Errors:

- Different code listed in document vs. the claim.
    - Example, documentation states services are for Intensive Outpatient Treatment Program (IOP), but non IOP codes are billed on the associated claim.
- Activities on documentation that do not meet the definition of the service code billed.

AD281 Invalid Provider Signature
AMPM 940(III)(A)(3); ARS18-106

Based on the review of the claim, the required Provider signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information.

This may mean that the electronic signature used does not meet the specific requirements or standards per AMPM 940 are not met.

Per ARS 18-106, “An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated.”

Edit Denial Prefix H001. - Service Provider ID

The prefix for edit denial H001. represents several edits including H001.1, H001.5 and H001.7. These edits refer to a provider ID that is missing or invalid.

Examples:

- AHCCCS provider ID may be in an incorrect format,
- Provider ID not active for the date of service.
- Billing information entered in the “service provider” ID field

Recommendation:

Review the claim and check the Edit Resolution guide for additional action steps.

Edit Denial Resolution Guide

H482.1 Participating Provider Field Missing

Providers must review the claim submission to determine if the participating provider was entered correctly in the "Additional Claim Information" (field 19).

Common Errors:

- Incorrect qualifier code was used.
- The participating provider information was not entered on the claim.
- Tax Id or Billing Provider ID was entered as the participating provider in error.

Recommendation: submit a correction/replacement claim.

H482.1 Participating Provider Field Missing (cont.)

The Participating Provider information is required for claims submitted by provider types :

- IC-Integrated Clinic
- 77- Behavioral Health Outpatient Clinic
- 05 - Clinic
- C2 - FQHC

The Participating Provider information would be entered in the Additional Claim Information field on the CMS 1500 with the appropriate qualifier code.

H482.1 Participating Provider Field Missing (cont.)

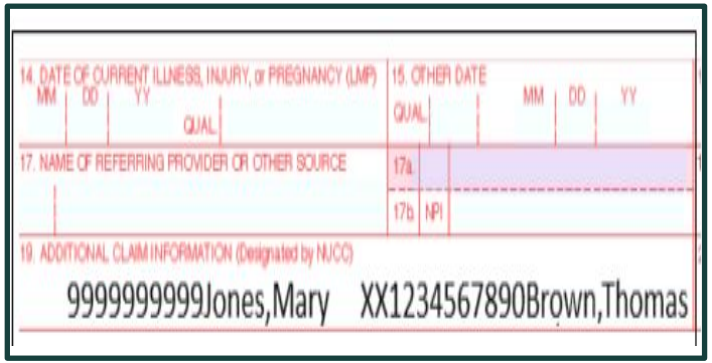
There are two participating provider qualifier codes:

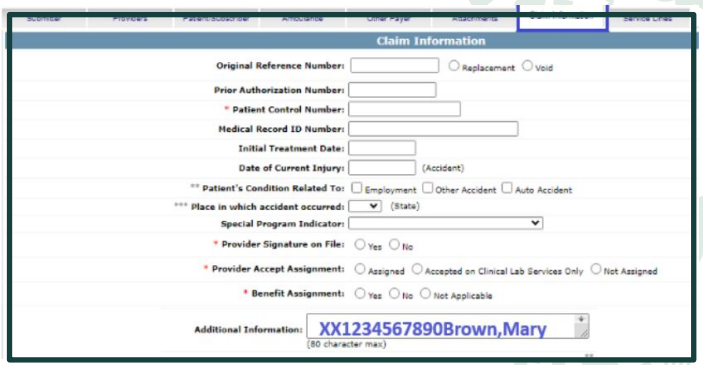
AHCCCS registrable provider type the qualifier code is XX followed by the NPI of the provider with the last and first name.	For a **Non-registrable provider type** the qualifier code (10 digits) is all nines with the last and first name of the participating provider.
Example:	**Example:**
XX1234567890Smith, Tom	**9999999999Smith, Tom**

A list of current Provider Types (PTs) and the regulatory agencies overseeing them are listed in the Provider Enrollment Screening glossary, available at: https://www.azahcccs.gov/PlansProviders/Downloads/apep/PEP903.xlsx.

H482.1 Participating Provider Field Missing (cont.)

The Participating Provider information of the practitioner who rendered the service, would be entered in the Additional Information field.





Up to two practitioners may be listed as the participating provider. If listing two practitioners, ensure to enter three blank spaces before entering the second practitioner.

H482.7 Participating Provider Not Valid for Provider

This edit will present when the participating provider reporting information was entered incorrectly or is in an invalid format.

Examples:

1. The participating provider information was not entered.

2. Erroneous entry - NTE:XX1234567890, NTE should not be added to field 19 (invalid format).

3. The qualifier code XX and NPI was entered but the provider is not registered with AHCCCS.

H482.7 Participating Provider Not Valid for Provider (cont.)

This edit will present when the participating provider reporting information was entered incorrectly or is in an invalid format.

Examples continued:

4. The XX qualifier code was entered for a non-registrable provider type with (9999999999).

5. The group NPI was entered incorrectly as the participating provider.

Recommendation:

Review the claim and resubmit a replacement/correction claim within the timely filing time-frame.

Participating Provider Resources

- FFS Provider Billing Manual, Chapter 10, Exhibit 10-1, Participating Provider
- Participating Provider Training
- Quick Guide: How to Complete the Participating Provider Reporting Requirements
- AMPM 610-AHCCCS Provider Qualifications
- Provider Enrollment Screening Glossary

Top 5 AD Edit Denials

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Top 5 AD Edit Denials

- AD075-Documentation Does Not Support Services/Charges
- AD281-Invalid Provider Signature AMPM 940(III)(A)(3); ARS18-106
- AD282-Missing Provider Signature
- AD283-Invalid Member ID Information AMPM 940(III)(A)(1)(B)
- AD364-No Records Submitted with Claim

Reminder: AD075 Documentation Does Not Support Services/Charges

This edit will present when information in the documentation does not match the claim.

Recommendations:

- Check the claim details to ensure that services outlined in the documentation match the code that is being billed.
- The number of units and any modifiers must also match the claim and documentation.

Reminder: AD281 Invalid Provider Signature AMPM 940(III)(A)(3); ARS18-106

Based on the review of the claim, the required provider signature requirements have not been met.

Providers should review signature requirements outlined in ARS 18-106 and the in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information.

Provider signatures must also include:

- Signature of staff that provided the service,
- Staff member's credentials (title, degrees, and/or licenses),
- Date and time document was signed.

AD282 Missing Provider Signature

This edit is a manual claim denial. Based on the review of the claim, the required provider signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information.

The submitter must secure the correct signature, resubmit the appropriate documentation.

Providers should implement a process of checking this information prior to the billing process to include training for staff on the importance of provider signatures in the claim process.

AD283 Invalid Member ID Information AMPM 940(III)(A)(1)(B)

Based on the review of the claim, the required member signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information. Unable to verify if the signature meets the state law Arizona Revised Statute 18-106.

Per ARS 18-106, “An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated.”

Recommendation:

The submitter must obtain an electronic signature that meets all necessary criteria.

AD364 No Records Submitted with Claim

This Is a manual claim denial edit and indicates that no documentation was received with the claim submission.

The provider **should not** resubmit the claim if there are no changes in coding or charges.

The documentation can be uploaded via EDI Solutions portal.

The AHCCCS 12-digit CRN/ICN number would be used for denied claims as the attachment/linking control number.

AD364 No Records Submitted with Claim (cont.)

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Required Documentation for Behavioral Health

Documentation must support services that are billed. The minimum types of supportive documentation that are required to be submitted for each billed claim include:

- **Comprehensive assessment:** The member's most recent comprehensive behavioral health assessment,
- **Treatment care plan:** The treatment plan for the services billed,
- **Consent to treat form:** A signed copy of the member's consent to treatment for the services billed, and
- **Records/documentation:** Medical record documentation for each claim line billed on the service date(s).

Top 5 Medical Documentation Edit Denials

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Top 5 Medical Documentation Edit Denials

- MD038-Charges/Services Do Not Match Documentation
- MD310-Documentation Incomplete
- MD317-Not Conforming To AMPM 310-B General Requirements
- MD324-Treatment Plan Does Not Contain Measurable Goal
- MD326-Assessment Does Not Support Need for Services

MD038-Charges/Services Do Not Match Documentation

This edit would present when the code and/or the number of units billed do not match the submitted documentation.

The Payment Error Rate Measurement (PERM) Audit is designed to measure improper payments in the Medicaid and CHIP programs.

It is the provider's responsibility to make sure that all claims are billed appropriately and accurately prior to submission for reimbursement.

Recommendation: Providers should conduct an internal audit of their documentation before submission to AHCCCS.

MD310-Documentation Incomplete

This edit is a medical review denial in which the documentation provided is incomplete and a claim payment decision cannot be made.

Examples:

- One of the required documents is missing (i.e., Assessment, Treatment Plan Consent to Treatment, progress Notes, etc.)
- Only one page out of multiple pages (i.e., Treatment Plan, etc.) are submitted.

MD310-Documentation Incomplete (cont.)

Action Steps:

1. Prior to resubmitting the documentation, make sure the docs are complete and legible and support the service provided.

2. **Do not** resubmit the claim if there are no changes to the coding details.

3. The documentation can be uploaded via the EDI Solutions portal.

4. The AHCCCS 12-digit claim number is used as the attachment/linking control number .

MD317-Not Conforming To AMPM 310-B General Requirements

AMPM 310-B describes Title XIX XXI behavioral health service benefits. This policy includes information on, but not limited to, the following general requirements:

- ICD diagnosis codes
- Service treatment and planning
- Emergency Behavioral Health Services
- Clinical oversight and supervision
- Referrals
- Provider Travel
- And more.

Recommendation: Providers should review their claim and documentation details to verify if they conform to the AMPM 310-B.

MD324-Treatment Plan Does Not Contain Measurable Goal

Treatment/Service planning shall:

- Encompass a description of all covered health services that are deemed as medically necessary and based on member voice and choice.
- A complete, written description of all covered health services and other informal supports, that may include individualized goals, family support services, peer and recovery support, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

MD324-Treatment Plan Does Not Contain Measurable Goal (cont.)

Treatment/Service planning shall:

- The service plan shall be developed and administered by the primary outpatient provider, FFS provider, or the ALTCS case manager, that includes all treatment plans developed by other providers involved in the member's care, and additional relevant documents from other service providers or entities involved in the member's care (e.g., education, probation).

MD324-Treatment Plan Does Not Contain Measurable Goal (cont.)

1. The service and/or treatment plan shall be based on a current assessment and/or specific treatment need (e.g., out of home services, specialized behavioral health treatment for substance use, trauma).

2. All services shall have identified goals that are measurable, including frequency, duration, and method for indicating member's definition of goal achievement.

3. The service or treatment plan shall identify the services and support to be provided, according to the covered, medically necessary services specified in AMPM Policy 310-B.

MD324-Treatment Plan Does Not Contain Measurable Goal (cont.)

4. The Contractor shall require subcontractors and providers to make available and offer the option of having a Credentialed Family Support Partner and/or Peer-and-Recovery Support Specialists to provide covered services when appropriate, as well as for the purpose of navigating members to treatment or increasing participation and retention in treatment and recovery support services.

Additional information for service and treatment planning can be found in the

AMPM 320-0 Behavioral Health Assessments and Treatment Service Planning.

Note: If a frequency of services are not listed in the Treatment plan, claims may deny with edit **MD341: SRVCS REND'D Don't Match FREQ In TX Plan per AMPM 320-0.**

MD326-Assessment Does Not Support Need for Services

This edit will present when the behavioral health assessment indicates that the individual's needs are not aligned with the specific services being considered.

Behavioral health services must be:

- Medically necessary.
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the member’s needs.
- Documented in the service plan.
- Furnished in a manner not primarily intended for the convenience of the member, the member’s caretaker, or the provider.

Resources

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Resources

Denial Edit Resolution Guide

AHCCCS Covered Behavioral Health Services Guide (CBHSG)

FFS Provider Billing Manual, Chapter 19, Behavioral Health Services

IHS/Tribal Provider Billing Manual, Chapter 12, Behavioral Health Services

AMPM 310-B Title XIX XXI Behavioral Health Service Benefit

AMPM 320-O Behavioral Health Assessments and Treatment Service Planning

AMPM 940 Medical Records and Communication of Clinical Information

DFSM Training Resources webpage