AHCCCS
Arizona Health Care Cost Containment System

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CLAIMS CLUES

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Provider Records Retention Requirements

The AHCCCS Provider Participation Agreement (PPA) section B. General Terms and Conditions item 5 advises that: "all books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider."

The PPA continues in item 6 "The Provider shall preserve and make available the records … for a period of six (6) years from the date of payment, … for a period of six (6) years from the date of termination…"

If a provider cannot produce the records to support the services as billed then the claim will be denied as unsubstantiated and paid monies will be recouped.

Provider "Going Out of Business" Process

The AHCCCS Provider Participation Agreement (PPA) section B. General Terms and Conditions item 31 advises that the Provider may voluntarily terminate the PPA upon a thirty (30) day written notice. Item 33 states that "the Provider must assist in providing for the orderly transition of care for members …". Provider must retain records for a period of six (6) years from the date of termination. (see above article)

Claims Customer Service Tips – Using AHCCCS Online

Every AHCCCS provider has free online tools and resources available 24/7/365 to simplify business practices and administrative processes.

Electronic claim submission (EDI) claim status can be viewed online. Note that EDI claims that fail to meet the completion requirements are not considered received claims and are rejected or returned to the provider or the provider's clearinghouse with the rejection reason(s). If an EDI claim is not showing as received, check with your clearing house for the error report.

Payment details for claims in approved status can be obtained by reviewing the remittance advice or online via the AHCCCS web portal.

Payment details for reimbursement checks including assigned EFT/Paper Check Number and Pay Check Dates are also available on the web portal, on the Claim Summary tab “OTH CLAIM INFO”.

Denial reason codes and descriptions on claims can be obtained by selecting the tab “Claim Status”, then enter the recipient ID# and date of service, then select the tab “Accounting Summary”, then select tab “OTH CLAIM INFO”. The denial edit and description will appear as well as the denial date.

Inpatient Outlier Review Process

AHCCCS reimburses in-state, non-IHS/638 hospitals for inpatient claims with extraordinary cost per day as outliers. A claim is defined as an outlier if the covered costs per day exceed the statewide average cost thresholds.

Every outlier claim requires medical review of records to verify charges. An itemized statement is required to determine which charges must be verified by medical records.

If the itemized statement and/or appropriate medical records are not included with the inpatient claim submission, the claim will be denied with a code requesting the needed documentation. The following charges must be supported by the medical records:

- Medications
- Operating room and anesthesia times (operative report and anesthesia records)
- All other minor procedures report
- High dollar radiology
- High dollar medical supplies
- Echocardiogram
- Cardiac Cath records
- Ventilator days
- Nitric Oxide days
- Dialysis records and CRRT
- Blood administration records
- PACU in/out times
- Perfusion
- Cardiac arrest reports
- If Observation Days are billed then physician orders must be verified
- Emergency Room records

Charges unsubstantiated by medical records are non-covered and are not considered when determining if the costs per day exceed the statewide average cost thresholds.

Refer to the FFS Provider Manual, Chapter 11 Hospital Addendum – APR/DRG.