

Revision Dates: 11/30/21; 7/10/2018; 4/13/2018; 3/28/2018; 2/9/2018; 1/12/2018; 09/14/2016; 05/24/2016; 03/31/2016; 09/15/2015; 12/18/2013

General Information

This chapter contains general information related to the AHCCCS billing rules and requirements. Policies regarding submission and processing of Fee-For-Service claims are communicated to providers via channels such as this AHCCCS Fee-For-Service Provider Billing Manual and the Claims Clues articles.

Claims must meet AHCCCS requirements for the submission of claims.

AHCCCS follows the HIPAA Compliant 837 transaction guidelines and the coding standards described in the UB-04 Manual; the 1500 Manual; the ADA Manual; International Classification of Diseases (ICD) Manual; Physicians' Current Procedural Terminology (CPT) Manual; Health Care Procedure Coding System (HCPCS) Manual; the CDT Manual for Dental (Current Dental Terminology); as well as the First Data Bank Blue Book for pharmacy information.

Claims Clues articles can be found on the AHCCCS website at:

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimscues.html>

Claim Submission Requirements for Paper Claims

When a claim is submitted please ensure that the printed information is aligned correctly with the appropriate section/box on the form. If a claim is not aligned correctly, it may cause the OCR system to read the data incorrectly and the claim will reject.

The preferred font for claims submission is Lucinda Console and the preferred font size is 10.

Claims for services must be legible and submitted on the correct form for the type of service(s) billed. Claims that are not legible or that are not submitted on the correct form will be returned to providers without being processed.

- If a claim is returned, you must resubmit the claim on the correct type of claim form, submit it within the required time frame, and ensure that it is legible.
- This resubmitted claim **cannot** be a black and white copy of the previously submitted claim. The resubmitted claim **must** be submitted on a new, red claim form.

AHCCCS retains a permanent electronic image of all paper claims submitted, in accordance with State retention record requirements, requiring providers to file clear and legible claim forms.

Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid (“White Out”) **may not** be used. Correction tape **may not** be used.

Any documentation submitted with a claim is imaged and linked to the claim image. Documentation is required when resubmitting claims, even if the documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim. Documentation **must** be resubmitted. Each claim must stand on its own, as the system is unable to pull documentation from the previously submitted claim.

All paper claims should be mailed, with adequate postage, to:

AHCCCS Claims
P.O. Box 1700
Phoenix, AZ 85002-1700

Claim Submission Requirements for 837 Submitted Claims

AHCCCS also accepts HIPAA-compliant 837 electronic Fee-For-Service claims from all certified submitters. Providers and clearinghouses must successfully complete testing to be certified to submit 837 transactions.

For EDI inquiries, roster issues or to become an AHCCCS Trading Partner, please email servicedesk@azahcccs.gov.

Claim Submission Requirements for AHCCCS Online (Provider Portal)

Claims may also be submitted through the AHCCCS Online claim submission process. Document attachments may be submitted through the web upload attachment process in the Transaction Insight (TI) Portal or through batch 275.

For further information on how to submit claims through the Provider Portal please review the provider training available at:

<https://www.azahcccs.gov/Resources/Downloads/DFMSTraining/2017/OnLineClaimsSubmission.pdf>

Claim Submission Time Frames

In accordance with ARS §36-2904 (G), an initial claim for services provided to an AHCCCS member must be received by AHCCCS no later than 6 months after the date of service, unless the claim involves retro-eligibility. In the case of retro-eligibility, a claim must be

submitted no later than 6 months from the date that eligibility is posted. For hospital inpatient claims, “date of service” means the date of discharge of the patient.

Claims initially received beyond the 6-month time frame, except claims involving retro-eligibility, will be denied.

If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

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

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

Prior Quarter Coverage Eligibility

Effective 1/1/2014, AHCCCS is required to expand the time period that AHCCCS pays for covered services for an eligible individual. The expanded time frame will include up to the three months prior to the month the individual applied for AHCCCS, if the individual met the eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

1. Received one or more AHCCCS covered service(s) during the month, and
2. Would have qualified for AHCCCS at the time services were received if the person had applied for Medicaid.

Note: If a member qualifies for AHCCCS during any one or more of the three months prior to their application, Prior Quarter Coverage will only apply to those months where there was a qualifying Medicaid claim.

If a member qualifies for Prior Quarter Coverage for January, February and March of 2014, but they only had one doctor’s appointment during this time frame that took place in February, then their Prior Quarter Coverage would only apply to the month of February. They would not have Prior Quarter Coverage for January or March, since they had no qualifying claims for those months.

The AHCCCS Administration will determine whether or not an applicant meets Prior Quarter Coverage criteria.

If the applicant meets the Prior Quarter Coverage criteria, providers will be required to bill the AHCCCS Administration for services provided during the prior quarter eligibility period. Providers will be required to bill the AHCCCS Administration for these services upon verification of eligibility or upon notification from the member of Prior Quarter Coverage eligibility.

Upon notification of Prior Quarter Coverage eligibility, A.A.C.R9-22-703 requires the provider to promptly refund to the member any payments that have been received for services in an approved prior quarter period and must accept payment by AHCCCS as payment in full. Providers failing to reimburse a member for any payments made by the member will be referred to the AHCCCS Office of Inspector General for investigation and action.

For covered services received during the prior quarter, which have not yet been reimbursed or billed, the provider must submit a claim to the AHCCCS Administration.

AHCCCS Managed Care Contractors are ***not*** responsible for determining Prior Quarter Coverage or for payment for covered services received during the prior quarter. Claims submitted to AHCCCS Managed Care Contractors for Prior Quarter Coverage will be denied.

Providers may submit Prior Quarter Coverage claims for payment to AHCCCS in one of the following ways:

1. The HIPAA compliant 837 transaction,
2. Through the AHCCCS Online claim submission process, or
3. By submitting a paper claim form.

All providers, including RHBA and TRHBA providers, must submit a claim directly to the AHCCCS Administration. Pharmacy point of sale claims must be submitted to the Pharmacy Benefits Manager (PBM). The current PBM is OptumRx, and further information regarding the PBM can be found in Chapter 12, Pharmacy, of the Fee-For-Service Provider Billing Manual.

Hospital Presumptive Eligibility (HPE)

Claims for persons determined to be presumptively eligible for AHCCCS by a qualified hospital should be submitted to the AHCCCS Administration until a full application is completed by the member and they have been enrolled with a Contractor.

Members eligible under HPE, where providers are billing for prenatal services, should bill the AHCCCS Administration for prenatal visits utilizing the appropriate E&M code performed during the HPE period.

Global obstetric billing for total OB care is only applicable for the plan in effect on the date of delivery and is only applied if global delivery guidelines are met (i.e. 5 or more visits performed while member is eligible under the plan). If guidelines are not met services should be billed as Fee-For-Service.

Retro-Eligibility

Retro-eligibility affects a claim when no eligibility was entered in the AHCCCS system for the date(s) of service(s), but at a later date eligibility was posted retroactively to cover the date(s) of service(s).

Fee-For-Service claims are considered timely if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of eligibility posting. Claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the AHCCCS date of eligibility posting. This time limit does not apply to adjustments which would decrease the original AHCCCS payment due to collections from third party payers.

Billing AHCCCS Members

Arizona Revised Statute §36-2903.01(K) prohibits providers 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:

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.

Note: "QMB Only" is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible and coinsurance amount when Medicare pays first.

For further information on QMB Only please refer to Chapter 9, Medicare/Other Insurance Liability, of the Fee-For-Service Provider Billing Manual.

Replacements and Voids

The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to you on the AHCCCS Remittance Advice. You should correct claim errors and resubmit claims to AHCCCS for processing within the 12 month clean claim time frame.

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 further information on how to correct claim errors please refer to Chapter 26, Claim Errors, of the Fee-For-Service Provider Billing Manual for a list of the most common denial and disallowance edits and how to fix them.

Replacements

For the purposes of this section, when a claim is resubmitted it will be referred to as a **replacement**. A replacement ***is*** the resubmission of a claim.

There are times when a previously submitted claim (paid or denied) will need to be replaced with a new submission.

You will **replace** a corrected claim when:

- The original claim was denied or partially denied; or
- When a claim was paid by AHCCCS and errors were discovered afterwards in regards to the amounts or services that were billed on the original claim. For example, you may discover that additional services should have been billed for on a service span, or that incorrect charges were entered on a claim paid by AHCCCS.

When **replacing a denied claim or adjusting a previously paid claim** you must submit a new claim form containing all previously submitted lines. The original AHCCCS Claim Reference Number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied due to it appearing to have been received beyond the initial submission time frame **or** it may be denied as a duplicate submission.

If any previously paid lines are blanked out the AHCCCS system will assume that those lines should not be considered for reimbursement and payment will be recouped.

When **replacing** a claim, you must resubmit any documentation that was sent with the denied or previously paid claim.

Every field can be changed on the **replacement** except the service provider ID number, the billing provider ID number and the tax ID number. If these must be changed, you must void the claim and submit a new claim.

To **replace** a denied CMS 1500 claim:

Enter "A" or "7" in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim or the CRN of the claim to be adjusted in the field labeled "Original Ref. No." *Failure to replace a 1500 claim without Field 22 completed will cause the claim to be considered a "new" claim and then it will not link to the original denial/paid claim. The "new" claim may be denied as timely filing exceeded.*

Replace the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example 1:

You submit a three-line claim to AHCCCS. Lines 1 and 3 are paid, but Line 2 is denied.

When replacing the claim, you should replace all three lines. If only Line 2 is replaced, the AHCCCS system will recoup payment for Lines 1 and 3.

Example 2:

You replace a three-line claim to AHCCCS. All three lines are paid.

You discover an error in the number of units billed on Line 3 and submit an adjustment.

When submitting the adjustment, you should replace all three lines. **If only Line 3 is replaced, the AHCCCS system will recoup payment for Lines 1 and 2.**

An adjustment for additional charges to a paid claim must include all charges -- the original billed charges *plus* additional charges.

Example 3:

You bill for two units of a service with a unit charge of \$50.00 and are reimbursed \$100.00. After receiving payment, you discover that three units of the service should have been billed.

When adjusting the claim, you should bill for three units and total billed charges of \$150.00 (3 units X \$50.00/unit). The AHCCCS system will pay the claim as follows:

Allowed Amount (3 units)	\$150.00
Previously Paid to Provider	< <u>\$100.00</u> >
Reimbursement	\$50.00

If you billed for the one additional unit at \$50.00, the AHCCCS system would recoup \$50.00 as shown below:

Allowed Amount (1 unit)	\$50.00
Previously Paid to Provider	< <u>\$100.00</u> >
Reimbursement (Amount recouped)	< <u>\$50.00</u> >

To **replace** a denied UB-04 claim:

Replace the UB-04 with the appropriate Bill Type:
xx7 for a replacement and corrected claim

Failure to replace a UB-04 without the appropriate Bill Type will cause the claim to be considered a “new” claim and it will not link to the original denial. The “new” claim may be denied as timely filing exceeded.

Type the CRN of the denied claim in the “Document Control Number” (Field 64).

To **replace** a denied **ADA claim** or a previously paid ADA claim, the CRN of the denied claim must be entered in Field 2 (Predetermination/Preauthorization Number).

- *Failure to replace an ADA claim without Field 2 completed will cause the claim to be considered a “new” claim and it will not link to the original denial or the previously paid claim. The “new” claim may be denied as timely filing exceeded.*

- **Do not put the CRN in the Remarks section or in the white space at the top of the form. Replacements that have the CRN in the wrong section will be denied. The CRN must go in Field 2.**

Voids

When **voiding a claim**, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.

Unlike resubmissions and adjustments, you should submit only the line(s) to be voided. Lines that should not be voided should be blanked out to avoid recoupment of payment for those lines.

To **void** a paid CMS 1500 claim enter “V” or “8” in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

To **void** a paid UB-04 claim:

Use bill type xx8

Enter the CRN of the claim to be voided in the “Remarks” field (Field 80).

If Field 80 is used for other purposes, type the CRN at the top of the claim form.

To **void** a paid ADA claim type the word “VOID” and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

Overpayments

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.

In the event that 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.

In the event that an entire claim needs voided so that the entire payment would be recouped then no documentation is required.

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.

General AHCCCS Billing Rules

Most of the rules for billing AHCCCS follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by AHCCCS:

- Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

- Billing Multiple Units:

If the same procedure is provided multiple times on the same date of service, the procedure code must be entered **only once** on the claim form.

The units field is used to specify the number of times the procedure was performed on the date of service.

The total billed charge is the unit charge multiplied by the number of units.

- Medicare and Third Party Payments

By law, AHCCCS has liability for payment of benefits after all other third party payers, including Medicare.

The provider must determine the extent of third party coverage and bill all third party payers **prior** to billing AHCCCS.

NOTE: For further information please refer to Chapter 9, Medicare/Other Insurance Liability, in the Fee-For-Service Provider Billing Manual.

- Age, Gender and Frequency-Based Service Limitations:

AHCCCS imposes some limitations on services based on member age and/or gender.

Some procedures have a limit on the number of units that can be provided to a member during a given time span.

AHCCCS may revise these limits as appropriate.

All claims are considered non-emergent and subject to applicable prior authorization requirements, unless the provider clearly identifies the service(s) billed on the claim form as an emergency.

UB-04 Claim Form

On the UB-04 claim form, the Admit Type (Field 14) must be “1” (emergency), “5” (trauma), or “4” (newborn) on all emergency inpatient and outpatient claims.

All other Admit Types, including a “2” for urgent, designate the claim as non-emergent.

CMS 1500 Claim Form

On the CMS 1500 claim form, Field 24 C must be marked to indicate that the service billed on a particular claim line was an emergency.

ADA Claim Form

AHCCCS staff will review ADA 2012 dental claims for adults to determine if the service provided was emergent.

Note: Adults are eligible for limited emergency dental services only. For further information please refer to the Dental Services section of Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual for coverage limitations.

Recoupment

A.R.S. §36-2903.01 L. requires AHCCCS to conduct post-payment review of all claims and recoup any monies erroneously paid.

Under certain circumstances, AHCCCS may find it necessary to recoup or take back money previously paid to a provider.

Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

Upon completion of the recoupment, the Remittance Advice will detail the action taken.

If payment is recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), you will be afforded additional time to provide justification for re-payment as outlined below.

In the case of recoupments, the time frame for submission of a clean claim differs from the time frames described earlier in this chapter.

In the case of recoupments, the time span allowed for resubmission of a clean claim will be the *greatest* of:

- Twelve months from the date of service, or
- Twelve months from the date of eligibility posting for a retro-eligibility claim, or
- Sixty days from the date of the adverse action.

If recoupment is initiated by the AHCCCS Office of Inspector General (OIG) as a result of identified misrepresentation, you will not be afforded additional time to resubmit a clean claim. For additional information please refer to Chapter 28, Claim Disputes, of the Fee-For-Service Provider Billing Manual.

Additional Billing Rules

Multiple Page Claims

Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.).

- To ensure that all pages of a multiple-page, UB-04 claim are processed as a single claim the pages **must** be numbered.

Keep all pages together, back-to-back. All pages should be paper-clipped or rubber-banded together. **Do not staple.**

Totals should not be carried forward onto each page, and each page can be treated as a single page. **The total should be entered on the last page only.**

Zero Charges

AHCCCS will key revenue and procedure codes billed with **zero charges**. AHCCCS **will not** key revenue and procedure codes billed with **blank charges**. When submitting zero charges, \$0.00 must be listed and it cannot be left blank.

Revenue codes with zero charges will not be considered for reimbursement.

Mothers and Newborns

Newborns whose mothers are AHCCCS members are eligible for AHCCCS services from the time of delivery.

Newborns receive separate AHCCCS identification numbers, and services for a newborn must be billed separately using the newborn's AHCCCS ID.

- Services for the newborn that are included on the mother's claim will be denied.

Contact the AHCCCS Eligibility Verification Unit for newborn eligibility and enrollment information. For further information please refer to Chapter 2, Eligibility, of the Fee-For-Service Provider Billing Manual.

Changes in Member Eligibility

If the member is ineligible for any portion of a service span, those periods should not be billed to AHCCCS.

If a member's eligibility changes, then each eligible period should be billed separately to avoid processing delays.

Changes in Reimbursement Rate

It is not necessary to split bill an inpatient hospital claim when the claim dates of service span a change in the inpatient hospital reimbursement rates.

If a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rates, then the claim must be split.

Documentation Requirements

Medical review is a function of the AHCCCS Claims Department and is performed to determine if services are provided according to AHCCCS policy as it relates to medical necessity and emergency services. Medical review and adjudication also are performed to audit appropriateness, utilization, and quality of the service provided.

In order for this medical review to take place, providers may be asked to submit additional documentation for Fee-For-Service CMS 1500 claims, which are identified in the AHCCCS claims processing system as near duplicate claims. The documentation is necessary to allow the AHCCCS Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

Near duplicate claims are claims for the same procedure, on the same day, for the same member, for different providers.

Near duplicate claims for certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, adjudication staff will release the claim for payment, assuming that the claim has not failed any other edits.

If no medical documentation is submitted, the adjudication staff will deny the claim with a denial reason specifying what documentation is required.

- For example, a claim may be denied with the Medical Review denial code "MD008 - Resubmit with progress notes." Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

It is expected that certain E&M codes such as 90491 (Critical care, evaluation and management) and 90431-90433 (Subsequent hospital care) will frequently fail the near duplicate edit, because it is feasible that a member could be seen by more than one

provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill AHCCCS for CPT Code 90491 for April 22 for Mr. Jones.

Either claim may fail the near duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the Medical Review nurse will deny the claim with denial code “MD008 - Resubmit with progress notes.”

Note: AHCCCS requires **all** claims related to hysterectomy and sterilization procedures to be submitted with the respective consent forms. For further information please refer to the sections on Hysterectomy Services and Family Planning Services in Chapter 10, Individual Practitioner Services, of the Fee-For-Service Provider Billing Manual.

While it is impossible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation. Also, not all Fee-For-Service claims submitted to AHCCCS are subject to Medical Review.

CMS 1500 Claims		
Billing For	Documents Required	Comments
Surgical procedures	History and physical, operative report, and emergency room report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, & pathology report	Information must substantiate fetal demise.
Emergency room visits	Complete emergency room record	Billing physician’s signature must be on ER record
Anesthesia	Anesthesia records	Include begin and end time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, & consult reports	Documentation should be specific to code(s) billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, & history and physical	Examples: Cardiac catheterizations, Doppler

UB-04 Claims		
Billing for	Documents Required	Comments
Observation	Refer to FFS Chapter 11 Hospital Services for required documentation.	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, & pathology report.	Information must substantiate fetal demise
Outlier	Refer to FFS Chapter 11, Hospital Services, and to Exhibit 11-4, the Outlier Record Request, for information on the required documentation.	

Providers should *not* submit the following unless specifically requested to do so:

- Emergency admission authorization forms
- Patient follow-up care instructions
- Nurses notes
- Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- Ultrasound/X-ray films
- Medifax information
- Nursing care plans
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays (Exception: claims that qualify for outlier payment.)
- Entire medical records

Social Determinants

Beginning with dates of service on and after **April 1st, 2018**, AHCCCS will begin to monitor all claims for the presence of social determinant ICD-10 codes.

As appropriate within their scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about the social determinant should be included in the member’s chart.

Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for AHCCCS members, in order to comply with state and federal coding requirements.

Note: Social determinants are **not** the primary ICD-10 code. They are secondary ICD-10 codes.

Dental providers will be **exempt** from the use of social determinants.

For a list of ICD-10 codes relevant to social determinants of health, please see Exhibit 4-1, Social Determinants of Health ICD-10 Code List in the Fee-For-Service Provider Billing Manual. The list of social determinants of health codes may be added to or updated on a quarterly basis. Providers should remain current in their use of these codes

Claim Submission & Provider Registration

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. All providers, including but not limited to out-of-state providers, attending and servicing providers both within and outside of a hospital setting, and billing providers must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

After January 1st, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny.

For additional information on 42 CFR 455.410 and the necessity for providers to be registered to receive payment from AHCCCS, please refer to Chapter 3, Provider Records and Registration, of the Fee-For-Service Provider Billing Manual.

Revision History

Date	Description of changes	Page(s)
11/31/21	Updated email for Service Desk	2
7/10/2018	The request for there to be no handwriting on claims was rescinded and the chapter was updated throughout to remove references to 'no handwriting on claims.' Handwriting (legible) may be permitted.	1-2

4/13/2018	Note on QMB Only Medicare reimbursable amounts updated to read as: <i>“QMB Only” is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 AHCCCS shall only reimburse the provider for the Medicare deductible and coinsurance amount when Medicare pays first.</i> Information on providers needing to be registered with AHCCCS in order to receive payment added.	6 16
2/9/2018	Social Determinants of Health section added Exhibit 4-1, Social Determinants of Health ICD-10 Code List added	15-16 Exhibit 4-1
1/12/2018	Claim Submission Requirements for Paper Claims section added Claim Submission Requirements for 837 (Electronic) Claims section added Claim Submission Requirements for AHCCCS Online (Provider Portal) section added Prior Quarter Coverage section updated with examples Hospital Presumptive Eligibility (HPE) section added Replacements and Resubmissions sections combined into one section titled “Replacements” Void section updated Documentation Requirements section updated Updates to Billing Rules Formatting	1-2 2 2 3-5 4 7-9 9 14-16 All All
09/14/2016	Correction to ARS §36-2901 from (H) to correct section (G) PBM section, removed name of PBM	2 3
05/24/2016	Clarified: when resubmitting a claim, documentation must also be resubmitted	1
3/31/2016	UB-04 Field 80 corrected to UB-04 Field 64	5
09/15/2015	New format HPE section added Grammar, language corrections Added language to advise consequences of failing to resubmit/replace with prior CRN indicated “ICD-9” replaced with “ICD”	All 3 All All All All



12/18/13	Prior Quarter Coverage section added	4
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