





Documentation for Claim Submission and Concurrent Review

DFSM Provider Training Team

Fourth Quarter 2020

AHCCCS
Arizona Health Care Cost Containment System

About This Course

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

This training covers the responsibility of providers to submit required documentation with claims, and to respond to AHCCCS requests for documentation for concurrent review.

- **NOTE:** This training does not fully cover ‘how to use’ the Transaction Insight Portal. The AHCCCS Provider Training Team offers a separate, comprehensive training on use of the Transaction Insight Portal.

Documentation Requests

AHCCCS may request supporting information and/or documentation from the rendering provider. This may include information and/or documentation substantiating the treatment rendered or the health service provided, or the delivery of services that are noted within the claim(s) submission.

Requested information and/or documentation may include, but is not limited to:

- More Detailed or Itemized Statements/Records;
- Medical Records, such as:
  - Office Notes;
  - Operative Reports;
  - Medical Records;
  - Physician Orders;
  - Progress Notes; and/or
  - Diagnostic Test Results Reports.

Documentation Requirements and Resources

Required documentation can be found on the AHCCCS website.

For documentation requirements for individual services, please refer to that service's corresponding chapter in the AHCCCS Medical Policy Manual.

- For Fee-for-Service (FFS) Providers, AMPM 820, FFS Prior Authorization Requirements, contains information on the documentation requirements necessary to obtain prior authorization (and therefore needed to ensure successful payment of the claim).

General requirements, along with detailed billing instructions, can be found in the FFS Provider Billing Manual and the IHS/Tribal Provider Billing Manual.

Medical Review and Documentation

When a claim is submitted to AHCCCS Fee-for-Service, medical review may be required prior to adjudicating the claim.

- Medical review is a function of CMSU 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.

If documents needed to complete medical review are not on file, an automatic request for documentation may be initiated.

If required documents are not received, a denial may be issued.

Other Reasons for Documentation Requests

Claims may be identified for post-service, prepayment review for a variety of reasons, in additional to reviewing for medical necessity.

- For example, FES claims must meet the federal definition of emergency criteria. So while a service may be medically necessary (such as a doctor's office visit) a claim for an FES member would need reviewed not just for medical necessity, but also to see if it met emergency criteria.

Claims that may be subject to such requests may include, but are not limited to, the following:

- Unlisted procedure codes.
- Claims for services that, due to their nature, require supporting clinical and/or other information/documentation to be submitted in order to determine whether they are payable.
- Claims where documentation may be required by other entities such as the Centers for Medicare and Medicaid Services (CMS) or under relevant state or federal regulations.

General Documentation Requirements

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

Near Duplicate Claims

The AHCCCS Claims Processing System (PMMIS) may place claims in a pended status if they appear to be 'near duplicate' claims. These are 'near duplicate claims' and they require medical review.

- 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 codes, such as certain evaluation and management (E&M) codes (e.g., emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review.

- In order for this medical review to take place, providers may be asked to submit additional documentation for Fee-For-Service CMS 1500 claims.
- It is vital for providers to submit the requested documentation. This 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.
- If the services are substantiated by the documentation, the claim will be released for payment, assuming that the claim has not failed any other edits.

Documentation and the Importance of Prior Authorization (PA)

To ensure successful payment of a claim, a provider must ensure that, for services requiring prior authorization, that prior authorization was obtained and that documentation requirements were met.

Documentation requirements needed to obtain PA can be found in the following locations:

- AMPM 820, FFS Prior Authorization Requirements
- The FFS PA Requirements Web Page at: https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/requirements.html
- Chapter 8, Prior Authorizations, of the FFS Provider Billing Manual
- Chapter 6, Prior Authorizations, of the IHS/Tribal Provider Billing Manual

General requirements, along with detailed billing instructions, can be found in the FFS Provider Billing Manual and the IHS/Tribal Provider Billing Manual.

Documentation and the Importance of Prior Authorization (PA)

It is the provider's responsibility to ensure that all Prior Authorization requirements have been met, and that PA has been submitted to AHCCCS in a timely manner

Keep in mind that PA is issued for AHCCCS covered services within certain limitations, based on the following:

- The member's AHCCCS eligibility;
- Provider status as an AHCCCS-registered FFS provider;
- The service requested is an AHCCCS covered service requiring PA;
- Information received from the provider meets the requirements for issuing a PA number; and if
- The service requested is not covered by another primary payer (e.g., commercial insurance, Medicare, other agency).



What Medical Documentation is Required?

What Does This Section Cover?

This section provides a general overview of documentation requirements for common Medicaid-covered services.

Please note, that this is not comprehensive and that documentation requirements may change, or additional documentation may be requested for concurrent review.

It is the provider's responsibility to remain current on documentation requirements and to submit any documentation requested by AHCCCS.

Services that May Require Documentation

Some services that may require documentation (not an all inclusive list), include:

- By-Report Procedures
- Multiple Surgery Claims
- Federal Emergency Services
- Members with Retro Eligibility status
- Procedures billed with certain modifiers
- Non-emergent hospital admissions
- Dialysis Services
- Secondary Payer Claims

What Does This Section Cover?

This section will help providers determine what documentation is required. This is not an exhaustive list. For additional details on each service type, please visit the AHCCCS Medical Policy Manual, the FFS and IHS/Tribal Provider Billing Manuals, and the AHCCCS website.

This training will cover documentation required for the following services:

- NEMT
- Sterilization and Hysterectomies
- Surgical Procedures
- Emergency Room Visits
- Federal Emergency Services Program coverage

Non-Emergency Medical Transportation Documentation Requirements

All non-emergency medical transport providers will be required to use the AHCCCS Daily Trip Report.

- Exhibit 14-1, the AHCCCS Daily Trip Report (PDF)
  - AHCCCS will accept PDF files of the AHCCCS Daily Trip Report.
- Exhibit 14-2, the AHCCCS Daily Trip Report (Excel)
  - AHCCCS will not accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they must convert to a PDF before submission. The Excel file was included at provider request, so that they may fill it out on Excel and then convert to a PDF prior to submission.

All providers rendering NEMT Services **must** use the Daily Trip Report. This includes BHRFs, Hospitals, NEMT Providers, etc.

Non-Emergency Medical Transportation Documentation Requirements

Detailed instructions for completing the Daily Trip Report can be found in Exhibit 14-2, Daily Trip Report Instructions .

Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Report found in Exhibit 14-1 will be denied.

AHCCCS offers a specific training on how to fill out the NEMT Trip Report for providers. This training is offered on a quarterly basis, and is also available on the AHCCCS DFSM Provider Training Web Page 24/7 as both a PDF under "Trainings by Subject" and a YouTube video under the "Provider Training Video Library".

Federal Emergency Services Program

Documentation must substantiate that emergency criteria were met.

The definition of 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 extreme pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the member’s health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part; or
4. Serious physical harm to self or another person (for behavioral health conditions).

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 for FESP.

Sterilization

AHCCCS requires all claims related to sterilization procedures to be submitted with its consent form.

Sterilization services are covered for both male and female members when the requirements specified for sterilization services (including for hysteroscopic tubal sterilizations), in AMPM 420, Family Planning Services, are met.

Any member requesting sterilization shall sign an appropriate consent form (Attachment A, Consent to Sterilization) with a witness present when the consent is obtained. Consent forms *must* meet the requirements outlined in 42 CFR 441.250 et seq.

Hysterectomy

A Hysterectomy is a medically indicated procedure that is exempt from a 30 day waiting period. Coverage of Hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis.

AHCCCS requires all claims related to hysterectomy procedures to be submitted with the respective consent form.

- Attachment A, AHCCCS Hysterectomy Consent and Acknowledgment Form, must be filled out and submitted to AHCCCS, unless the physician determines that the member is:
  1. Already sterile prior to the procedure, or
  2. The hysterectomy is needed because of a life-threatening emergency situation.

  NOTE: These Exceptions are listed in full detail in AMPM 310-L, Hysterectomy.

Hysterectomy

Prior to performing a hysterectomy, unless the exceptions in AMPM 310-L, Hysterectomy are met, a provider shall comply with the following requirements. They shall:

1. Inform the member and member's representative, if any, both orally and in writing that the Hysterectomy will render the member incapable of reproducing (i.e. result in sterility); *and*

2. Obtain from the member or member's representative, if any, a signed and dated written acknowledgment stating that the information above has been received and that the member has been informed and understands that the Hysterectomy will result in sterility. This documentation shall be kept in the member's medical record.

It is the provider's responsibility to maintain any required documentation, such as what is described above, and provide it to AHCCCS if requested.

Emergency Room Visits

AHCCCS requires all claims related to an emergency room visit to be submitted with the complete emergency room record.

- Please note, that when billing, the billing physician's signature **must** be on ER record.

Please note that in accordance with the Balanced Budget Act, prior authorization is not required for emergency physical and behavioral health services.

Surgical Procedures

AHCCCS requires all claims related to surgical procedures to be submitted with the following items:

- History and physical,
- Operative report, and
- Emergency room report (if applicable).

Certain surgical claims require additional distinction, such as procedures that involve bilateral procedures, multiple procedures performed on the same date, secondary procedures, or procedures performed during the same operative session by the same physician.

- Please note, these are typically indicated through use of a modifier when billing, and any submitted documentation will need to distinguish this.

Federal Emergency Services Program

All emergency services provided under the Federal Emergency Services Program (FESP) in any setting, are subject to retrospective review to determine if an emergency existed at the time of service.

Consequently, AHCCCS requires the review of claims for members enrolled in the Federal Emergency Services (FES) Program, to ensure that emergency criteria were met. All FES claims are routed for review.

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

Federal Emergency Services Program

Examples of documentation include:

- ✔ Emergency room records,
- ✔ Physician progress note(s),
- ✔ Operative reports,
- ✔ OB triage records, discharge summary, etc.
- ✔ Itemized Statement

The documentation must verify the medical emergency as defined in the federal guidelines. **Providers should not attach the entire medical record.**

- Claims submitted without documentation will be denied because AHCCCS will not be able to substantiate an emergency medical condition.

Federal Emergency Services Program & Dialysis

Emergency services under the FES Program also include outpatient dialysis services, if the FES Program Member has End Stage Renal Disease (ESRD), when the criteria specified in A.A.C. R9-22- 217(B) and Section B of AMPM 1100, Federal Emergency Services Program are satisfied.

There are two documentation items of note for providers:

1. **Initial Certification:** When dialysis services for ESRD are needed for the first time, the treating physician must issue an initial certification in writing, that in his/her opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in any one of the following:
   a) Placing the member's health in serious jeopardy.
   b) Serious impairment of bodily function.
   c) Serious dysfunction of a bodily organ or part

   This initial certification is created by having the physician fill out the Initial Dialysis Case Creation Form , which certifies that the aforementioned criteria have been met. The treating physician shall complete and sign this "Initial Dialysis Case Creation" form and then submit the form to AHCCCS/DFSM.

Federal Emergency Services Program & Dialysis

2) **Monthly Certification:** The member's treating physician must certify in writing, for each month in which the dialysis services are received, that in his/her opinion the absence of receiving dialysis at least three times per week would reasonably be expected to result in any one of the following:

   a) Placing the member's health in serious jeopardy.
   b) Serious impairment of bodily function.
   c) Serious dysfunction of a bodily organ or part.

   The provider certifies this by using Attachment B ("Monthly Certification of Emergency Medical Condition").

Dialysis

Free-standing dialysis facilities are reimbursed a composite rate, and services included in the composite rate may not be billed separately.

Chapter 15, Dialysis Services, of the AHCCCS FFS Provider Billing Manual, provides a list of drugs and tests covered under the composite rate.

- Separately billable drugs and vaccines that are *not* included in the composite rate require medical documentation to be submitted with the claim.
- Tests performed more frequently than specified in policy may be covered by AHCCCS only if medically justified by supporting documentation.

Services that are billed separately from the composite rate, because they were provided more frequently than specified by policy, must be justified by supporting documentation. If no documentation is submitted with the claim, or if the documentation does not support the charges, then payment for those services will be disallowed.

Secondary Payer Claims

Federal law 42 USC 1396a (a)(25)(A) requires Medicaid to take all reasonable measures to determine the legal liability of third parties for health care items and services provided to Medicaid members.

AHCCCS has liability for payment of benefits after Medicare and all other first- and third party payer benefits have been paid. Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

AHCCCS is the payer of last resort unless specifically prohibited by state or federal law. This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted per A.R.S. §36-2946.

Secondary Payer Claims

Under state and federal law and R9-22-1003 (E), AHCCCS must pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement from the First- or Third-Party payer (Post-Payment Recovery) when the claim is for:

1. Preventive pediatric services, including EPSDT services and administration of vaccines under the Vaccines For Children (VFC) Program; or
2. The liability is from an absent parent whose obligation to pay support is being enforced by Division of Child Support Enforcement.

Secondary Payer Claims

Per R9-22-1002, AHCCCS is not the payer of last resort (AHCCCS will be the primary payer) when the following entities are the third-party:

1. The payer is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

Secondary Payer Claims

AHCCCS maintains a record of each member's primary coverage by Medicare and Other primary insurance plans.

If a member's primary payer's record indicates a first-party coverage (such as Medicare or employer's health plan) or a third-party coverage (i.e. third party liability, or TPL) and the claim is filed **without** the primary payer's EOB the claim will be denied.

For additional information on this process, please refer to either Chapter 9, Medicare and Other Insurance Liability, of the FFS Provider Billing Manual or (for IHS and 638 providers), Chapter 7, Medicare and Other Insurance Liability, of the IHS Tribal Provider Billing Manual.

Secondary Payer Claims

For members with Medicaid and a First-Party or Third-Party Liability (such as a secondary health insurance of Medicare coverage) a copy of the primary payer's Explanation of Benefits (EOB) will be required for consideration of the claim.

- For members that have a primary insurance, AHCCCS will be the last payer to consider reimbursement of the claim. A claim must first be submitted to the member's primary health insurance, prior to submission to AHCCCS.
- For members with Medicare as the primary coverage, AHCCCS will be the last payer to consider reimbursement of the claim. A claim must be submitted to Medicare to obtain the denial and EOB, even if it is for a service not covered by Medicare.
    - Medicare will automatically transfer claims that have been approved for payment to AHCCCS for consideration.

Secondary Payer Claims – Dual Eligible Medicare/Medicaid Members

Providers who qualify for Medicare payment, but have not applied to Medicare, must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

- Medicare allows providers to bill for denials, even for non-covered services, to obtain an EOB for Medicaid. For example:
  - Based upon the bill type code (i.e. this can be done with non-covered SNF claims)
  - There are some diagnosis codes that Medicare does not cover for DME. Providers still must submit a claim to Medicare for Denial.
  - There is a modifier that Medicare allows providers to bill Medicare, that indicates that it is a non-covered service. Providers till must bill Medicare to ensure a Denial is received.

Receiving the denial is important, to ensure that the provider has the Explanation of Benefits (EOB) for when they submit their Medicaid claim.

Global OB Documentation

In addition to standard documentation requirements associated with billing for the Total Global OB code, medical complications of pregnancy may require additional resources outside the global OB care package as outlined in Chapter 10, Individual Practitioner Services, of the FFS Provider Billing Manual, and may be reported separately.

The medical complication(s) must be present as supported by the medical documentation, including but not limited to, maternal medical history & physical, lab results and imaging reports.

Rehabilitative Services Documentation

The following written documentation must be in the member's medical records and available upon request for audit, as it pertains to rehabilitative services (physical, occupational, speech and respiratory therapies):

- Nature, date, extent of injury/illness and initial therapy evaluation,
- Treatment plan, including specific services/modalities of each therapy, and
- Expected duration and outcome of each therapy provided.

NOTE: Outpatient rehabilitation services are NOT covered for FES members.

Attending/Teaching Physician Documentation

The attending/teaching physician may submit a claim for professional services if certain criteria outlined in Chapter 10, Individual Practitioner Services, of the FFS Provider Billing Manual have been met.

Documentation substantiating the outlined criteria must be available for audit purposes.

All claims are subject to post-payment review and recovery per A.R.S. §36-2903.01 L.

Nutritional Therapy for EPSDT Members and Documentation

Per AMPM 430, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services AHCCCS must verify medical necessity of nutritional therapy through the receipt of supporting medical documentation dated within three months of the request for coverage, prior to giving initial or ongoing authorizations for nutritional therapy.

Documentation shall include clinical notes or other supporting documentation from the member's PCP, specialty provider, or registered dietitian, including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on Attachment B, AHCCCS Cert. of Medical Necessity for Comm. Oral Nutritional Supplements.

NOTE: Refer to AMPM 430 for additional information on all EPSDT services and their subsequent claims.

Inpatient Hospital Claims

Inpatient hospital claims require the following documentation:

- An admission face sheet;
- An itemized statement, submitted by the provider;
- An admission history and physical;
- A discharge summary or an interim summary if the claim is split;
- An emergency record, if admission was through the emergency room;
- Medication Administration Record (MAR);
- Operative report(s), if applicable;
- A labor and delivery room report, if applicable;
- Physician orders;
- Diagnostic test results;
- Progress notes; and/or
- Documentation listed in Exhibit 11-4, Outlier Records Request, for claims qualifying for outlier payments.

Periodically, retrospective review will be conducted by AHCCCS based upon a variety of criteria.

Outlier Claims

Claims that qualify for Outlier payments require additional documentation.

The Outlier Records Request Form, Exhibit 11-4, Outlier Records Request , in the FFS Provider Billing Manual, should be used by providers to submit this.

Outlier Claims

The Outlier Records Request Form lists the documentation required to perform a review of an Outlier Claim. Documentation required includes:

- Medication Administration Record (MAR)
- Operating room and anesthesia times. (Need the operative report and anesthesia records as they contain some of the charges/supplies/implants/medications that might not be listed elsewhere)
- All other minor procedures (bronchoscopy, laceration repair, lumbar puncture, PICC insertion, etc.)
- High dollar radiology (CT's, MRI's, MRA's, Nuclear Med scans, IR (Interventional Radiology).
- High dollar medical supplies
- Echocardiogram
- Cardiac Cath records

Outlier Claims (Continued)

- Ventilator days
- Nitric Oxide days
- Dialysis records and CRRT
- Blood administration (copy of the blood administration tag that has the date, start/stop times, and signature of administrator)
- PACU in/out times
- Perfusion
- Cardiac Arrest reports
- If Observation Days are billed then physicians' orders must be verified per policy
- Emergency Room records (procedures performed and meds given in ER may not be listed anywhere else).
- Other

Additional Documentation Requirements

Thus far this training has covered documentation requirements for several scenarios.

While it is impossible to offer specific guidelines for each possible situation that may arise, the following slides show tables listing out the required documentation that should be submitted when billing for certain services on a CMS 1500 or a UB-04 Claim Form.

- These tables have been designed to give providers some *general* guidance regarding the submission of documentation.

Please note, that not all Fee-For-Service claims submitted to AHCCCS are subject to Medical Review.

Modifiers and Documentation

Modifiers and Documentation

Per national coding standards, in order to support accurate reporting of certain procedures/services, modifiers may need to be added to procedure codes when billing.

- **NOTE:** It is the provider's responsibility to adhere to national coding standards, and to consult with their billing personnel regarding accurate billing practices (including the use of modifiers).

When a modifier is used to distinguish certain services, the documentation must substantiate its use.

This section provides several examples. It is not an all inclusive list, and is being offered to provide *examples* only.

Modifier 25

In order to support reporting a separate E/M with modifier 25, the evaluation must extend beyond what will be treated by the procedure.

When a preventive medicine service is reported in combination with problem-oriented E/M service, the visit documentation must clearly indicate the separate history, exam, and medical decision-making components related to the problem or abnormality being addressed.

No portion of the preventive service documentation may be used to support the problem-oriented E/M code selected; the documentation related to the problem must stand on its own to support the level of service and key components of the procedure code.

Modifiers

E/M Service Modifiers

- **Modifier 25 (Significant Separately Identifiable)** is used to identify E/M (Evaluation and Management) services as separate from another service performed on the same day by the same provider.
- **Modifier 26 (Professional Component)** is used to identify the professional component of a service performed by a physician or interpretation of the services performed by a physician.

Modifiers

Surgical Procedure Modifiers

- **Modifier 50 (Bilateral Procedures)** is used to identify bilateral procedures during the same operative session.
- **Modifier 51 (Multiple Procedures)** is used to identify multiple procedures performed on the same date, secondary procedures, or procedures performed during the same operative session by the same physician.
- **Modifier 59 (Distinct Procedural Service)** is used to identify services or procedures performed on the same day due to special circumstances that are not normally reported together.


Transaction Insight Portal

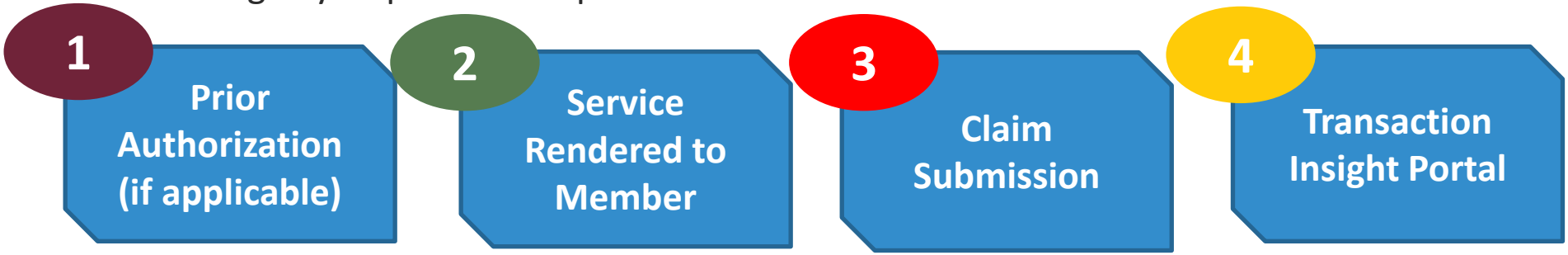
How is Documentation Submitted to AHCCCS?

AHCCCS
Arizona Health Care Cost Containment System

What is the Transaction Insight Portal?

The Transaction Insight Portal is an integral part of the overall claim submission process, which allows providers to receive reimbursement for services rendered.

The overall Claim Submission Process includes submitting for Prior Authorization for the service to be rendered (if applicable), rendering the service, submitting the claim, and submitting any required or requested documentation.



Note: Services rendered to members are subject to medical necessity.

What is the Transaction Insight Portal?

The Transaction Insight Portal allows providers to submit and link required documentation to submitted claims. Attachments are uploaded online, and the submitted documentation is then linked to the corresponding claim.

The Transaction Insight Portal has also been known as the:

- T.I. Portal
- Transaction Insight Web Upload Portal
- TIBCO Portal
- TIBCO Foresight Transaction Insight Portal, and
- The 275 Transaction Insight Portal.

Why do Providers Submit Documentation?

Certain types of claims require additional documentation to be submitted with each claim.

- i.e. NEMT Providers submit the AHCCCS Daily Trip Report with NEMT Claims.
- i.e. Claims for Surgical Procedures are submitted with a history and physical, an operative report, and an emergency room report (if applicable).

Please note the above list is not comprehensive. For additional information on what documentation is required to be submitted with each claim type, please visit the AHCCCS website and also the FFS and IHS/638 Provider Billing Manual.

Why do Providers Submit Documentation?

There are also times when AHCCCS will request that the provider submit additional documentation with an existing claim, to substantiate that services were provided in accordance with AHCCCS policy, as it relates to medical necessity and emergency services.

- Medical review and adjudication also are performed to audit appropriateness, utilization, correct coding, and quality of the service provided.

What Happens if No Documentation is Received?

If documentation is required, and no medical documentation is submitted, the claim may be denied. A denial reason specifying what documentation is required will be provided.

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



Transaction Insight Portal and the Control/PWK Number

Linking Documentation to a Submitted Claim

AHCCCS
Arizona Health Care Cost Containment System

Transaction Insight Portal and the Control/PWK Number

Using the Transaction Insight Portal is the ***fastest and most efficient*** way to attach documents to a claim.

The Control/PWK Number

- A unique number that a provider creates for each claim/document that they submit.
- This unique number forms an electronic match between the claim and submitted documentation. It allows the system to link the attachment to the correct claim.

The Control/PWK Number is entered in ***twice.***

- ***First,*** it is entered in by the provider when they submit their claim via the AHCCCS Online Provider Portal; and then
- It is ***entered in a second time*** when they submit their documentation on the Transaction Insight Provider Portal.

The Transaction Insight Portal and the Control/PWK Number

Attachments submitted through the Transaction Insight Portal can be linked to a claim using the Control/PWK Number.

- The Control/PWK Number is also called:
  - The **Control Number** (in the AHCCCS Online Provider Portal when submitting a claim)
  - The **Provider Attachment Control Number** *or* **Payer Claim Control Number** (in the Transaction Insight Portal when submitting documentation)

The Transaction Insight Portal and the Control/PWK Number

The Control/PWK number **MUST** match the exact format that is entered in the Control Number field on the Claims Attachment tab (in AHCCCS Online) and as the Provider Attachment Control Number (in the Transaction Insight Portal).

- **AHCCCS Online Claim Submission tab** – The Control/PWK Number is the number entered in the Control Number field.
- **Transaction Insight Portal** – The Control/PWK number field is the Payer Claim Control Number or Provider Attachment Control Number.

******Failure to match these between the two portals, can result in documentation failing to match to the appropriate claim.***

The Transaction Insight Portal and the Provider Identifier

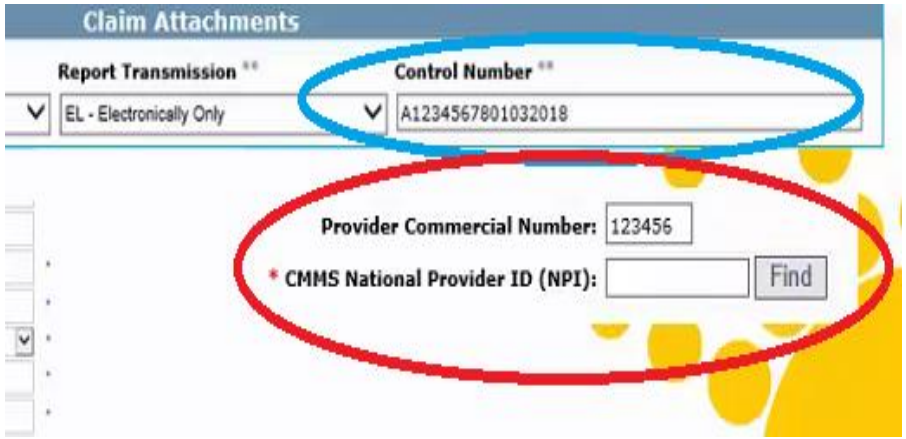
The **Provider Identifier** is another area that must match between the *AHCCCS Online Provider Portal* (where the claim is entered) and the *Transaction Insight Portal* (where the documentation is attached).

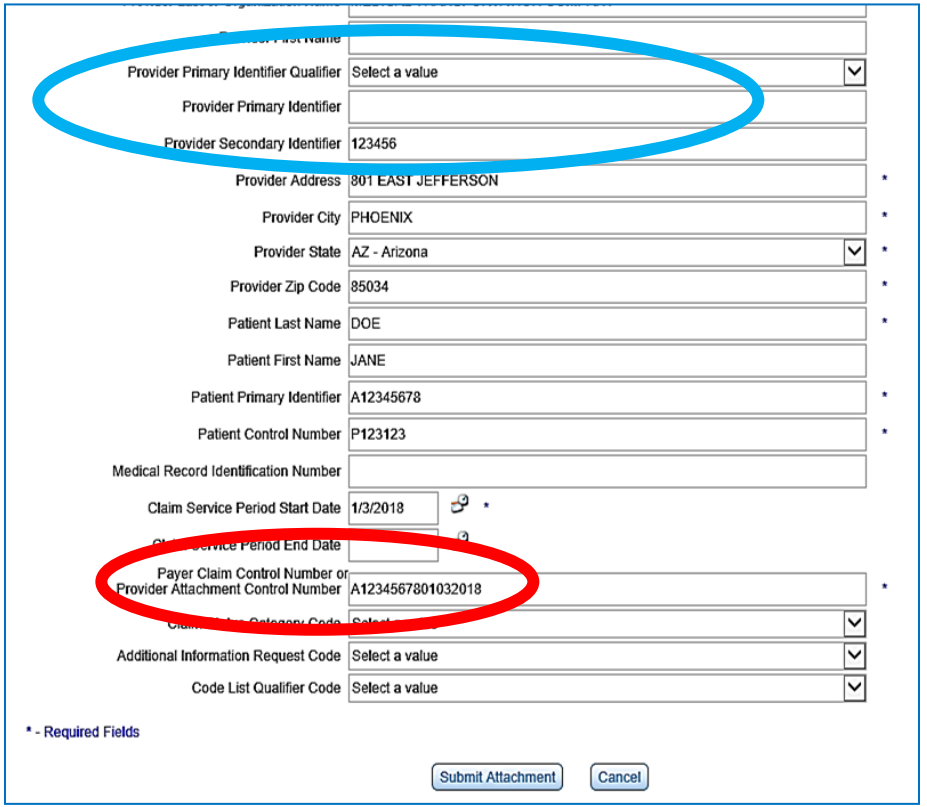
- **AHCCCS Online Provider Portal:** the Provider Identifier is called either the Provider Commercial Number or the CMMS National Provider ID (NPI).
  - Depending on what type of provider it is, the provider may choose to enter one or the other, or they may be required to enter a particular ID in (such as the NPI).
- **Transaction Insight Portal:** the Provider Identifier is called either the Provider Secondary Identifier or Provider Primary Identifier.

******Failure to match these between the two portals, can result in documentation failing to match to the appropriate claim.***

The Control/PWK Number and Provider Identifier

The blue circled areas must match, and the red circled areas must match.





AHCCCS Online Provider Portal	Transaction Insight (TI) Portal
The Control Number must match…	Payer Claim Control Number or Provider Attachment Control Number
Provider Commercial Number *or* the CMMS National Provider ID (NPI) must match….	The Provider Secondary Identifier Note: This number *must* match what is entered in on the AHCCCS Online Provider Portal. · If the Provider Commercial Number (the AHCCCS 6 digit Provider ID) is entered in on AHCCCS Online, then this *must* be the AHCCCS 6 digit Provider ID on the TI Portal and *cannot* be the NPI, or the claim and attachment will *not* match. · If the CMMS National Provider ID (NPI) is entered in on AHCCCS Online, then this *must* be the NPI on the TI Portal and *cannot* be the AHCCCS 6 digit Provider ID, or the claim and attachment will *not* match.

Control/PWK Number Reminders

REMINDER: A Control/PWK number is a unique number that you will create for each claim/document that you submit. It allows the system to link the attachment to the correct claim.

1. The Control/PWK number must begin with an upper case "A".

2. Make sure the Control/PWK number that is entered on the ***Claim Attachment tab*** (in the AHCCCS Online Provider Portal) is entered in the same format in the ***Transaction Insight Portal***.

****Spacing MATTERS. A single space before or after the PWK number can result in a mismatch.**

Incorrect Format	Correct Format
a0934000710012019	**A0934000710012019**

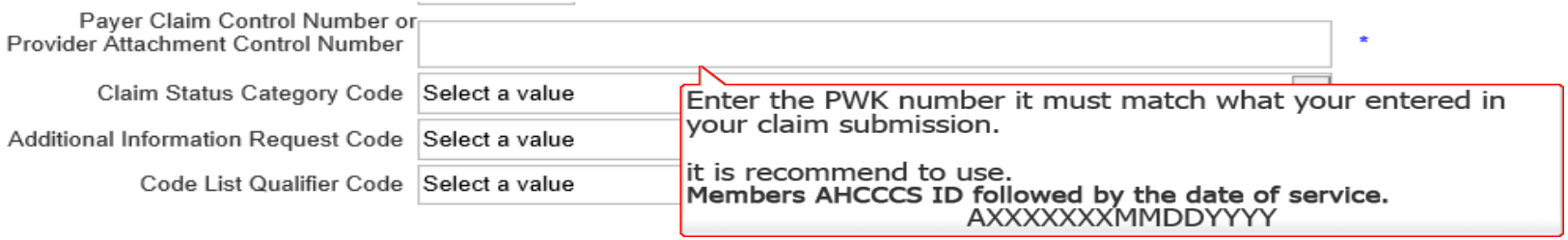
Please note that this PWK number should have already been entered into the AHCCCS Online Provider Portal when the provider first submitted the corresponding claim.

Control/PWK Number Reminders

Example of a PWK number using a member's AHCCCS ID and the Date of Service	
AHCCCS ID (**9-character AHCCCS ID**) The A in AHCCCSID must be in uppercase	A12345678
Date of Service	01/03/18
PWK for Claim 1, Document 1	A1234567801032018
Different AHCCCS ID member with the Same Date of Services	
AHCCCS ID (**9-character AHCCCS ID**) The A in AHCCCSID must be in uppercase	A87654321
Date of Service	01/03/18
PWK for Claim 2, Document 2	A8765432101032018

The combination of the member's AHCCCS ID and the Date of Service is what makes the PWK number unique to each claim.

Payer Claim Control Number or Provider Attachment Control Number (AKA PWK Number)

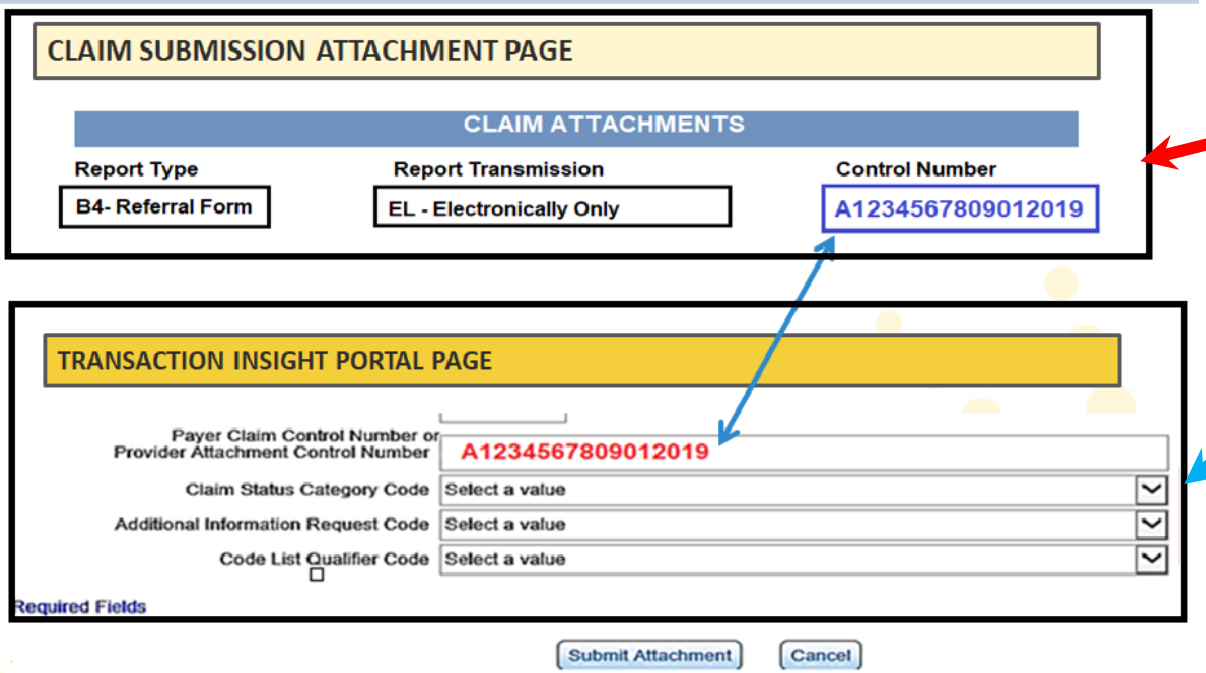


The *exact same* PWK number will be entered into the Payer Claim Control Number "backslash" Provider Attachment Control Number field. If there is even a space of difference the two PWK numbers will not match up. They must match in order for the documentation on the Transaction Insight Portal to "match" to the correct claim in the AHCCCS Online Provider Portal.

Remember: This same PWK number should have already been entered under the ***Claims Attachment Tab*** in the ***AHCCCS Online Provider Portal***, if the AHCCCS Online Provider Portal had been used to submit the claim.

- AHCCCS recommends the PWK number to be the members AHCCCS ID number beginning with an upper case "A" followed by the two digit month, two digit day, and four digit year for the date of service. This ensures a unique PWK for each claim submitted.

Control/PWK Number Reminders



What you see in the AHCCCS Online Provider Portal

What you see in the Transaction Insight Portal

REMINDER: The Control/PWK Number is also called the Payer Claim Control Number or Provider Attachment Control Number!

Tips & Tricks to Prevent Mismatches

When the unique PWK number is created, even if the PWK numbers both match (between the AHCCCS Online Provider Portal and the Transaction Insight Portal), the claim and attachment will still fail to link up if the Provider Identifiers do not match. ***These must match.***

- For example: If a Clearinghouse enters in the NPI on the AHCCCS Online Provider Portal or via the 837 Transaction submission process, and the provider enters in the AHCCCS 6 digit Provider ID on the TI portal when submitting their attachments, the claim and the attachment will fail to link. *These must match.*

Tips & Tricks to Prevent Mismatches

An area where a mismatch may occur is when a clearinghouse submits the claim, with the provider submitting the attachments. In such cases the clearinghouse will often submit using a different provider identifier than what the provider actually uses, when uploading their attachments.

- This results in claims not linking to their attachments.

In the event of a mismatch, a manual linking process may have to occur. It can take up to 4 to 6 weeks for an attachment to be manually linked to a claim, so it is very important for providers to ensure that the information matches.

Tips & Tricks to Prevent Mismatches

Example: Non-Emergency Medical Transportation (NEMT) providers can submit using their AHCCCS 6 digit Provider ID via AHCCCS Online.

To ensure that their claim linked to their attachment, they would not only ensure that the Control Numbers (PWK Numbers) matched between AHCCCS Online and the Transaction Insight Portal, but they would also need to ensure that they input their AHCCCS 6 digit Provider ID into the Transaction Insight Portal as well, rather than their NPI.

If an NPI is entered into the Transaction Insight Portal, when the AHCCCS 6 digit Provider ID was entered into AHCCCS Online, or vice versa, the claim will not link to the attachment.

Training on Submitting Documentation Using the Transaction Insight Portal

AHCCCS offers a regular monthly to quarterly group training session, and individualized 1:1 training sessions for providers on how to use the Transaction Insight Portal.

This course teaches a provider how to log onto the Transaction Insight Provider Portal and to submit documentation successfully, so that it links to the accompanying claim.

The PowerPoint Slide Deck to this presentation is available 24/7 on the DFSM Provider Training Web Page at:

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

The AHCCCS YouTube Channel also has a video presentation on using the Transaction Insight Portal available 24/7. This can be accessed on The DFSM Provider Training Web Page, under the Provider Training Video Library.


DFSM Provider Education and Training Unit

AHCCCS
Arizona Health Care Cost Containment System

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

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

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

The Claims Customer Service team 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 the Claims Customer Service team 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.

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

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

Prior Authorization Questions?

For questions that cannot be resolved on the portal, please outreach the Fee-for-Service Authorization Phone Line at:

- Within Maricopa County: 602-417-4400, Select option 1 for transportation
- Statewide: 1-800-433-0425
- Outside Arizona: 1-800-523-0231
- FESP Dialysis: 602-417-7548

NOTE: Providers should not call the FFS Prior Authorization team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, claims, or for status updates.

Policy Information

AHCCCS FFS Provider Billing Manual:

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

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStriballbillingManual.html

AHCCCS Medical Policy Manual

- https://www.azahcccs.gov/shared/MedicalPolicyManual/

Questions?

Thank You.