

Quick Training Guide

Behavioral Health Claim Status Check and Documentation

This guide will provide general review steps on the following topics:

- How to Check the Status of an Outpatient Behavioral Health Claim (sequence number and status dates)
- How to Attach Missing Behavioral Health Documentation
- How to Create a Unique PWK Number for the Replacement Claim

The Provider Work (PWK) number segment is created by the provider during the initial submission of the claim and may only be used once on the **initial claim submission**. The PWK and the 275 Transaction Insight attachment processes are key components to the successful linking of the documents.

Providers should allow a minimum of 2 days to allow the initial attachment process to be completed. Documents that do not successfully link to the claim providers should

(1) Check the PWK number that was created, and

(2) Verify how the details were entered in the Transaction Insight Portal

(3) Check the claim details on the portal, check for activity under the sequence number and status date fields (see Step 1 below which provides instructions on how to status the claim).

The PWK number can only be used on the initial claim submission, subsequent /replacement claims will require a **New unique/distinctive PWK number**.

To check the status of your behavioral health claim can be done using the AHCCCS Online Provider portal. Claims submitted via the web portal or EDI will normally be received within 24 hours of submission.

Fee-for-Service providers should follow these steps to check the status of the behavioral health claim, become familiar with reading the status history and date fields, denial reason codes, and next action steps to take based on the denial code(s).

Step 1: Check the online claim status: Select the **Other Claim Info** tab, next review the information under the Status History and Denial Reasons sections.

Claim Status: Other Claim Info

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Status History			
Seq	Clean Claim Date	Adjudication Status	Status Date
01	10/30/2023	NOT ADJUDICATED	10/30/2023
02	10/30/2023	DENIED	11/08/2023
03	11/09/2023	NOT ADJUDICATED	11/14/2023

Denial Reasons				
Line	Status Date	Denial Code	Description	Reason
000	11/08/2023	AD966	DENY CLAIM/LINE	MISSING CONSENT FORM

- The **Sequence Number** is a sequential number used to identify a specific adjudication status at a given point in time.
- The **Status Date** is the effective date of the claim’s adjudication.
- The status **Not Adjudicated** is a claim that has not been approved or denied but is holding for review.

In this example, the claim submission and documentation attachment via TIBCO were both done on 10/30/2023. This update shows under **Status Date 10/30/2023 (sequence 01)**.

Important Note: Outpatient behavioral health claims will hold in an “not adjudicated” status for up to seven calendar days to allow providers time to attach the required documentation. If all documents are on file, the claim and records will be forwarded for review. If documents are not linked within the seven day window, the claim will be denied.

Important Note: Claims that contain errors will be denied. The attachment process will still occur, but the claim will remain in a denied status until the claim denial(s) have been resolved by the submitter.

[How to Review Claim Error Messages](#)

On 11/8/2023 (**sequence 02**) the **Status Heading** field indicates the claim is **Denied**. The denial reason will be listed under the **“Denial Reasons”** section. The Denial Code **AD966** indicates **“Missing Consent Form”**.

When is a provider action required

If the denial code states a specific document is missing or no documents submitted, the provider must take the appropriate action which means uploading the documentation to the claim. In this example, the provider submitted the missing document and this action was completed by the provider on **11/9/2023** and the receipt of the documentation was confirmed on the **Status Date 11/14/2023**.

After the missing/requested documents are received the claim status will change from “**Denied**” to “**Not Adjudicated**” and the claim is now holding for review.

Things to Know:

- **A replacement claim is not required unless there is a data/submission error that requires correction and you must upload the required documents to the replacement claim for review. *Submitting an unnecessary replacement claim will extend the time period to complete the review process.***
- **After the seven day period has passed providers can still upload required documents to the claim. Internal reports will identify additional documentation has been received and the claims will be updated to hold for review.**
- **The 12-Digit AHCCCS claim number and Set Purpose Code 11 (TIBCO) would be used to upload any missing documentation requests to an existing claim.**

Creating the PaperWork Number (PWK)

The PWK number segment is created by the provider during the initial submission of the claim and may only be used once on the **initial claim submission**.

Paper Work Number (PWK)

The PWK number is used when submitting an electronic claim and its attachment at the same time. This is an automatic process when the PWK number finds its match between the document and the claim, it will link automatically and the claim will continue with the editing process.

The PWK number is a unique number that you will create for each claim and its' attachment. The system will use the PWK to link the attachment to the correct claim.

The PWK number created during the claim submission process must match exactly with the PWK entered on the 275 Attachment upload. If the PWK does not match, this will result in the document not linking and the claim will be denied.

Behavioral Health Claims:

If a claim requires documentation and a PWK number is entered on the electronic claim the system will hold the outpatient behavioral health claim for seven calendar days to allow providers time to submit the attachment **within the designated time frame.**

After seven calendar days if the attachment hasn't been submitted or the link failed the claim will be denied. At this point you can still **(re)submit the attachment** but instead of using a PWK you will use the Claims Reference Number (CRN) to upload the attachment. **Providers do not need to re-submit the claim unless there is a change to the claim details**

Important Note: 275 Transaction Insight Portal - When using the CRN as the attachment control number, you must select Set Purpose Code 11.

How to Create a PWK Segment for Replacement Claims:

When submitting a correction or replacement claim, providers must enter in the Original Claim number field the AHCCCS 12-digit claim reference number. The replacement claim must contain a **new/unique PWK attachment number.**

Example:

- The first claim submission the provider created the PWK number **A1234567811142023**
- A correction or replacement claim is required for correcting data errors, which also means you must upload the required documents to the replacement claim for review.

Note: The PWK number for the replacement claim must be ***unique*** or have a distinguishing character from the PWK number created on the first claim submission. If the same PWK number is used the documentation will be linked to the original claim and not to the replacement claim and may cause the replacement claim to be denied for **no documentation.**

When to create a Unique/Distinctive PWK Number

A unique or distinctive character can be something as easy as adding the number **1** at the end of the “NEW” PWK number for the replacement/correction claim. This will indicate that the PWK number is ***unique and distinctive from the first claim submission***.

In this example, we show the original PWK number that was created. For the replacement claim the provider used the same PWK number format but also included the number 1 at the end to meet the “**unique and distinctive**” requirement.

Original Claim Submission PWK Number	Replacement Claim PWK Number
A1234567811142023	A12345678111420231

Reminder: If the provider uses the same PWK from the original claim submission, the documents will link to the original claim and not to the replacement claim.

Important Claim Tips:

- Outpatient behavioral health services provided on the same day must be billed on a single claim form.
- Documents must be submitted to support all services billed.
- Failure to submit claims in the appropriate manner may result in a delay of payment and or denial.