AHCCCS
Arizona Health Care Cost Containment System
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

March 2024

March is National Nutrition Awareness Month

Each month there are many national and international days to raise awareness and support for many causes. This month we want to recognize National Nutrition Month and share the importance of nutrition for children and adults.

Extension of the Provider Moratorium to June 8, 2024.

In accordance with Section 42 CFR 455.470, I, Carmen Heredia, Cabinet Executive Officer of the Arizona Health Care Cost Containment System (AHCCCS), will implement for an additional 6 months a statewide moratorium on the enrollment of Behavioral Health Outpatient Clinic, Integrated Clinic, Non-Emergency Medical Transportation, Community Service Agencies, and Behavioral Health Residential Facility providers.

This moratorium extension will **expire on June 8, 2024**. This moratorium allows provider enrollment applications to be considered for an exemption on a case by case basis, under any of the following circumstances:

1. Medically Underserved Service Area and access to care with review and approval by State Medicaid Agency,
2. Service expansion in support of a State Medicaid Agency initiative,
3. At the request of an AHCCCS contracted managed care plan to ensure that access to care standards (i.e., time and distance) are not out of compliance, or
4. Additional exemptions as appropriate and as needs are identified.

These moratoria were approved by the Centers for Medicare and Medicaid Services (CMS) and is effective on December 8, 2023. This action is necessary to safeguard AHCCCS members, public funds, and to maintain the fiscal integrity of the AHCCCS program.

Billing Companies and Clearing House Cannot Submit a Request for ERA (835) Setup

For Electronic Remittance Advice (ERA) 835 requests AHCCCS considers the provider their trading partner, and a request for ERA/835 setup must come from an authorized individual from within the provider organization. The request cannot come from the provider's billing company or clearinghouse.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Fee-for-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 7:30am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding provider-related enrollment, policy, or APEP user issues email APEPTrainingQuestions@azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 417-5500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

Transaction Insight Portal (TIBCO/TI) users, for account creation, to add additional users, or for password resets please make sure to use the following email address: servicedesk@azahcccs.gov

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ProviderTrainingFFS@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

Please note that these materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

Referring, Ordering, Attending (ROPA) Providers Required to Register with AHCCCS

Beginning July 1, 2024, claims submitted by fee-for-service providers that include a referring, ordering, or attending provider who is NOT registered with AHCCCS will be denied.

Fee-for-service claims that include an unregistered prescribing provider are not subject to this deadline. Referring Ordering Attending Provider Information. To begin the enrollment process, visit AHCCCS Provider Enrollment.

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who **refer** AHCCCS members for an item or service, who order non-physician services for members, who **prescribe** medications to members, and who **attend**/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA."

Until these acts passed, referring, ordering, prescribing, and attending providers were required to obtain and maintain a National Provider Identifier (NPI), but were not required to be registered as an AHCCCS provider, but with the implementation of ROPA requirements any registrable healthcare provider who is not already registered as an active AHCCCS provider must register or be identified as an Exception non-registerable provider*, if applicable.

To make the ROPA registration process as simple as possible, AHCCCS developed a streamlined application for ROPA providers who meet all of the following criteria:

- Have a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES),
- Already fully enrolled in Medicare or another state's Medicaid program, and
- Do not intend to bill AHCCCS for services.

Steps To Comply with ROPA

If you are a provider who refers, orders, or acts as an attending provider for AHCCCS members, and you are not represented on either of the above lists, you must begin the registration or exception provider designation process.

If you are a provider who receives a referral or order from a provider who is not on either of these lists (as appropriate), your fee-for-service claim will not be paid as of July 1, 2024.

ROPA enrollment can be initiated using the AHCCCS Provider Enrollment Portal (APEP)

Review Of Documentation Signature Requirements

Valid signatures may be electronic or physically handwritten, however both shall have legible name of the signer printed, signer's credentials (specific license type of professional credentials), and date of signing. The signature must be unique to that individual and linked to the medical record. Providers shall adhere to all electronic signature requirements as described in detail in AHCCCS policy AMPM 940, ARS 44-7031 and applicable CMS rules.

Not allowed: Rubber stamps, copy/paste signatures, manually typed or word-processed name or "electronic signature" or typed timestamp if not part of certificate of secure electronic system.

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

Special Billing Information and Updates

Notice Remittance Advice Claim Denial Code AD364 *(2/23/2024)*

Billing Clarification: Behavioral Health Per Diem Service Codes *(2/6/2024)*

AHCCCS Reimbursement for Rapid Whole Genome Sequencing (rWGS) *(2/16/2024)*

Notice Provider Type B8 Billing Requirements Effective March 1, 2024 *(2/23/2024)*

Common Behavioral Health Claim Denial Edits

The Arizona Health Care Cost Containment (AHCCCS) recommends that before you submit a claim or any medical records that have been requested, you ensure that the medical records for that specific service meet Medicaid's guidelines for signatures. Documentation must meet AHCCCS signature requirements. The AHCCCS clinical review team checks for signed and dated medical documentation that meets the signature requirements. If entries aren't correctly signed and dated, AHCCCS may deny the claim. Documentation must have enough information to show the date the service was performed and by what practitioner.

Providers must make sure that all staff involved in the billing process including if you are using a billing service that they are trained to identify where signatures are necessary and understand the importance of obtaining them before the claim and documents are submitted for review.

Claim Denial Code AD282 Missing Provider Signature

Denial edit AD282 means that the documentation submitted with the claim does not meet the necessary requirements for processing. It is the provider's responsibility to review each page of the documents that were uploaded to determine which document is in non-compliance. Providers must address these issues by reviewing and ensuring that all required documentation is properly signed by the authorized individual before claim submission. Corrective action is required by the provider to resolve the claim before the claim can be adjudicated. A Service ticket should not be initiated for this denial code

- The provider's signature is not present on the required forms or documents that were submitted with the claim.
- The signature provided is illegible or does not match the signature on file.
- The documentation may have a signature, but it lacks the necessary credentials or titles.
- The provider must take corrective action by obtaining a signature that meets all necessary criteria and updating any relevant records.

Claim Denial Code AD283 Invalid Member ID Information AMPM940(III) (A) (1) (B)

The first page of the documentation must include the primary identifier which is the AHCCCS Medicaid member ID, first and last name and date of birth. Each subsequent page of the documentation must identify at a minimum two of the following elements, AHCCCS member ID, first and last name and date of birth.

If this information is missing, corrective action is required by the provider to resolve the claim before the claim can be adjudicated. A Service ticket should not be initiated for this denial code.

Behavioral Health Documentation Requirements

As a reminder, AHCCCS requires providers to submit documentation for ALL HCPCS and CPT codes that are billed to verify claim documentation will adequately support all services billed.
The minimum types of supportive documentation that are required to be submitted for each billed claim are listed below.

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

In addition, when submitting your documentation via TIBCO, we recommend to utilize document dividers to help organize each document type and to upload only one (1) black/white .pdf file that contains all supportive documentation for each individual claim.

Reminders: TIBCO Transaction Insight Web Upload Attachment

If you are using the Claim Reference Number (CRN) as your Payer Claim Control Number, you must use the AHCCCS **12 digit CRN** (do not include the service line number i.e. 001,002) as this is not part of the claim number used in TIBCO.

Providers do not have other functions in the AHCCCS 275 Transaction Insight portal (TIBCO) other than the capability to **upload** required documentation for review to include the AHCCCS NEMT Daily Trip Ticket.

It is the provider's office responsibility to keep track of the documents they upload. Providers can create a simply tracking tool such as shown in the example below:

Claim Submission Information			Transaction Insight (TI) Portal Information			
Claim Source (837 or Online/ Web)	Claim Record Number (CRN#)	Claim PWK#	First Name and Last Name of staff who uploaded the trip reports	Date/Time Trip Reports were uploaded	10-digit NPI or 6 digit Provider ID	Payer Claim Control Number or Provider Attachment Control Number

If you opened a ticket inquiring about your uploaded attachments through Transaction Insight, please always provide the following.

- First Name and Last Name of staff who uploaded the trip reports,
- Date and Time the Trip Reports were uploaded,
- Ten (10) digit National Provider Identification number or,
- Six (6) digit AHCCCS assigned provider ID number for providers that do not have a NPI.
- Payer Claim Control Number or Provider Attachment Control Number that was used for the upload in TIBCO

Checking Your Claim Status

Providers have a number of options to obtain claim status information. It is important to understand the status of your claims in order to resubmit them properly. Providers should monitor the claims submitted to AHCCCS FFS to verify the claims were received and do not require follow up action by the submitter.

For claim status information, simply search by using one of the options below when you select Claim Inquiry.

The online portal will bring back all claims for the member, provider and date of service to include the status of each claim submission. Click this link to view the training presentation How to Status a Claim using the AHCCCS Online Provider Portal

Do not submit another claim until you have verified the status of the claim and most importantly what corrective action is needed. If the claim has been received by AHCCCS and approved for payment, any additional claims will be denied as a duplicate claim. Providers should first review their available resources, the remittance advice or check the claim status using the Online Provider portal. Any questions that you have regarding the claim that cannot be answered after reviewing the claim via the portal, providers can contact Provider services at 602-417-7670 for additional claim assistance.

Submitting a Replacement Claim

Providers can electronically resolve a claim denial or incorrect payment for 837I (Institutional), 837P (Professional) and 837D (Dental) electronic claims. A corrected or replacement claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates, etc.

Once the replacement claim is submitted, the orginal claim is considered ***null and void*** and no longer viable. The AHCCCS claim system will automatically **Void** the claim number that you list as the replacement claim; as your corrected submission replaces the previous or prior claim.

This is a standard process and providers do not need to contact AHCCCS regarding the void of the original claim when you have submitted a replacement claim.

Special Note: Every field can be changed on the replacement except the:

- Service provider NPI number, *(providers who have a 6-digit AHCCCS assigned provider ID number will use their 6-digit number)*
- Billing provider NPI number, and *(providers who have a 6-digit AHCCCS assigned provider ID number will use their 6-digit number)*
- Tax Identification number.

If these fields must be changed, you must **Void** the claim and submit a **new claim**. The new claim must meet the 6 month timely filing timeframe.

Submitting a corrected claim may be necessary when the original claim was submitted with incomplete information (e.g., procedure code, date of service, diagnosis code). The preferred process for submitting corrected claims is to use the 837 transaction for both professional and facility claims or to submit via the AHCCCS Online Provider portal. Replacement claim may also be referred to as corrected claim; void claim may also be referred to as a cancel claim.

The corrected claim must represent the entire new claim—not just the line or item that you are changing. The correction claim can include changes to the original claim, plus new charges for services not previously submitted. However, it must meet the timely filing guidelines outlined in the AHCCCS FFS provider billing manual.

Replacement claims are accepted only when submitted within timely filing requirements: AHCCCS FFS timely filing limits are:

In accordance with **ARS §36-2904 (G), an i*nitial claim for services provided to an AHCCCS member must be received by AHCCCS no later than:***

- Six (6) months f***rom 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 retroeligibility, will be denied.

Replacement claims received outside of timely filing limits will result in claim denial. Failure to indicate the 12-digit AHCCCS claim number as the corrected claim may result in a denial as a duplicate claim or timely filing.

Providers cannot submit one replacement claim for multiple original claims (numbers).

When should a Replacement Claim be submitted
Correction to coding, for i.e.; place of service, date of service, modifier, CPT/HCPCS, charges.
Diagnosis code change.
Correction to the participating provider reporting details.
Emergency indicator field is missing and is required.
Hospital late charges – the entire claim must be rebilled to include the late charges.
To correct / change the type of bill for a institutional claim.
If the original claim was submitted prior to approvial of the prior authorization and you have verified that the authorization status now shows approved and match the claim details, submit a replacement claim.

When not to submit a Replacement Claim
When documents are required for review and there is no change to the coding details. Use the Transaction Insight Portal to attach documents to the existing claim. How to Attach Documentation via Transaction Insight Portal
Claims that were denied due to not meeting Fee-for-Service timely filing.
When submitting hospital only late charges. The entire claim must be rebilled to include the late charges.
Submitting a copy of the Medicare Explanation of Benefits or EOB from the primary payer. This will include when the provider has recieved an adjusted EOB. Use the Transaction Insight Portal to attach documents to the existing claim. How to Attach Documentation via Transaction Insight Portal
Do not submit a replacement claim to appeal a denied claim. If your claim has an error, send the replacement claim first with any documentation that was submitted.
A replacement claim cannot be submitted to change the service provider ID number, the billing provider ID number and the tax ID number. Providers must follow the billing guidance in the AHCCCS FFS Billing Manual, Chaper4 General Billing Rules

Corrections to Previously Processed Claims

When it is necessary to correct a previously processed claim, it is important to file the corrected claim according to the instructions provided in the FFS Provider billing manual.

Please include all services rendered, including previously paid services, on any corrected claim. When submitting a corrected claim, you must ensure that your corrected claim contains a valid AHCCCS Member ID and Billing Provider Tax ID that matches the original claim submission.

Important Note:

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 fields must be corrected or changed, you must void the claim and submit a ***new claim.***

What is the difference between a replacement and void claim?

A Void is a straight recoupment of a claim, with the entire claim being recouped. When a claim is voided, all payment if previously issued is recouped. This process should only be used when there is no other alternative.

If identifying information (i.e. patient demographic information) was incorrectly presented, resulting in charges billed to an incorrect patient, a void claim request is required, and replacement claim functionality should not be used.

FRAUD, WASTE AND ABUSE

The Office of Inspector General (OIG) investigates reports of suspected fraud, waste, and abuse of AHCCCS programs. Each year, OIG recovers and saves tens of millions of dollars in fraudulent claims against Medicaid.

Who Can Report Fraud or Abuse

Absolutely anyone can report fraud, abuse, or member abuse. There are no restrictions and you may remain anonymous. OIG depends on employees, members, providers and the general public to report any suspicious fraud or abuse.

- Report Member, Provider, or Contractor Suspected Fraud or Abuse of the Program (Online Form)

Report Provider Fraud

If you want to report suspected fraud by medical provider, please call the number below:

- In Arizona: 602-417-4045
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686

Report Member Fraud

If you want to report suspected fraud by an AHCCCS member, please call the number below:

- In Arizona: 602-417-4193
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686

Contact the AHCCCS Office of Inspector General with questions about fraud, waste or abuse of the program, or abuse of a member at AHCCCSFraud@azahcccs.gov.