REVISION DATES: 10/1/2018; 10/01/2015

General Information

All claims submitted to the AHCCCS Administration are extensively edited by the AHCCCS claims system. When a claim fails an edit, an error record is created for that claim. All failed edits related to the claim denial are displayed on the Remittance Advice with an edit number, decimal point, and a single digit that further defines the problem. A description of the edit code is listed on the Processing Notes page of the Remittance Advice.

Status Checks Online

AHCCCS has a web application that allows AHCCCS registered providers to check the status of claims using the Internet. To create an account and begin using the application, providers must go to the following web address:

https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

There is no charge for creating an account and there is no transaction charge.

> Note: When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the **master account holder**. For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration.

Providers can check the status of a claim using the member's AHCCCS ID number and the date of service. The Claim Status page allows providers to view the claim status history, edit history, and accounting summary.

Other services available at AHCCCS Online are:

- Online Claim Submissions
- Checking Online Claims Status
- Member Eligibility and Enrollment Verification
- Newborn Notifications
- Prior Authorization Inquiry
- Prior Authorization Submission
- Provider Information Updates (such as correspondence address updating)

Understanding Common Billing Errors

A relatively small number of errors account for the vast majority of pended and denied claims. It is important to understand the nature of these errors and the actions to be taken to resolve them. This section presents a summary of common denial or disallowance edits,

including the error number, error message, a brief description of the error, and a brief statement of the action required. This summary is not all-inclusive.

V005 Prior Authorization

These edits relate to the validity of the authorization, from the status of the authorization to the procedure and units billed. The following section further describes the edits needed to match the billed service to the authorized service.

V005.1 Prior Authorization; PA Not Active (Cs, Evnt, Actvty)

The AHCCCS system does not show a valid, active prior authorization for the service(s) and date(s) of service(s) billed. Contact the AHCCCS Prior Authorization Unit or the ALTCS Case Manager, as appropriate. (Please see the references section at the bottom of the chapter for contact information.)

V005.2 Prior Authorization; PA Units Exceeded

Total units for all claims billed under this authorization exceed the units allowed. The AHCCCS Claims System will pay the number of units remaining and cutback the excess. Contact the AHCCCS PA Unit or ALTCS Case Manager, as appropriate, to determine if the number of authorized units can be increased to cover the services billed.

V005.3 Prior Authorization; PA Units Consumed

All units have been billed and paid prior to this claim. Contact the AHCCCS PA Unit or ALTCS Case Manager, as appropriate, to determine if there should be units remaining or if units can be added. (See References Section at bottom of chatper for contact information for PA.)
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V005.6 Prior Authorization; PA Not Found

No authorization for the service for the period. Review the authorization letter and determine if the correct combination of service and dates of service were billed.

V005.7 Prior Authorization; Primary Proc Code Not Approved

Provider billed an incorrect procedure code. Verify if the service billed is the same as displayed on the authorization letter. Contact the AHCCCS PA Unit or ALTCS Case Manager if the authorized service needs to be changed to another code. Otherwise, resubmit the claim with the correct procedure code that was authorized.

L019 Diagnosis Code #1 Test

This edit relates to the validity of the diagnosis code entered on the CMS 1500 claim form. The following further describe the edits related to the diagnosis code.

L019.1 Diagnosis Code #1 Has Missing Reference Code

L019.2 Diagnosis Code #1 Has Invalid Reference Code

L019.3 Diagnosis Code #1 Is Missing

L019.4 Diagnosis Code #1 Has Invalid Format

L019.5 Diagnosis Code #1 Is Not On File

For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD diagnosis code and entered correctly on the claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

H094 UB-04 Primary Diagnosis

This edit relates to the validity of the diagnosis code entered on the UB-04 claim form. The following further describe the edits related to the diagnosis code.

H094.1 Primary Diagnosis Code - Field Is Missing

H094.2 Primary Diagnosis Code - Field Is Invalid Format

H094.3 Primary Diagnosis Code - Field Is Not On File

For all of the diagnosis edits, determine if the primary diagnosis is a valid ICD diagnosis code and entered correctly on the claim form. Behavioral health providers must use valid ICD codes and **not** DSM-4 codes.

L023 Age/Gender Test for Diagnosis Code #1

This edit relates to the validity of the diagnosis code entered on the CMS 1500 claim form as it relates to the member's age and/or gender. The following further describe the edits.

L023.1 Diagnosis Code #1 - Invalid For Recipient Age and Gender

L023.2 Diagnosis Code #1 - Invalid For Recipient Age

L023.3 Diagnosis Code #1 - Invalid For Recipient Gender

For all of the edits, determine if the correct diagnosis was used for the member. If the diagnosis is correct, contact Claims Customer Service and request a review of the diagnosis. If the diagnosis is incorrect, enter the correct diagnosis and resubmit the claim.

L001 Procedure Code Test

This edit relates to the validity of the procedure code entered on the CMS 1500 claim form. The following further describe the edits related to the procedure code.

L001.1 Procedure Code - Field Is Missing

L001.2 Procedure Code - Field Is Invalid Format

L001.3 Procedure Code - Field Is Not On File

For all of the procedure code edits, verify that the procedure code was entered on the claim, that the code was entered in the correct format, and that the code is a valid five-digit CPT or HCPCS code.

L060 Procedure Modifier #1

This edit relates to the validity of the first procedure modifier entered on a line of the CMS 1500 claim form. The following further describe the edits related to the procedure modifier.

L060.1 Procedure Modifier #1 - Field Is Missing

L060.2 Procedure Modifier #1 - Field Is Invalid Format

L060.3 Procedure Modifier #1 - Field Is Not On File

For all of the edits, verify that the first procedure modifier was entered on the claim line, that the modifier was entered in the correct format, and that the modifier is valid for the procedure code billed on that line. To determine if a modifier is valid, contact the AHCCCS Claims Customer Service Unit. If the modifier is not appropriate for the procedure, providers may request a review.

L067 Medicare Crossovers (CMS 1500)

L067.1 Recipient Has Part B; Medicare Must Be Indicated, Is Missing

If an AHCCCS member has Medicare coverage, the provider must bill Medicare first. Please refer to Chapter 9, Medicare/Other Insurance Liability for information on Medicare and other insurance.

L077 Service Provider Status Test (CMS 1500)

This edit relates to the service provider's ability to bill for the service indicated on a CMS 1500 claim.

L077.1 Service Provider Status Not Active; Not Authorized to Bill for Service

Either the service provider was not enrolled as an active provider with AHCCCS on the date of service, the service provider was not licensed/certified to provide the specific service on the date of service, or the procedure may not be billed by the service provider's provider type. Providers should contact AHCCCS Provider Registration for assistance. (Please see the references section at the bottom of the chapter for contact information.)

H200 Service Provider Status Test (UB-04)

This edit relates to the service provider's ability to bill for the service indicated on a UB-04 claim.

H200.1 Service Provider Status Not Active; Not Authorized to Bill for Service

This edit indicates that the service provider was not enrolled as an active provider with AHCCCS on the date of service, the service provider was not licensed/certified to provide the specific service on the date of service, or the procedure may not be billed by the service provider's provider type. Providers should contact the AHCCCS Provider Registration for assistance.

L078 Billing Provider Status Test (CMS 1500)

This edit relates to the billing provider's ability to bill for the service indicated on a CMS 1500.

L078.1 Billing Provider Status Not Active; Not Authorized To Bill For Service

The billing provider's AHCCCS ID was terminated prior to or during the claim dates of service. Contact Provider Registration for reinstatement procedures.

L016 Category of Service (CMS 1500)

This edit relates to the provider's ability to perform a service based on AHCCCS policy.

L016.1 Category of Service - Not Found For Provider

L016.3 Category of Service - Provider Is Not Authorized

For both category of service edits, verify that the correct procedure was billed. If there is no error in the procedure billed on the claim and the provider believes that the service was billed correctly, the provider should contact the AHCCCS Provider Registration.

H211 Billing To Service Provider Relationship

This edit relates to the billing provider's ability to bill on behalf of the service provider identified on the claim.

H211.1 Billing Provider Not Valid Group ID - Invalid Combination of Codes

The provider submitted a claim with both a service provider ID and a group billing ID. If a group billing ID is present on the claim, the AHCCCS system will check for a provider authorized affiliation.

For that affiliation to be valid, the provider must have notified Provider Registration in writing that a specific group is authorized to bill for the provider's services.

Contact Provider Registration to determine if the necessary authorization has been made. If not, Provider Registration will send the provider a form to complete and return. The affiliation may be retroactively established at the provider's request.

H216 Recipient Eligibility/Enrollment (UB-04)

This edit relates to the member's eligibility for the services billed on the UB-04 claim form.

H216.1 Recipient Not Elg/Enrl For Entire DOS; Invalid Eligibility

H216.2 Recipient Not Elg/Enrl For Entire DOS; Invalid Enrollment

For all member eligibility edits, the member is either not AHCCCS eligible or not eligible for the service(s) on the date(s) of service. Verify the member's AHCCCS ID number and eligibility standing with the AHCCCS the Division of Member Services (DMS). (Please see the references section at the bottom of the chapter for contact information.) . See Chapter 2, Eligibility.

L099 Recipient Eligibility/Enrollment (CMS 1500)

This edit relates to the member's eligibility for the services billed on the CMS 1500 claim.

L099.1 Recipient Not Elg/Enrl For Entire DOS; Invalid Eligibility

L099.2 Recipient Not Elg/Enrl For Entire DOS; Invalid Enrollment

For all member eligibility edits, the member is either not AHCCCS eligible or not eligible for the service on the date(s) of service. Verify the member's AHCCCS ID number and eligibility standing with the AHCCCS Division of Member Services (DMS). See Chapter 2, Eligibility.

H199 Timeliness Test (UB-04)

This edit relates to the timeliness requirement for submitting UB-04 claims to AHCCCS.

H199.4 Claim Received - Past 6 Month Limit

The initial claim for services was received by AHCCCS more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. For hospital claims, the end date of service is the date of discharge. If the claim was originally submitted within the six-month time frame, resubmit the claim with the CRN of the previously denied claim.

H199.2 Claim Received - Past 12 Month Limit, Deny

A resubmission of a denied claim was received by AHCCCS more than 12 months from the end date of service or date of retro-eligibility posting. For hospitals, the end date of service is the date of discharge. Verify the From and Through dates of service entered on the claim.

L076 Timeliness Test (CMS 1500)

This edit relates to the timeliness requirement for submitting CMS 1500 claims.

L076.4 Claim Received - Past 6 Month Limit

The initial claim for services was received by AHCCCS more than six months from the end date of service or the date of eligibility posting for a retro-eligibility claim. If the claim was originally submitted to AHCCCS within the appropriate six-month time frame, resubmit the claim with the CRN of the previously denied claim.

L076.2 Claim Received - Past 12 Month Limit, Deny

A resubmission of a denied claim was received by AHCCCS more than 12 months from the end date of service or date of retro-eligibility posting. Verify the From and Through dates of service entered on the claim form.

Note: Refer to the section "Resubmission, Replacement, Void" in Chapter 4, General Billing Rules, for the AHCCCS required fields on the various claim forms. If information is missing (failure to complete specific claim form fields) the resubmission/replacement won't link to the original claim causing the resubmission/replacement to be denied as a duplicate or for timely filing.

As other edits are encountered, providers should contact the AHCCCS Claims Customer Service Unit for assistance.

References

For additional information on the **PA process** and for contact information for **the Division of Fee-For-Service Management (DFSM) Care Management Systems Unit (CMSU)**, which does prior authorization, please visit:

https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/submissionprocess.html

To outreach Provider Registration:

In Maricopa County: 602-417-7670 and select option 5
Outside Maricopa County: 1-800-794-6862
Out-of-State: 1-800-523-0231

To outreach the Division of Member Services (DMS):

Providers may call the Interactive Voice Response (IVR) within Maricopa County at (602) 417-7200 and all other counties at 1-800-331-5090. There is no charge for this service.

A provider may use their National Provider ID (NPI) to verify a member's eligibility, enrollment via the provider IVR. The provider's IVR allows unlimited verification information by entering demographic information or the member's AHCCCS ID Number, without having to wait in the phone queue.

This allows providers access to the AHCCCS Prepaid Medical Management Information System (PMMIS) for up-to-date eligibility and enrollment. Verification can be made for a single day or for a date range within the two years of the placed phone call.

Providers may also request a faxed copy of eligibility for their records via the IVR.

Provider may also use the AHCCCS Online Portal to verify eligibility and claim information at:

https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f

Revision History

Date	Description of changes	Page(s)
10/1/2018	The link to AHCCCS Online was updated	1
	(Master Account Holder information added) The following was added to the Status Checks Online section: "Note: When a newly registered provider registers with AHCCCS Online for the first time the user must request designation as the **master account holder**. For additional information on the Master Account Holder designation please refer to Chapter 3, Provider Records and Registration."	1
	The "Other Services Available at AHCCCS Online" section was clarified	1
	Clarification was added to V005 – Prior Authorization.	2
	UB-92 updated to UB-04	3
	Edits V00.5.4 and V005.5 descriptions have been removed due to lack of use.	2
	The Understanding Common Billing Areas section was comprehensively updated. The edits had more detail added to provide additional clarification for providers. Clarifications were added to the following edits: • V005	1-7

	• L019 • L067 • L077 • H200 • L016 • H216 • L099 L067.2 edit removed as it has not been utilized in over 5 years. A References Section with contact information for DFSM's CMSU (the PA area), Provider Registration, and the Division of Member Services (DMS) was added Changed "recipient" to "member" Formatting .	 4 7-8 All (except edits) All
10/01/2015	New format "ICD-9" replaced with "ICD	All