

December 2023

## Behavioral Health Claims - Missing Documentation Denial Reason Codes

Checking claim status via the AHCCCS Online Portal is the most effective option. Providers are able to review when an action is initiated by AHCCCS in “real time”.

During the review process providers should not submit a replacement/correction claim if there are no corrections required for the existing claim.

**Submitting an unnecessary replacement claim will extend the time period to complete the review process.**

The AHCCCS denial reason code will explain exactly what document is needed. Providers should use the Transaction Insight Portal to submit the missing documentation using the claim number as the attachment number

- A replacement claim is never required to submit missing documentation, unless there is a change in billing/coding.
- Since the denial reason codes are specific, providers do not need to contact provider services to verify which document is missing or needed.
- The provider training team does not verify the document type that is missing or needed.
- For behavioral health claims, if the required documents are missing, the claim will deny with one of the following missing records denial reason codes:

Denial Reason Code and Descriptions
AD364 No records submitted with claim.
AD075 Documentation does not support services/charges.
AD963 Missing Progress Notes/Report
AD964 Missing Plan of Treatment
AD965 Missing Mental Health Assessment
AD966 Missing Consent Form

## Transaction Insight Portal Reminders for Provider Types 77, 05 and IC

Behavioral Health Outpatient Clinic (PT 77), Clinic (05) and Integrated Clinics (IC) who are required to submit the **Signed Consent to treat form, Treatment plan, Comprehensive progress notes and Medical documentation** for behavioral health service codes the supporting documentation must be received within 7 Calendar days of the receipt date of the claim; or the claim will deny for documentation not received.

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](mailto:APEPTrainingQuestions@azahcccs.gov). Your email will automatically create a service ticket to Provider Enrollment for assistance.

**AHCCCS Warrants -** 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](mailto: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](mailto: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](mailto:ProviderTrainingFFS@azahcccs.gov)

**COVID FAQ:** [FAQ COVID Fact Sheet](#)

## Behavioral Health Services Billing and Coding H2016 and H0038 Same Day Billing Denial Edit L237.4



Claims billed with the HCPCS code H2016 (Comprehensive Community Support Services, per diem) H0038 (Self-Help/Peer Services per 15 minutes) that are billed on the same date of service will automatically deny with the denial edit **L237.4 “Service Not Allowed On The Same Day”**.

Arizona Health Care Cost Containment (AHCCCS) for purposes of consideration for behavioral health services, per billing and policy may use American Medical Association Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definition purposes only and do not imply any right to reimbursement.

### Inpatient Psychiatric Facility (Provider Type 71) Prior Authorization Submission Tips

- Event Type must be BI = Behavioral Health Inpatient.
- Make sure to complete the Activity Tab with the appropriate Revenue code that identifies the level of care for the member (for example revenue code 0124 or 0126).
- To add the missing Activity information, simply navigate to the PA case, click on the sequence number and complete the required fields on the ACTIVITY tab. The admit and discharge dates are required.
- Providers should include the Certificate of Need (CON) For Level 1 Facilities with the initial prior authorization request and or the Recertification of Need (RON) for Level 1 Facilities for continued stay requests. All forms must be uploaded using the Attachment tool.



### Checking Claim Status using the AHCCCS Online Provider Portal

#### Claim Status:

- Any claim action initiated by AHCCCS will reflect on the AHCCCS Online Provider portal the same day the claim is processed.

If the claim status shows “Unadjudicated” this means the claim is currently under review and no action at this time is required by the provider.

### Important Billing Code Change: Place of Service Code 56 for BHRF Provider Type (B8) Only

Effective for dates of services **beginning** December 01, 2023 and after, Behavioral Health Residential Facility (BHRF), provider type B8” must submit claims with **Place of Service (POS) code 56** “Psychiatric Residential Treatment”. This change will impact claims billed with HCPCS code H0018 only.

This change applies to BHRF providers that are a behavioral health and or substance use disorder provider.

***Please make sure your billing staff are aware of this change.***

## Documentation Requirements for Behavioral Health Outpatient Claims



The easiest and most efficient way to attach your documentation for review is to use the Transaction Insight Portal (TIBCO). For payment reviews, documentation is required and to help expedite the review process, we suggest that providers insert a “title sheet” identifying each document type that is uploaded followed by the documents. All combined services rendered on each day billed to FFS will require documentation to include physical services rendered and any services units billed.

## New Denial Code AD281 Medical Documents Do Not Conform to AMPM Policy 940

AMPM Policy 940 Medical Records and Communication of Clinical Information establishes requirements for protection of member information and documentation requirements for member physical and behavioral health records and specifies record review requirements including the use of Electronic Health Records (EHR) and external health information systems. Providers are required to maintain comprehensive documentation related to care and services provided to members.

Common Errors:

- The member’s full name, date of birth and AHCCCS ID must be on each page of the Assessment, progress notes and treatment plan.
- Missing member signature on the Consent to Treat and the treatment plan.

To review this policy in full please go to [Medical Records and Communication of Clinical Information](#)

## Coming January 2024! New 2024 American Dental Association Claim Form

A new version of the 2024 American Dental Association claim form and its updated completion instructions will be effective January 1, 2024.

- AHCCCS Fee-for-Service (FFS) will accept the current version ADA 2012 dental claim form until December 31, 2023.
- Beginning January 1, 2024 AHCCCS will only accept claims for dental services that are submitted on the new ADA 2024 Dental Claim Form.
- Replacement claims submitted on and after 01/01/2024, must also be submitted on the new dental claim form.

## Hysterectomy Consent and Acknowledgement Form

AHCCCS requires the hysterectomy consent form to be submitted with the claim. This form may be found in the [AMPM Chapter 800 Exhibit 820-A Hysterectomy Consent Form](#). If this form is not available the hospital consent form that contains the same information as the Exhibit. 820-A can be submitted for consideration. The consent form must state that the patient will be permanently incapable of having children.

## Elective Sterilization Consent Form Requirement

AHCCCS requires a completed [AMPM Exhibit 420A Federal Sterilization Consent Form](#) to be submitted with all claims for voluntary sterilization procedures. For additional information related to this sterilization service providers can review

For additional information related to these services and guidelines, providers can review [FFS Provider Billing Manual Chapter 10 Individual Practitioner Services](#)

## Community Health Workers and Community Health Representatives (CHW/CHR)



Effective April 1, 2023, the following codes can be reported. You can find more information on the [Community Health Worker and Community Health Representatives \(AHCCCS CHW/CHR\)](#) web page, including the [CHW/CHR Frequently Asked Questions](#). The approved provider types are listed on the FAQ page. There will be a policy update published shortly, please watch for this policy.

The following codes can be reported by those who meet the criteria. There are limits of 4 units in one day and not more than 60 units in 30 days. Each unit is 30 minutes per code description.

The limits are for either a single code or a combination of the codes listed and not 60 units per code.

- 98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.
- 98961 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients.

98962 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients. **1289731936**

### New Quick Training Guides!

The Division of Fee-for-Service Management (DFSM) provider training unit has a variety of training topics relating to prior authorization, claim submission and (TIBCO) documentation and more. We have added new training resources for Fee-for-Service (FFS) providers to use.

These quick guides will provide direct “How to” step by step instructions that are user friendly with more training updates to come. We invite you to participate in our live webinars and as new topics are added to check the [DFSM Provider Training Web Page](#) often for updates.

[Quick Guide - Behavioral Health Claim Status Check and Documentation](#)

[Quick Guide - Paper Work Numbers \(PWK\)](#)

### Prior Authorization Lookup Tool

[Providers can use the Fee-for-Service Authorization Guidelines](#) lookup tool to easily and quickly determine if a code requires an prior authorization. Using the prior authorization guide you will be able to (1) determine if a PA is required, (2) be able to submit the PA request immediately.

## Common Prior Authorization Submission Errors

AHCCCS has identified several common PA submission errors that include but are not limited to:

- PA request entered for CPT/HCPCS code that does not require a PA.
- Incorrect Date of Service(s).
- Incorrect Event type.
- Failure to complete the Event Tab.
- Failure to complete the Activity Tab.

PA request entered under the incorrect provider NPI number.

To learn more about procedures that may or may not require a prior authorization view the [Fee for Service Prior Authorization Guide](#)

## Prior Authorization Submission Tips

### Provider Type 02 Hospital – Outpatient day surgery

If the PA request is for a same day surgery but spans multiple dates due to the member was placed in Recovery or Observation after the procedure, the prior authorization request must cover the entire service dates.

- H220.3 Prior authorization mismatch – This edit will set if the dates of services billed do not match the date span on the PA.
- H228.6 Therapy Requires Prior Authorization; P/A mismatch

### PA Tip: Outpatient Surgery – Physician Prior Authorization Request

- The Event Type must be **MD** for the surgeon.
- The actual date of the scheduled procedure only must be entered on the PA request for the surgeon. **Date spans are not accepted and will result in a denial of the request.**
- CPT code(s) must be entered on the Activity tab with the correct number of units.
- Only modifier 50 (Bilateral) procedure should be submitted when applicable. The PA request for surgery should not include modifiers LT, RT, 59 etc.

## What Happens When The Prior Authorization Does Not Match The Service?

### What Not to Do:

Filing an appeal should never be done when the prior authorization and the claim details do not match.

### What to do:

- The provider must review the claim details and prior authorization details to determine what information is inconsistent and may require correction.
- For those cases in which the prior authorization does not match the services provided, this information should be communicated to your staff to initiate the appropriate changes to the prior authorization (if applicable)
- The [Prior Authorization Correction Form](#) is used to identify what services were actually provided and the documented reasons for the change i.e. changes to the dates of service, HCPCS/CPT, the number of units.
- The PA Correction Form must be uploaded via the PA Submission tab, ***faxed copies are not accepted.***
- For those cases in which the PA details are correct, but the claim details are incorrect this information should be communicated to your billing staff to submit a correction claim (*if applicable*).
- If a correction claim is required, the correction claim should not be billed until the PA is corrected (*if applicable*) and the updated changes are reflected on the AHCCCS Online Provider portal.
- Timely file timeframes will still apply to the initial claim and for replacement/correction claims. Submitting a correction to a prior authorization does not extend the clean claim timely filing period.

## How to Correct the Duplicate Prior Authorization Case Creation Error

The “duplicate case error” message will present when the system identifies an existing prior authorization case number is on file for the member and the same provider NPI or AHCCCS 6-digit ID number that is used for for atypical provider types only.

The PA portal is reading the **effective dates span** field on the existing authorization case number and comparing the effective date span of the existing PA with the dates the provider is attempting to enter for the **New PA** request.

If the date of service is within the effective date span of the first case a new Event should be created under the same PA case number.

**Existing Case Example:** 001234567

Note: this case is created under the same provider NPI/ID number.

**Effective Date** span field for this case spans **01/01/2023 - 12/31/2023**.

**Next Step:** Adding a New Event Under The Existing Case Number.

- Click on the PA Submission tab and search for the appropriate case number, i.e. 001234567.
- Click on the case number, this will take you to the **Event List** page.
- Click on the tab “**Create a New Event**” and enter the service begin and end date and other details for the new PA request.
- Complete the **Activity Tab** and click submit to finalize the new PA request.

## Selecting the Correct Claim Number To Submit a Replacement Claim

A corrected claim is a replacement of a previously submitted claim. When you submit a corrected claim, it's important to complete all required fields with the correct, required information. Providers can submit a replacement claim using the AHCCCS Online Provider portal or Electronic Data Interchange (EDI) 837 transactions.

Providers can obtain the Original Reference Number (CRN) using the AHCCCS Provider portal or your Explanation of Benefits (EOB). When submitting a replacement claim, providers must reference the Original Reference Number to submit a correction claim.

### Example of Claim Number Assignment For a Replacement Claim

In this example, the date of service is 11/1/2023 and the claim was received on 11/5/2023. This is the first claim on file for the member, date of service and service provider. The claim is assigned a claim reference number or ICN (**240000000812**).

### Submitting The First Replacement Claim:

- The first claim is approved for payment on 11/10/2023, however, the provider determines that a correction claim is required. During the replacement claim process, the provider must enter the original claim number (240000000812) in the original reference number field.

### What Happens To The Original Claim Number?

- When the first replacement claim is received, the AHCCCS processing system will change the original claim number (240000000812) status to **"Void"**.
- The first replacement claim will be assigned a new claim reference number (240000000920). The replacement claim will then become the next viable claim number in the order the claim is received.

### Submitting A Second Replacement Claim To Correct The First Replacement Claim:

- The second replacement claim is denied for "invalid place of service code" and the provider determines that another correction claim is required.
- This will be the second replacement claim that the provider will submit. The provider enters the first replacement claim number (240000000920) in the original reference number field.
- After the second replacement claim is received, the AHCCCS processing system will change the status of the first replacement claim number to "Void" and assign a new claim reference number to the second replacement claim (240000001090).
- Important Note: Once the claim status is changed to Void, that claim number no longer exists in the processing system and the claim number can no longer be used to initiate any type of claim action.

Note: Replacement claims may impact payment if the claim is not submitted:

1. Within the timely filing period for a correction claim, or
2. The claim is submitted incorrectly, contains errors.
3. If the original claim is in a paid status, a replacement claim will result in a Void and recoupment of the previously paid claim.
4. All claims submissions must meet the clean claim timeframes.
5. The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported on the AHCCCS Remittance Advice. Providers should correct claim errors and resubmit claims to AHCCCS for processing within the 12 month clean claim time frame.

## Modification Request: How to Add a Missing Provider Service Location In APEP

If you are submitting a claim using the AHCCCS Online Provider portal and do not see the specific service location in the dropdown option, you can easily verify if the location is on file. Click on the Provider Verification tab and you should see the providers pay-to-location, correspondence and service locations. If the service location is not listed providers can do an update or modification in the APEP system.

There are many training tutorials online for the APEP system. The Modification Request guide is a resource that providers can use that provides instructions for completing a modification request in APEP.

### [Modification Request: Steps on how to complete a modification in APEP](#)

A “Modification” is a change or update. Some examples of a “Modification” include:

- A change in Correspondence, Pay-To, and Service location addresses.
- Group NPI/Tax ID Association
- Adding an owner or managing employee.
- Updating a license/certificate

## 275 Transaction Insight Portal Batch Option

Did you know that your billing company or clearing house can request to become a 275 Transaction Insight Portal Trading Partner with AHCCCS. The AHCCCS Information Services Division (ISD) Service Desk is the first point of contact for all questions related to submission of electronic transactions and data.

The preferred method of contact is email. All inquiries/requests will result in a Customer Support Ticket Number assignment. Contact information: Email: [servicedesk@azahcccs.gov](mailto:servicedesk@azahcccs.gov)

If you are interested in signing up to become a 275 Trading Partner, review the guide below: [www.azahcccs.gov/Resources/Downloads/EDIchanges/CCICompanionGuide.pdf](http://www.azahcccs.gov/Resources/Downloads/EDIchanges/CCICompanionGuide.pdf)