



CORRECTING CLAIMS

All claims submitted to the AHCCCS Administration are extensively edited by the AHCCCS claims system. When a claim fails an edit or an audit, an error record is created for that claim. All failed edits related to the claim denial are displayed in the Denied Claims section of 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 (See [Chapter 27, Understanding the Remittance Advice](#)).

Providers may call the AHCCCS Claims Customer Service Unit and correct some common CMS 1500 claim errors over the phone without resubmission of a claim. Providers also may use the Claim Correction Request Form to correct many common CMS 1500 claim errors without resubmitting a claim.

The following CMS 1500 claim errors can be corrected over the phone or by using the Claim Correction Request Form:

- Enter Medicare or other insurance amounts if provider faxes the explanation of benefits with the Claim Correction Request Form
- Change, add, or delete a procedure modifier
- Change the number of units

Providers may not correct UB-92 claim errors over the phone. UB-92 billers must either use the Claim Correction Request Form or resubmit the claim.

The Claim Correction Request Form must be faxed to the AHCCCS Claims Research/Adjudication Unit at (602) 253-5472.

The completed Claim Correction Request Form ([Exhibit 26-1](#)) must include the provider's name and AHCCCS ID Number and a contact person's name. The recipient's name and AHCCCS ID, the claim date(s) of service, billed amount, the Claim Reference Number (CRN) of the claim to be corrected, and the fields to be changed must also be included. Providers may include comments or questions as well.

Providers who want to correct their CMS 1500 claims over the telephone may call the AHCCCS Claims Customer Service Unit at:

Phoenix Area: (602) 417-7670, Option 4
In state: 1-800-794-6862
Out of state: 1-800-523-0231



STATUS CHECKS

AHCCCS has developed a Web application that allows providers to check the status of claims using the Internet.

To create an account and begin using the application, providers must go to the AHCCCS Home Page at www.ahcccs.state.az.us. Once at the Home Page, click on the Information for Providers link to go to the Providers page. A link on the Providers page allows providers to create an account.

Providers can check the status of a claim using the recipient'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.

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

The Claim Status Request Form ([Exhibit 26-2](#)) also may be used to request a status of the provider's claims. Status checks can be provided for paid, denied, and in-process claims.

The Claim Status Request form may be faxed to the AHCCCS Claims Research/Adjudication Unit at (602) 253-5472. The completed form must include the provider name and AHCCCS ID number as well as a contact name. Recipient name and AHCCCS ID, claim date of service, and the claim billed amount must also be included.

UNDERSTANDING COMMON BILLING ERRORS

A relatively small number of errors account for the vast majority of pended and denied claims. 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

This edit relates to the validity of the authorization, from the status of the authorization to the procedure and units billed. The following further describe the edits related to matching the service billed to the service authorized.

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

The AHCCCS system does not show a valid, active authorization for the services and date(s) of service billed. Contact the AHCCCS Prior Authorization Unit or the ALTCS case manager, as appropriate.



UNDERSTANDING COMMON BILLING ERRORS (CONT.)

V005 Prior Authorization (Cont.)

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.

V005.4 Prior Authorization; Claim Modifier Not Found On PA

The claim was billed with a procedure and modifier combination that was not found on the PA file in the AHCCCS system. Review the authorization letter to determine if the correct procedure and procedure modifier were entered on the claim.

V005.5 Prior Authorization; PA Modifier Not Found On Claim

The service authorized requires a procedure and modifier combination, and the provider did not bill the procedure with the appropriate modifier. Review the authorization letter to determine if the correct procedure and procedure modifier were entered on the claim.

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.



UNDERSTANDING COMMON BILLING ERRORS (CONT.)

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-9 diagnosis code and entered correctly on the claim form. Behavioral health providers must use ICD-9 codes and **not** DSM-4 codes.

H094 UB-92 Primary Diagnosis

This edit relates to the validity of the diagnosis code entered on the UB-92 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-9 diagnosis code and entered correctly on the claim form. Behavioral health providers must use ICD-9 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 recipient'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 recipient. 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.



UNDERSTANDING COMMON BILLING ERRORS (CONT.)

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
- L067.2 Recipient Has Part B; Medicare Starts Between Service Dates

If the recipient 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.



UNDERSTANDING COMMON BILLING ERRORS (CONT.)

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 the AHCCCS Claims Customer Service Unit or AHCCCS Provider Registration for assistance.

H200 Service Provider Status Test (UB-92)

This edit relates to the service provider's ability to bill for the service indicated on a UB-92 claim.

H200.1 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 the AHCCCS Claims Customer Service Unit or 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 Claims Customer Service Unit or AHCCCS Provider Registration.



UNDERSTANDING COMMON BILLING ERRORS (CONT.)

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-92)

This edit relates to the recipient's eligibility for the services billed on the UB-92 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 recipient eligibility edits, the recipient is either not AHCCCS eligible or not eligible for the service on the date(s) of service. Verify the recipient's AHCCCS ID number and eligibility standing with the AHCCCS Verification Unit. See [Chapter 2, Recipient Eligibility and Enrollment](#).

L099 Recipient Eligibility/Enrollment (CMS 1500)

This edit relates to the recipient'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 recipient eligibility edits, the recipient is either not AHCCCS eligible or not eligible for the service on the date(s) of service. Verify the recipient's AHCCCS ID number and eligibility standing with the AHCCCS Verification Unit. See [Chapter 2, Recipient Eligibility and Enrollment](#).



UNDERSTANDING COMMON BILLING ERRORS (CONT.)

H199 Timeliness Test (UB-92)

This edit relates to the timeliness requirement for submitting UB-92 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.

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