ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

May 2025

Importance of Reviewing The Behavioral Health Documentation Prior to Submission

Documentation Prior To Submission Behavioral health documentation errors can include inconsistent documentation, incorrect diagnoses, treatments, and charting of services and duration. Creating and maintaining accurate records can reduce these types of errors.
It is critical for clinical and billing staff to review the documentation and claim specifics before submitting the claim to prevent any discrepancies in the information provided. For example the denial reason code MD418 "Claim Mismatch Units/Code Documented" indicates that there is a discrepancy between the CPT code, the recorded start and end times of the services, and the units reported on the claim.

EDI Solutions Upload Attachment Process

When using the AHCCCS Claim Reference Number (CRN) as your document attachment number or Payer Claim Control Number, enter only the first 12-digits of the CRN. It is important to exclude the service line number, such as 001 or 002, as this information is not part of the claim number and will result in documents not linked to the associated claim.

Tips For Checking a Claim Status

Providers are encouraged to access AHCCCS Online Provider Portal for real-time claim and prior authorization updates, and information, including eligibility verification, claims status, prior authorization status, and more.

Provider Claim Research Tips:
To research a claim denial online, navigate to the "claims" inquiry section, and then filter to view only the
claims for the member and date span.

Review Claim Denial Details:
Once you select a claim, the portal should display the reason for the action taken on the claim. This will usually
provide details about the reason for the denial, including specific policy codes and explanations for why the
claim was not approved.

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, 8:00am-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

To upload documents to the new EDI Solutions portal ServiceNow, users will need to have access. If you do not have an account, please follow the instructions outlined in the EDI Portal Provider Signup and Login Guide.

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 ServiceDesk@azahcccs.gov

COVID FAQ: FAQ COVID Fact Sheet

Outpatient Behavioral Health Claims Documentation

Unnecessary claim resubmissions to include missing documents, can be addressed by ensuring all necessary supporting documentation is included in the initial claim submission. Behavioral health providers should not void and replace a claim when documentation has been requested and when there is no change to the billing details.

- ✓ Corrected claims are required when the provider has found incorrect information was submitted on a claim or when charges need to be added or corrected.

Claims documentation is an essential process. It ensures that claims are processed accurately and efficiently. However, errors in documentation can lead to delays and claim denials. The correct process is to upload the requested documentation using the EDI Solutions portal. Documents should be associated with the claim within 48 hours of submission. Next submit a service ticket to have the claim reopened for review.

Steps to Take When a Claim is Denied

1. **Review the Denial Notice**: Carefully check the reason for the denial.
2. **Identify the Errors**: Determine if the issue was due to missing documents, incorrect data, or coding errors.
3. **Submit the necessary documentation –** remember do not submit a replacement claim if there is no change to the billing details.

Understanding the Basics of BH Claims Documentation Requirements

Claims documentation refers to the collection and submission of necessary paperwork to support a claim request. Proper documentation ensures that all required details are correctly recorded.

Lack of Supporting Evidence

- Claims often require additional documents,
- Failure to attach these supporting documents can lead to denial.
- Incorrect or incomplete documentation is a leading cause of claim denials as evidenced by the claim denial edit codes.

Best Practices to Avoid Errors in Claims Documentation

- Double-Check All Documents Before Submission, check and make corrections in advance.

Train Your Staff on Proper BH Documentation Procedures

- Ensuring quality reviews and checks for accuracy of documentation requires continuous improvement and staff training. Organizations should adopt a proactive approach to minimize errors and enhance efficiency.
- Conduct regular staff training in the latest documentation requirements, procedures and compliance standards.
- Proper training reduces errors.

Reminder: AHCCCS Solutions Center Training Guide

New to using the Solutions Center portal, please refer to the training guide for provider services. AHCCCS Solutions Center User Guide - Providers

Reporting Incident, Accidents and Death via the Quality Management Portal

The AHCCCS Division of Fee-for-Service Management (DFSM) Quality Administration Unit has put together a great training overview for reporting Incident, Accidents and Death (IAD) reporting via the AHCCCS WM portal, and effects to improve healthcare quality, safety, efficient, as well as compliance and monitoring actions for providers to improve quality program integrity. The QM team will host monthly presentations on this topic and notifications of upcoming training dates will be emailed to registered attendees via the Constant Contact email list.

How to sign up for DFSM Email Alerts

We encourage providers to review this presentation, as it encompasses a wealth of information regarding the appropriate timing and methods for reporting (IADs).

Quality Management Overview (4/08/2025)

Fee-for-Service Prior Authorization Issues:

Common Error: Additional information requested not received; preauthorization request rejected.

Corrective Action: Providers must review their prior authorization requests (PA) in the AHCCS Online Portal. Providers should check the portal frequently; if a PA is in a "Pending" status, please review the notes to determine if additional information has been requested. Providers can review FFS Billing Manual, Chapter 8 Prior Authorization manual as well as additional information regarding submitting additional documents that are requested by the PA review team.

Submitting Claims with Other Insurance (Third Party Liability)

What is Third Party Liability? Third Party Liability (TPL), or other health care coverage, is any other insurance coverage that is not Arizona Medicaid.

Where can a provider access a recipient's TPL/Medicare information? Providers/users can login to the

AHCCCS Online Provider Portal and select "Member Eligibility Verification" and click on the TPL/Medicaid tab. A service ticket should not be submitted to correct a member's record.

Who should a provider contact if incorrect TPL or Medicare Replacement information is on file with AHCCCS? The Member not the provider may contact the member services team to report a change. A Service Ticket should not be submitted to correct a member's TPL/Medicare information.

Submitting a Medicare Inpatient Claim for Member's With Part B Coverage Only

For Institutional Inpatient Claims, when a recipient only has Medicare Part B or their Part A benefits are exhausted, what is the process for billing AHCCCS Medicaid?

Providers are to bill Medicare Part B for Ancillary Charges, then submit an Institutional Claim (not a Crossover Claim) to AHCCCS with the full billed charges. For more information, review the AHCCCS FFS Provider Billing Manual, Billing on the UB-04

Behavioral Health Coding and Billing Guides Updates

The AHCCCS Behavioral Health Services Matrix (B2 Matrix) is updated and published monthly, with the current month's information. Refer to the 'as of' date in the header of the Matrix document below:

- B2 Matrix *(updated 04/17/2025)*

The AHCCCS Covered Behavioral Health Services Guide (CBHSG) is updated and published as needed. Refer to the CBHSG below:

- AHCCCS Covered Behavioral Health Services Guide **(updated 04/01/2025)**

The AHCCCS Same Day Disallow Table includes the most commonly used per diem, single day, counseling, treatment, and assessment/screening/evaluation code combinations. This is not an exhaustive list of all available codes. Refer to the AHCCCS Same Day Disallow Table below:

- AHCCCS Same Day Disallow Table (Updated 04/03/2025)

Easily determine if prior authorization is required for CPT, HCPCS and non-emergency admissions with our search tool. To determine if prior authorization is needed, providers can use the FFS Prior Authorization Guidelines (*updated 4/14/2025)* Providers should also refer to the FFS Provider Billing Manual, Chapter 8 Prior Authorization

The Edit Resolution Guide is a tool that was created to help providers understand the denial edits, descriptions, and actionable next steps. New denial edits will be added periodically to the guide. Providers maintain the responsibility to ensure all claims are billed appropriately.

Provider Denial Resolution Guide *(04/29/2025)*

FES Prior Authorization Submission Errors

AHCCCS FFS require prior authorization for scheduled inpatient admissions, including those to acute hospitals, long-term hospitals, and rehabilitation facilities. Prior authorization is NOT required for members enrolled in the Federal Emergency Services Program and should not be submitted as this results in delay.