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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

July 2026

DFSM Third Quarter Provider Training Schedule

AHCCCS offers various Fee-for-Service provider training opportunities, which covers the AHCCCS Online Provider portal, general processes to include claim submissions and corrections, Fee-for-Service prior authorization, and EDI AHCCCS Solution Center for documentation uploads. Training dates and times for the Third Quarter will be posted on the provider's training webpage.

AHCCCS 3rd Quarter Provider Training Schedule.

AHCCCS Solutions Center Repeat from June

The AHCCCS Solutions Center launched May 4, 2026. This portal replaced ServiceDesk. This change streamlines how Fee-For-Service providers interact directly with AHCCCS.

- Providers will be able to submit tickets,
- Interact with agents and monitor the progress of your issues all in the same place.
- For some requests, such as complex claim inquiries and Training request.

These efforts reflect our commitment to modernization through secure, cloud-based solutions that simplify processes and enhance transparency.

Visit our Knowledge Base to find User Guides, FAQs, training videos, and more!

Exhibit 11-2 Fee-for-Service Outlier Exclusion List

The Arizona Health Care Cost Containment Program (AHCCCS) would like to inform you of some important updates to the Fee-for-Service Outlier Exclusion List effective July 20, 2026.

AHCCCS has updated the Fee-for-Service Outlier Exclusion List for clarity. Providers are encouraged to review the list in its entirety to ensure awareness of the applicable exclusions.

For more information on outlier pricing please see the Inpatient APR DRG Reimbursement Values in the AHCCCS APR-DRG Payment System Design Payment Policies

Resource links:
AHCCCS Archive
AHCCCS Fee-for-Service Provider Billing Manual
AHCCCS Medical Policy Manual (AMPM)

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

Report an Incident, Accident, and/or Death in the AHCCCS QM Portal FFS providers are required to report any Quality of Care (QOC) Concerns and Incidents, Accidents, and Deaths (IADs) as soon as they are aware, and no later than 24 hours after discovering the issue. Reports should be submitted through the QM portal.

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

FQHC/RHC Reimbursement for Case Management (T1016)

Case Management is not an FQHC/RHC visit reimbursable at the all-inclusive per visit PPS rate. Case Management (T1016) is reimbursed at the capped fee-for-service fee schedule when provided by a provider within their scope of practice.

Case management services are provided by individuals who are qualified behavioral health technicians (BHT) or behavioral health paraprofessionals (BHPP).

Best Practices for Pending Prior Authorizations and Meeting Initial Claim Submission Time Frames

If the Prior Authorization Request is in a pend status and the claim filing deadline is approaching, providers should submit the claim to ensure the initial six-month timely filing period is met.

This process does not replace or supersede the requirement to submit a timely prior authorization request. Prior authorizations must be submitted via the AHCCCS Online Provider Portal.

Claim Submission Time-Frame: If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

Reference: Fee-for-Service Provider Billing Manual Chapter 04 General Billing Rule

Prior Authorization Requirements
Nothing has changed regarding the requirement for FFS providers to submit prior authorization requests for medical and behavioral services that require prior authorization.

Receiving authorization approval does not guarantee payment. The service must be supported by medical documentation establishing medical necessity, and the claim must meet all AHCCCS criteria including clean claim and timely filing criteria.

Identify Services That Require Prior Authorization
Providers are responsible for identifying which services require prior authorization before submitting a PA request. Providers should avoid submitting PA requests for services that do not require prior authorization, such as office visits, laboratory services, x-rays, and evaluation and management codes.

Reference: Fee For Service Prior Authorization Guidelines.xlsx

Prepare and Submit Complete Prior Auth Requests
Complete and accurate prior authorization submissions help reduce processing delays. Providers should:

- Include all necessary documentation such as clinical notes, lab results, and diagnostic codes if required.
- Make sure to verify the member and patient information is accurate.
- Regularly check the status of the prior authorization request and respond promptly to requests for additional information.

System Claim Denial Issue L243.1

AHCCCS Fee-for-Service has identified a system error that may have caused certain provider claims to deny in error under denial reason code L243.1. AHCCCS is actively working to correct the issue, and affected claims ***will be reprocessed by AHCCCS***.

No action is required from providers at this time.

- Providers do not need to resubmit affected claims.
- It is not necessary to contact Provider Services regarding this denial reason code.

Participating Provider Reporting Details Description of Service Is Not Required

When reporting Participating Provider details in the "Additional Information" field, providers should not include a description of the behavioral health service code.

Following the required participating provider and claim submission process helps support timely reimbursement and can assist with reducing claim denials.

- The CPT/HCPCS code submitted on the claim identifies the behavioral health service provided.
- Only include information that is required to support accurate claim processing.

Example: Description of Service Included but Not Required

9999999999Jones, Tom
Skills Training and Development, Per Diem

We have provided the link to the AHCCCS training web page.

AHCCCS Provider Education and Training Web Page