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

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

June 2026

AHCCCS Solutions Center

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!

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.

New AHCCCS Eligibility Training Resource Guide

AHCCCS has posted a new training eligibility lookup guide to support providers in verifying AHCCCS eligibility for American Indian and Alaska Native (AIHP) members.

This guide serves as a quick reference to help providers understand eligibility considerations and identify available tools and resources that support timely eligibility verification and care coordination. It is especially useful for provider staff involved in admissions, eligibility verification, billing, and care coordination.

The guide is available here: AHCCCS Medical and Behavioral Health Eligibility Lookup Guide for Providers for Care Coordination

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

AHCCCS Medical Coding Resource Guide

AHCCCS Medical coding has created a AHCCCS Medical Coding Resource Guide

The AHCCCS Medical Coding Unit is responsible for updating and maintaining all medical coding used in AHCCCS claims and encounter processing. This includes place of service, modifiers, new procedure codes, new diagnoses, and coding rules. The unit also reviews and responds to medical-coding guidelines and questions, including questions related to daily limits and procedure coverage. This guide is intended for use by AHCCCS MCOs and Fee-for-Service providers.

Referring, Ordering, Attending and Prescribing Providers (ROPA)

Beginning September 1, 2026, claims submitted by fee-for-service providers that include a referring, ordering, attending and Prescribing Provider who is NOT registered with AHCCCS will be denied.

To begin the enrollment process visit AHCCCS Provider Enrollment.

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. AHCCCS calls this initiative, and these providers, "ROPA."

Prior to the passage of these Acts, referring, ordering, prescribing, and attending providers were required to obtain and maintain a National Provider Identifier (NPI), but were not required to be registered as an AHCCCS provider. With the implementation of ROPA requirements, any registrable healthcare provider who is not already registered as an active AHCCCS provider must register or be identified as an Exception non-registerable provider, if applicable.

To make the ROPA registration process as simple as possible, AHCCCS developed a streamlined application for ROPA providers who meet all of the following criteria:

- Have a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES),
- Already fully enrolled in Medicare or another state's Medicaid program, and
- Do not intend to bill AHCCCS for services.

Steps To Comply with ROPA

If you are a provider or work with a provider who refers, orders, or acts as an attending provider for AHCCCS members, and you or the provider you work with are not registered with AHCCCS, you must begin the registration or exception provider designation process.

Intensive Outpatient Program Services (IOP) Event Type

Currently, Intensive Outpatient Program (IOP) prior authorization requests must be submitted using Event Type OP.

AHCCCS is currently working to add IOP as a selectable event type.

Until that update is available, providers should continue submitting IOP prior authorization requests using Event Type OP.

AHCCCS DFSM will send an email notification when the IOP option becomes available for use.

General Billing Guidance HQ (Group) Modifier

Billing for behavioral health in a group setting requires adherence to coding requirements, group size limits, and individual client documentation.

Use of the Group (HQ) Modifier: The HQ modifier must be appended to the applicable behavioral health service code when services are rendered in a group setting rather than on an individual, one-to-one basis. Behavioral health service delivered to multiple clients simultaneously is required to include the HQ modifier.

Failure to append, the HQ modifier when required will result in inaccurate billing and may directly affect reimbursement. This information is outlined in the Behavioral Health B2 Matrix and the AHCCCS Covered Behavioral Health Services Guide and follows standard billing criteria.

This billing guidance applies to service performed in a group setting, including both timed and per diem service codes.

Examples include but are not limited to the following:

- H0004 Behavioral health counseling and therapy, per 15 minutes,
- H2038 Behavioral Health skills training and development (timed),
- H2014 Skills training and development, per diem,
- H2018 Psychosocial Rehabilitation Services, per diem.

Behavioral Health Cloned Documentation: Documentation cloning is strictly prohibited.

Documentation & Time: Group progress notes must include complete and accurate documentation. As outlined in AMPM 940, documenting exact service duration, diagnosis, patient member's response to services, and the type and description of services provided during the group session.

Documentation must substantiate that the services billed were rendered as documented and provided in accordance with applicable billing and clinical requirements.

Examples include but is not limited to the duration of the service (time increments) which meets per diem requirements, signatures with credentials which demonstrates clinical qualifications and must contain documentation showing the differences and the needs of the patient for each visit or encounter.

AHCCCS Fee-for-Service Timely Filing: AHCCCS requires the initial claim be received within six months of the date of service. Initial claims submitted after the 6-month timely filing period are subject to denial.

Reference Sources:
AMPM 940 Medical Records and Communication of Clinical Information
AMPM 320-0 Behavioral Health Assessment, Service and Treatment Planning
AMPM 310-B Title XIX/XXI Behavioral Health Service Benefit

Dental Claim Submission Error Tooth Numbers

When using "JO" (ANSI/ADA/ISO Specification No. 3950) use two digits to indicate the tooth system. If a procedure is done to tooth 1 enter in 01. If a procedure is done to tooth 2, enter 02. Failure to list the tooth number in a two-digit format can result in return of the claim to the provider or denial.

Medicare and Third-Party Liability Claims Correction

Providers are responsible for correcting errors that are a result of the direct claim submission. This applies to claims submitted on the AHCCCS Online Provider portal and direct EDI claim submissions.

Providers must submit a replacement/correction claim with any previously entered fields submitted with the correct information.

AHCCCS cannot edit/change or alter details entered by the provider.

This includes instances where Third Party Liability (TPL) and/or Medicare cost-sharing amounts were entered in the incorrect fields. If you are uncertain which fields should be used for Other (OTH) or Medicare amounts, leave these fields blank and submit a copy of the Explanation of Benefits (EOB) to ensure accurate processing.

Submitting a Correction/Replacement Claim

AHCCCS Claims Replacement: The initial claim must be received by AHCCCS within 6-months from the date of service to meet the timely filing period.

Step 1. Check the date(s) of service (DOS).

- Confirm the earliest DOS on the claim and verify the claim was received within 6 months of the DOS.

Step 2. Confirm the resubmission/adjustment is still **within 12 months of the DOS** (unless retro-eligibility applies).

- If the DOS is past the 12-month timely filing period and the provider submits a replacement claim, any payments issued **will be automatically recouped and the identified claim will be placed in Void status. No action will be taken on the replacement claim.**

Why NOT Sharing your User ID and Login Information is VERY Important -Repeat from May 2026

As an AHCCCS provider, you are responsible for all activities that occur under your AHCCCS Online Provider Portal account. Sharing account information is prohibited.

You are responsible for any activity conducted under your AHCCCS Online Provider Portal account that constitutes non-compliance with the Provider Participation Agreement, or that constitutes fraud, waste, or abuse.

You are responsible for all activities when your login ID and password are used.

Each time an individual logs onto the AHCCCS Online Provider Portal, the following message is displayed:

** ATTENTION - SHARING ACCOUNTS IS PROHIBITED! ** Please remember that sharing account logins is prohibited and violates the AHCCCS User Acceptance Agreement.

You should NOT share your username and password with any other individuals. Each user must have their own web account. Access to the website can be terminated if the Terms of Use are violated. This means that even if two individuals work for the same facility, they cannot share usernames and passwords. Doing so would violate the AHCCCS User Acceptance Agreement.