CHAPTER 6 – "HOW TO…"

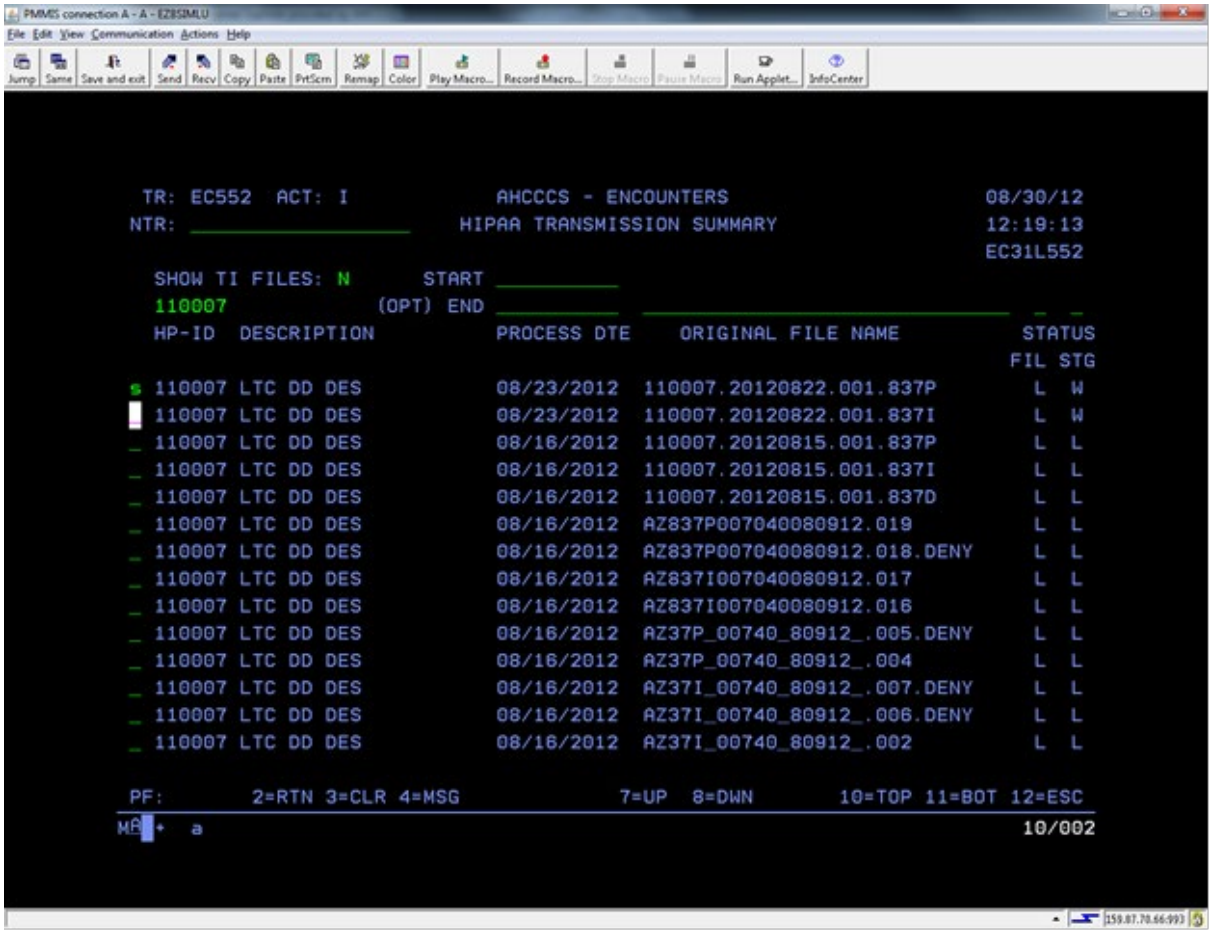
I. INTRODUCTION

The purpose of this chapter is to provide additional clarification of those common questions presented to AHCCCS from the Contractors regarding encounter processing. This section will cover a variety of topics is updated quarterly as issues/questions are presented and is further supplemented by the AHCCCS encounter keys newsletter.

It is important to note that the AHCCCS contract requires that Contractors follow claims processing guidelines, applicable to managed care, that are maintained within the AHCCCS Fee for Service Provider Manual unless otherwise specified (where allowable) in written contract between the Contractor and the provider. Therefore, the billing requirements and coding standards and instructions reflected in that manual are the general guidelines for editing of encounters.

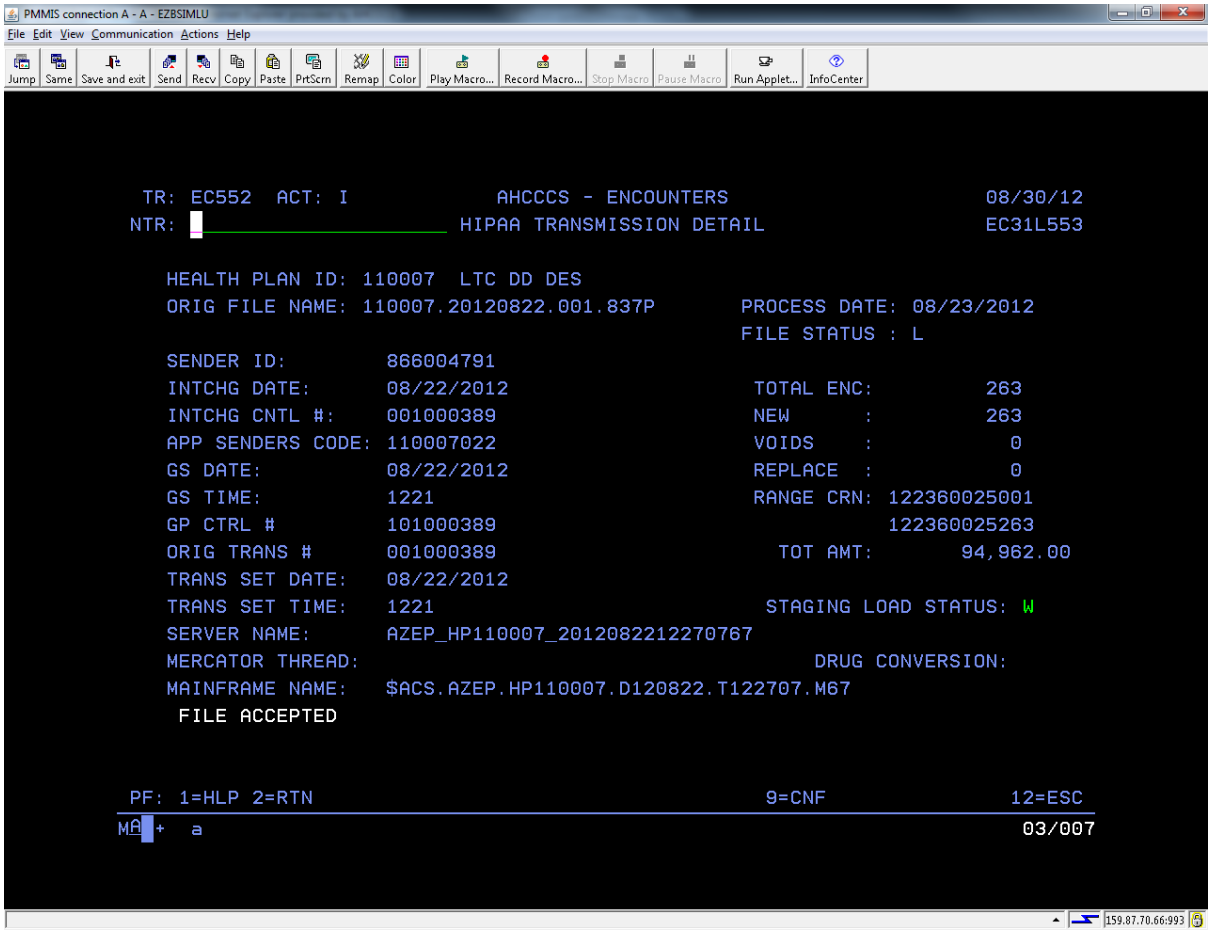
II. CHECK STATUS OF ENCOUNTER FILE SUBMISSION

Mainframe availability for the inquiry of encounter files status is listed on this HIPAA TRANSMISSION SUMMARY screen EC552.



STG = Staging Load Status – "STG" on EC552 Summary screen is the same as "Load Status" on EC552 Detail screen. (Staging) Load Status: W = Waiting, H = Hold, L = Loaded, E = Exclude. Fil – File Processing Status: U = Unprocessed, L = Loaded, F = Failed

To get to the next screen to view the file, you must put an "s" to select the file then hit "enter". You will then see the HIPAA Transmission Detail screen below.



STG = Staging Load Status – "STG" on EC552 Summary screen is the same as "Load Status" on EC552 Detail screen. (Staging) Load Status: W = Waiting, H = Hold, L = Loaded, E = Exclude. Fil – File Processing Status: U = Unprocessed, L = Loaded, F = Failed

III. REPORTING INPATIENT COVERED DAYS

General reminders related to the reporting of Covered Days

- This data element is critical to the tracking of the Inpatient Days actually covered and paid by each Contractor, and is *required* to be submitted on all Inpatient encounters. If this required data is not submitted, encounters may be rejected at validation.

- Covered Days should only be reported on Inpatient encounters.

- Contractors should report the *actual number of days they covered* for that encounter. If the length of stay is 20 days, but the Contractor only reimburses 15, for whatever reason, the covered days reported should be 15.

- Covered days *cannot exceed the actual length of stay* on the encounter. If the length of stay is 4 days, the contractor cannot report covered days greater than 4.

- Covered days *cannot be zero (0) unless the encounter is submitted as Contractor Administrative Denial or Zero Paid.* On an Inpatient claim, other than a same day admission discharge/transfer, the Contractor must report covered days greater than zero, unless reporting the encounter as Contractor Administrative Denial or Zero Paid.

- For Inpatient claims all allowed/covered days should be reflected only in the Covered Days reported by the Contractor; do not also include in non-covered related accommodation revenue code charges, as it will result in edit failures for out of balance conditions.

- If Covered Days are required by the outlined criteria and are not submitted on the encounter a Covered Days Validation error 32006 will result: "2300 HI Value Information – Value code '80' Covered days required for Inpatient encounters"

- Please refer to the guidance found in the current version of the UB04 manual, page 94-95 (FL 39-41) to report the following value codes:
  '80' Covered Days
  '82' Co-insurance Days
  '83' Lifetime Reserve Days

  To report the above value codes, please reference the following 2-digit Bill types that are assigned as an Inpatient designation for the AHCCCS Encounters process and considered for the Covered Days validation edit mentioned above:

11	Hospital Inpatient (Including Medicare Part A)	IP
12	Hospital Inpatient (Medicare Part B Only)	OP (AHCCCS uses as IP)
65	Intermediate care – Level I	IP/3
66	Intermediate care – Level II	IP/3
86	Residential Facility	IP/3
89	Special Facility - Other	IP/OP

Sample 837I:
CLM*128000052*1505.1***11:A:7**A*Y*
DTP*434*RD8*20111001-20111002
DTP*435*DT*201110010600
CL1*4*5*01
REF*F8*113200010117
REF*EA*1892807 03-66-741
HI*BK:V3000
HI*BJ:V3000
HI*BF:V053
HI*BE:80:::5*BE:82:::10*BE:83:::30
NM1*71*1*ATTENDING*PROVIDERNAME****XX*1799742047
SBR*P*18*******MC
AMT*D*487.77
OI***Y***Y
NM1*IL*1*LASTNAME*FIRSTNAME****MI*A99999999

N3*801 E JEFFERSON ST
N4*PHOENIX*AZ*85034
NM1*PR*2* HEALTH PLAN OF ARIZONA*****PI*0101010782
REF*F8*128000052
LX*1

IV. REPORTING OF NON-COVERED CHARGES/PARTIAL DENIALS

Reporting Non-Covered Charges

- It is important that Contractors report applicable non-covered charges on encounters as outlined in the TR3 and AHCCCS Companion Guides.
- Non-covered charges should not be subtracted from the total billed charge as the provider submitted billed charge itself should not be altered.

Administrative Denials/Zero Paid Encounters

- If all charges are non-covered on an encounter, it is an applicable Administrative Denial or Zero Medicaid Payment Claim. It should be reported as Administratively Denied/Zero Medicaid Paid per the instructions in Chapter Three (3).

Disallowed Lines

- Inpatient or outpatient facility encounters may have both paid and disallowed lines. To ensure that such encounters pass validation, do not split the encounter between covered and disallowed lines but submit as AHCCCS Partial Disallowed per instructions below and in Chapter Three.

Professional Paid versus Denied lines

- Only zero paid lines which meet the criteria for inclusion as outlined in the Encounter manual should be submitted in the denied/zero paid file, all others should be submitted in the paid file.

- Denied lines should only be submitted if they meet the criteria for inclusion as outlined in the Encounter manual, otherwise we do not expect that MCO's will submit their denied Encounters even if a claim has mixed status (i.e. some paid, some denied not meeting administrative denial criteria) of lines.

FQHC Claims Paid versus Denied

- If the T1015 is paid greater than zero and it has an approved ancillary code paid at zero, all lines write to the paid file.

- If the T1015 is denied, do not write to either file. Unless the reason for denial meets the criteria for inclusion as an administrative denial.

Sample Claims Scenario

3 line claim
line 1 approved
line 2 approved
line 3 denied (non-adminstrative reason)

In this scenario we would expect that lines 1 and 2 be sent in the paid claims/new day file, and that we would not receive line 3

3 line claim
line 1 approved
line 2 denied for an administrative reason
line 3 paid zero due to for example - bundling with another service or under a capitation arrangement

In this scenario we would only expect that lines 1 and 3 be sent in the paid claims/new day file, and that line 2 be sent in the denied file

V. IMPLANT CARVE OUT ENCOUNTERS CONSIDERATION FOR REINSURANCE

Implant carve-out Implants (VAD) are to be carved out of UB charges and reported as non-covered charges on the encounter. The implant itself is supposed to be submitted/encountered on a 1500 claim form.

For acute care cases where 1500's are not auto-associated to Reinsurance (RI), submit a Reinsurance Action Request form (RAR) to the RI Unit and they will manually associate/recognize it through the RAR.

In the event that a Contractor's provider contract designates carve out and separate payment of Implants, Biological items, etc. the Contractor must reflect this processing on Encounters as follows:

Inpatient Claim

Do not alter the billed charges or claim detail. Billed charges and detail should include the implantable or biological as well as the associated charges and the associated charges should be non-covered with an appropriate reason code. Health Plan Allowed and Paid should reflect that the associated charges were non-covered and separately reimbursed.

1500 Claim

This form must be used to report the carve out item under an appropriate HCPCS code and include the applicable Billed Charges and Health Plan Allowed/Paid. To be considered for Reinsurance the charges must be substantiated by contract/invoice/etc. and the Plan must request Reinsurance consideration.

VI. BENEFIT SERVICE LIMITATIONS AND TIMING OF ENCOUNTER SUBMISSION

Benefit limits-"first in basis"

Certain AHCCCS Medicaid benefits have annual contract year service unit or per diem limits**.** Contractor's staff working encounter pends must be aware of these benefit limitations. These benefit restrictions are listed in AHCCCS contract Section D and delineated in AMPM Chapter 300. Contractors are notified of any changes to these benefit limitations.

For example:
Effective 1/1/2014, outpatient physical therapy for adults (age 21 years and older) is limited to the following:

- 15 visits per contract year to restore a particular skill or function the recipient previously had but lost due to injury or disease and maintain that function once restored; and
- 15 visits per contract year to attain or acquire a particular skill or function never learned or acquired and maintain that function once acquired.

When such a service limitation applies, AHCCCS combines AHCCCS Fee For Service (AFFS) paid claims and all Contractor approved encounters on a" first in basis" to calculate services applied during the contract year.

Contractors may receive Z295 pended encounters (A and O) indicating that the adult PT service units have been exceeded. Contractors may have prior authorized services and paid for services, but due to payment or encounter submission delays another Contractor or AFFS (having an enrollment period within the same plan year) may have already submitted and had approved encounters exhausting the benefit. In such cases the pended claims must be recouped and encounters voided.

Other similar benefit exhausted pend codes include Z297 (Inpatient limits exhausted) and Z298 (Respite Care Limits Exceeded)

It is imperative that Contractors have clear language in provider contracts and/or their provider manuals indicating that no payment may be made when the benefit is exhausted, even if the contractor issued a Prior Authorization (PA). PA is not a guarantee of payment; all claims must be for AHCCCS covered benefits and be medically necessary at time of service.

Duplicate or Near Duplicate Service Encounters from Different Contractors
There are a series of encounter edits that indicate that the Contractor has submitted an encounter that is either an exact or near duplicate of a service for a member for which another Contractor has already reached AHCCCS adjudicated/ approved status.

VII. ENCOUNTER/REFERENCE TABLE UPDATE COMMUNICATION

AHCCCS endeavors to keep all reference/code tables in PMMIS up to date with issuing agency regular revisions and AHCCCS specific coding requirements.

Contractors receive and have Web access to multiple communication tools to alert them of table and code updates. Several of these website locations also provide updates electronically by Listserv. To subscribe go to the website go to (http://listserv.azahcccs.gov) and follow directions.

"PMMIS System/Table Update E-mails"
AHCCCS Division of Analysis and Research (DAR) staff send out regular e-mails informing Contractor encounter staff and Contract Compliance Officers about significant AHCCCS program changes including policy, scheduling, required reporting, benefits, PMMIS table updates and encounter editing. These e-mails give you first notice of items and issues, including Encounter Manual changes, which may require Contractor system and

encounter reporting remediation. If you want to be added to e-mail distribution related to encounters contact your health plan's assigned encounter liaison or request through your Contract Compliance Officer.

Encounter Keys Newsletter
Encounter Keys is a periodic supplement to the Encounter Manual containing updates and system changes. Published quarterly by DAR, this newsletter provides a recap, summarized by code type, of the table changes and other information that Contractor's received by e-mail since last newsletter issue. Current and historical issues are available on the Web at:
https://www.azahcccs.gov/PlansProviders/HealthPlans/encounterkeysnewsletter.html

Provided as current encounter requirements, Contractors are held responsible to incorporate the information into there encounter processes. It is important to note that some table values and relationships are retroactively dated and my effect previously adjudicated claims and encounter submissions. You will also find SFTP file layout changes and EDI technical interface changes and other clarification that needs to be shared with Contractor IT staff.

AHCCCS Fee-for-Service Provider Manual
AHCCCS contract requires that Contractors follow claims processing guidelines, applicable to managed care, that are maintained within the AHCCCS FFS provider manual, unless otherwise specified (where allowable) in provider subcontract. Therefore, the billing requirements and coding standards and instructions reflected in that manual are the general guidelines for editing of encounters. This manual is located on the web at:
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

Claims Clues Newsletter
Claims Clues is produced periodically by the AHCCCS Claims Department for Fee-For-Service (FFS) providers as adjunct to the AHCCCS FFS Provider manual. As such it is also very useful for Contractors to keep up with changes in the AHCCCS FFS provider Manual. Issues can be accessed at the link
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html
It provides useful information including, but not limited to, the following:

- Changes to the program
- System changes and updates
- Billing policies and requirements
- Provider Training opportunities

AHCCCS Contractor's Operations Manual (ACOM)
This Manual provides AHCCCS policy specific to operations and reporting for Contractors. It is divided into chapters for Administrative, Claims, Financial, and Operational Policies of the AHCCCS Administration.

AHCCCS staff issue monthly update Memos to Contract Compliance Officers for internal distribution. (Note: ACOM update memos are also available by Listserv). These memos are intended to alert Contractors to a summary of changes. It is, however, incumbent on every Contractor to fully review all policy changes and assess impact on claims processing and encounter reporting.
https://www.azahcccs.gov/shared/ACOM/

AHCCCS Medical Policy Manual (AMPM)
This Manual contains information regarding services that are covered within the AHCCCS program. The AMPM is applicable to both Managed Care and Fee-for-Service members. Relevant to encounter reporting, this manual defines covered services and their limitations, including special maternal and child health programs and services. Chapter 600 designates provider qualifications and licensing requirements;
The AMPM should be referenced in conjunction with State and Federal regulations, other Agency manuals [AHCCCS Contractors' Operations Manual (ACOM) and the AHCCCS Fee-for-Service Manual], and applicable contracts.

It is available on-line https://www.azahcccs.gov/shared/MedicalPolicyManual/
"What's New" memos (summaries of policy revisions), issued as needed and sequentially numbered by contract year, are distributed to AMPM holders and Contract Compliance Officers. A revision history is available at bottom of manual webpage.

VIII. CONTRACTOR REFERENCE TABLE REVIEW UPDATE (RTRU) REQUESTS

AHCCCS makes every effort to keep the PMMIS reference table sub-system properly updated to reflect nationally recognized and AHCCCS specific coding standards and requirements. Even so, Contractors may discover apparent inconsistencies or missing values driving encounter edits that they believe are inappropriate.

Important Note: *encounter pends related to provider registration issues, for example P353- Provider type not eligible for service billed, must be directed to AHCCCS Provider Registration Unit. Contractors should be working with the provider in question, assisting them in contacting AHCCCS provider registration to have the provider's profile modified.*
For questions regarding the provider registration process, please contact the AHCCCS Provider Registration Unit.
In Maricopa County: 602-417-7670 and select option 5
Outside Maricopa County: 1-800-794-6862
Out-of-State: 1-800-523-0231

Reference Table Review Update (RTRU) issues appropriate for review usually revolve around reference table values and relationships, for example, units, modifiers, POS, coverage, effective dates, etc. For example, a Contractor may have multiple claims, from various providers, pending for POS invalid for service procedure code. If, after researching, the Contractor has determined that it is industry standard to provide that service in that POS and a RTRU is submitted and approved, the table maintenance will allow all of the related pends to clear next encounter cycle. It is important to indicate what effective DOS is needed in the tables to clear the related pends, so that the table maintenance may cover all of the pended encounters.

Contractors are encouraged to thoroughly research their issues before submitting a RTRU e-mail request to AHCCCS for reference table revisions or updates. Contractors are provided PMMIS training to assist in this research effort. And it is important to review any communications (see section VII above) related to the specific issue. Contractor staff can also contact their assigned encounter representative to review the issue.

Contractor staff may submit clearly labeled RTRU requests by e-mail to: AHCCCSEncounters@azahcccs.gov.

The subject line should indicate that this is a reference table review update request. If larger files are required as supporting documentation they can be placed on SFTP server and indicated in the e-mail.

These e-mails should explain the issue and document the Contractor's research findings and any reference or authority supporting the update request. If a retroactive effective date is being requested AHCCCS will evaluate and make the final determination on the appropriate start date for the table maintenance

In many instances update requests must be deferred to the office of the AHCCCS Chief Medical Officer (CMO) for medical review and medical determination. Whether approved or not Contractors will receive feedback on submitted requests.

Because of the multiple unit review process, turn around time on these RTRU requests may take up to 30 days.

IX. CONTRACTOR ON-LINE VOIDS AND REINSURANCE PAYMENT CYCLE

The timing of Contractor entered PMMIS pend corrections/voids can adversely effect the Reinsurance (RI) payment cycle. Therefore, Contractors are prohibited from performing online encounter voids during the monthly Reinsurance payment cycle.

The Reinsurance Payment/Pricing Cycle runs on the first Wednesday of every month. It takes two days for files to pass back and forth between systems. The Reinsurance Databases will be closed for online updates from the first Wednesday of the month, starting at 5pm until the following Wednesday morning. **Online voids cannot be performed during this time.**

Contractor compliance with this policy will insure accurate disbursement of RI funds and prevent misallocation to closed RI years and RI payment recoupments.

X. ENCOUNTERS FOR MEDICARE PART B ONLY AND MEDICARE PART A EXHAUSTED CLAIMS

AHCCCS has reviewed the encounter processing logic for members with Medicare Part B Only coverage and for members who have exhausted all of their Medicare Part coverage. AHCCCS has subsequently revised the encounter instructions to ensure the Contractors receive full Reinsurance reimbursement when these encounters are associated with a reinsurance case.

Institutional Inpatient encounters being submitted by the Contractors for a member who effectively has only Medicare Part B Coverage (either Medicare Part B Only or the member has exhausted all of their Medicare Part A coverage) should have the Medicare Part B payment reported using the following segments:

2320/SBR - Other Subscriber Information
2320/CAS - Claim Level Adjustments
2320/AMT – COB Payer Paid Amount

Loop	Element	Description	837 Note	AHCCCS Usage/Expected Value
2320	**SBR**	**OTHER SUBSCRIBER INFORMATION**		
2320	SBR01	Payer Responsibility Sequence Number Code		Expect any value
2320	SBR02	Individual Relationship Code		Expect any value
2320	SBR03	Insured Group or Policy Number		NOT USED BY AHCCCS
2320	SBR04	Other Insured Group Name		NOT USED BY AHCCCS
2320	SBR05	Insurance Type Code		NOT USED
2320	SBR06	Coordination of Benefits Code		NOT USED
2320	SBR07	Yes/No Condition or Response Code		NOT USED
2320	SBR08	Employment Status Code		NOT USED
2320	SBR09	Claim Filing Indicator Code		Expect any value
2320	**CAS**	**CLAIM LEVEL ADJUSTMENTS**		01/08/13: AHCCCS expects Co-pay amounts to be reported at the 2430/CAS segment for Institutional files.
2320	CAS01	Claim Adjustment Group Code		Expect any value
2320	CAS02	Adjustment Reason Code	Occurrence 1	Expect Adjustment Reason Code
2320	CAS03	Adjustment Amount		Net Allowed Amount (Approved Amount): Final value of the encounter if paid as FFS after all other payments have been considered Capitated = Amount Paid $0, use CAS*CO*24 segment FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported Per section 1.4.5 Allowed/Approved Amount is determined as: Prior payer's payment (2320, AMT*D*$) + Total of all patient responsibility adjustment amounts (CAS*PR*RSN CD*$*, CAS03, 06, 09, 12, 15, 18) = Allowed Amount
2320	CAS04	Adjustment Quantity		Expect Adjustment Qty
2320	CAS05	Adjustment Reason Code	Occurrence 2	Expect Adjustment Reason Code
2320	CAS06	Adjustment Amount		Expect Adjustment Amount
2320	CAS07	Adjustment Quantity		Expect Adjustment Qty
2320	CAS08	Adjustment Reason Code	Occurrence 3	Expect Adjustment Reason Code
2320	CAS09	Adjustment Amount		Expect Adjustment Amount
2320	CAS10	Adjustment Quantity		Expect Adjustment Qty
2320	CAS11	Adjustment Reason Code	Occurrence 4	Expect Adjustment Reason Code
2320	CAS12	Adjustment Amount		Expect Adjustment Amount
2320	CAS13	Adjustment Quantity		Expect Adjustment Qty
2320	CAS14	Adjustment Reason Code	Occurrence 5	Expect Adjustment Reason Code
2320	CAS15	Adjustment Amount		Expect Adjustment Amount
2320	CAS16	Adjustment Quantity		Expect Adjustment Qty
2320	CAS17	Adjustment Reason Code	Occurrence 6	Expect Adjustment Reason Code
2320	CAS18	Adjustment Amount		Expect Adjustment Amount
2320	CAS19	Adjustment Quantity		Expect Adjustment Qty
2320	**AMT**	**COB PAYER PAID AMOUNT**		
2320	AMT01	Amount Qualifier Code		Expect 'D'
2320	AMT02	Payer Paid Amount		Expect COB Payer Paid Amount
2320	AMT03	Credit/Debit Flag Code		NOT USED

XI. INPATIENT HOSPITAL DRG ENCOUNTER EDITING

On October 1, 2014 AHCCCS implemented Inpatient Hospital APR-DRG payment methodology. The technical and policy aspects of this payment methodology were developed in collaboration with existing AHCCCS Contractors, Arizona Hospitals and other stakeholders statewide. Detailed specifications and policy requirements can be accessed on the AHCCCS website www.azahcccs.gov/PlansProviders/RatesAndBilling/ManagedCare/DRGbasedpayments.html

Additional information regarding claims and coding has been included in AHCCCS FFS Provider Billing Manual
www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap11.pdf

New encounter editing related to APR-DRG pricing was implemented and included in encounter keys issue Sept/OCT 2014 as follows:

A956 DRG - DOES NOT MEET CRITERIA FOR ANY DRG
This edit information was also posted in the October 2014 updated web version of the Encounter edit status report:
www.azahcccs.gov/PlansProviders/Downloads/Encounters/adjudication/EncounterEditStatusList.pdf

XII. RECORD STATUS CODE AND CLEARING H290 PENDS

Contractors receiving pend error code H290 "Adjustment/ Void Code Invalid" are advised to check the Record Status Code (Element 399). That value must be accurate for the type of transaction being submitted. A mismatch on this code will fire this pend.

The edit status code values are for transactions as follows:

1 Paid	Code indicating that the transaction was adjudicated using plan rules and was payable. **(New encounter submission)**
2 Rejected	Code indicating that the transaction was denied/rejected. **(HP Denied)**
3 Reversed	Code indicating that the paid transaction was cancelled. **(Voided)**
4 Adjusted	Code indicating that the previous transaction was changed. **(Replaced)**

XIII. SAME DAY ADMIT DISCHARGE ENCOUNTER REPORTING

Effective October 1, 2014 AHCCCS implemented APR-DRG inpatient claims payment methodology. Inpatient claims with an admission date equal to the date of the discharge will be paid using the AHCCCS outpatient fee schedule methodology, including same day admission and discharge claims for maternity and nursery.

There is one exception to this methodology. Claims with a same date of admission and date of death will be reimbursed a full DRG payment. The DRG edit A956 DRG - DOES NOT MEET CRITERIA FOR ANY DRG will apply if encounter financial fields do not match AHCCCS DRG calculation. For detailed information on DRG billing requirements see AHCCCS Fee for Service provider manual addendum Chapter 11 on the web:
www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap11_Addendum.pdf

This payment methodology differs from the Tiered Per Diem methodology for claims with discharge dates prior to 10-01-2014. Billing information for that methodology is available in FFS Provider Manual, Chapter 11.

XIV. KEY STROKES FOR ONLINE ENCOUNTER OVERRIDES

PMMIS screen (EC780), provides an override summary of edit encounter errors which Contractors can override online. Each encounter override performed online must include a numeric override reason located on PMMIS screen (RF747) and a notation explaining why override is appropriate. Below is the functional key strokes by form type utilized to perform an on-line override and where the override reason (F4) and notation (F5) is entered in the record.

1500 – EC205C and Dental – EC203C	**Pharmacy – EC215C**	**UB – EC810C**
Enter CRN	Enter CRN	Enter CRN
F4 and enter override reason code	F4 and enter override reason code	F4 and enter override reason code
F2	F2	F2
F3	Move from panel 2 to panel 3	Move from panel 3 to panel 4
F8	F8	F11
F5	F5	F8
Enter error code and override comment	Enter error code and override comment	F5
F9	F9	Enter error code and override comment
F2	F2	F9
F2	F2	F2
F9	F9	F2
		F9

XV. ENCOUNTERS SUBMITTED FOR "UNIDENTIFIED" INDIVIDUALS

When encounters are submitted for "unidentified" individuals (such as in crisis situations when a person's eligibility or enrollment status is unknown), the Contractor(s) shall require the provider to use the applicable pseudo ID numbers that are assigned to each RBHA. For assistance, contact the DHCM/DAR Encounters Unit. Pseudo-ID numbers are not assigned to TRBHAs. Encounters are not submitted for prevention services.