AHCCCS ON-LINE CLAIM SUBMISSION MANUAL

Section 8:

Adjustment (CMS 1500)

CLAIM SUBMISSION TIME FRAMES

In accordance with ARS §36-2904 (G), claims for services provided to an AHCCCS recipient must be received by AHCCCS in a timely manner.

- ☑ Fee-for-Service claims are considered timely submissions if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of service, except for retro-eligibility claims. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

- ☑ Claims initially received beyond the 6-month time frame, except retro-eligibility claims, will be denied

- ☑ 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 resubmit the claim in order to achieve clean claim status or to adjust a previously processed claim, unless the claim is a retro-eligibility claim.

- ☑ If a claim does not achieve clean claim status or is not adjusted correctly within 12 months, AHCCCS is not liable for payment.

- ☑ This time limit does not apply to adjustments, which would decrease the original AHCCCS payment due to collections from Medicare or other third party payers.

RETRO-ELIGIBILITY CLAIMS

A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

- ☑ Retro-eligibility Fee-for-Service claims are considered timely submissions if the initial claim is received by AHCCCS not later than 6 months from the AHCCCS date of eligibility posting.
- ☑ Retro-eligibility claims must attain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.
- ☑ Adjustments to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.
- ☑ This time limit does not apply to adjustments, which would decrease the original AHCCCS payment due to collections from Medicare or other third party payers.

Note:

Adjustment (replacement) of a denied CMS 1500 claim:

Correct the claim and resubmit the claim in its entirety, including all original lines if the claim contained more than one line.

Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.

Adjustment (replacement) of a paid claim:

Make changes/add lines to the new claim and submit the claim containing all previously submitted lines.

If any previously paid lines are omitted, the AHCCCS system will assume that those lines should not be considered for reimbursement, and payment will be recouped.

Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

Payer/Receiver Electronic Transmitter Identification Number: 866004791

NOTE: You cannot view the processing status of claims submitted by other users.

If billing your claims on-line this is where you would find the CRN's

Attention! Invalid/Missing Submission Date(s).

You can either enter a specific date or a span date here

Claim Submission Status

This is the view when entering a specific date.

Claim Type	Submission Date/Time	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN	Adjudication
Professional	02/14/13 12:25 PM	AAA			01/01/13	01/02/13	Processed	02/14/13 02:00 PM	130455600001	Denied
Record Count: 1										

< Previous

This is where you will find the CRN

Claim Submission Status

This is the view when entering a span date.

Claim Type	Submission Date/Time	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN	Adjudication
Institutional	03/12/13 06:41 PM	PROCEDURE CODE 11,21			03/12/13	03/12/13	Processed	03/13/13 10:00 AM	130726600001	Denied
Institutional	03/12/13 07:04 PM	1121 PROCEDURE			02/01/13	02/01/13	Processed	03/13/13 10:00 AM	130726600002	Denied
Institutional	03/19/13 03:12 PM	00-00-83			11/06/12	02/28/13	Processed	03/19/13 04:00 PM	130786600001	Denied
Institutional	04/01/13 02:23 PM	ACCCT			01/01/13	01/01/13	Processed	04/01/13 04:00 PM	130926600001	Denied
Institutional	04/09/13 09:27 AM	000082			01/01/13	01/31/13	Processed	04/09/13 10:00 AM	130996600001	Denied
Professional	02/14/13 12:25 PM	AAA			01/01/13	01/02/13	Processed	02/14/13 02:00 PM	130455600001	Denied
Professional	03/04/13 02:30 PM	A848101636			01/01/13	01/01/13	Processed	03/04/13 04:00 PM	130635600001	Denied
Record Count:	7									

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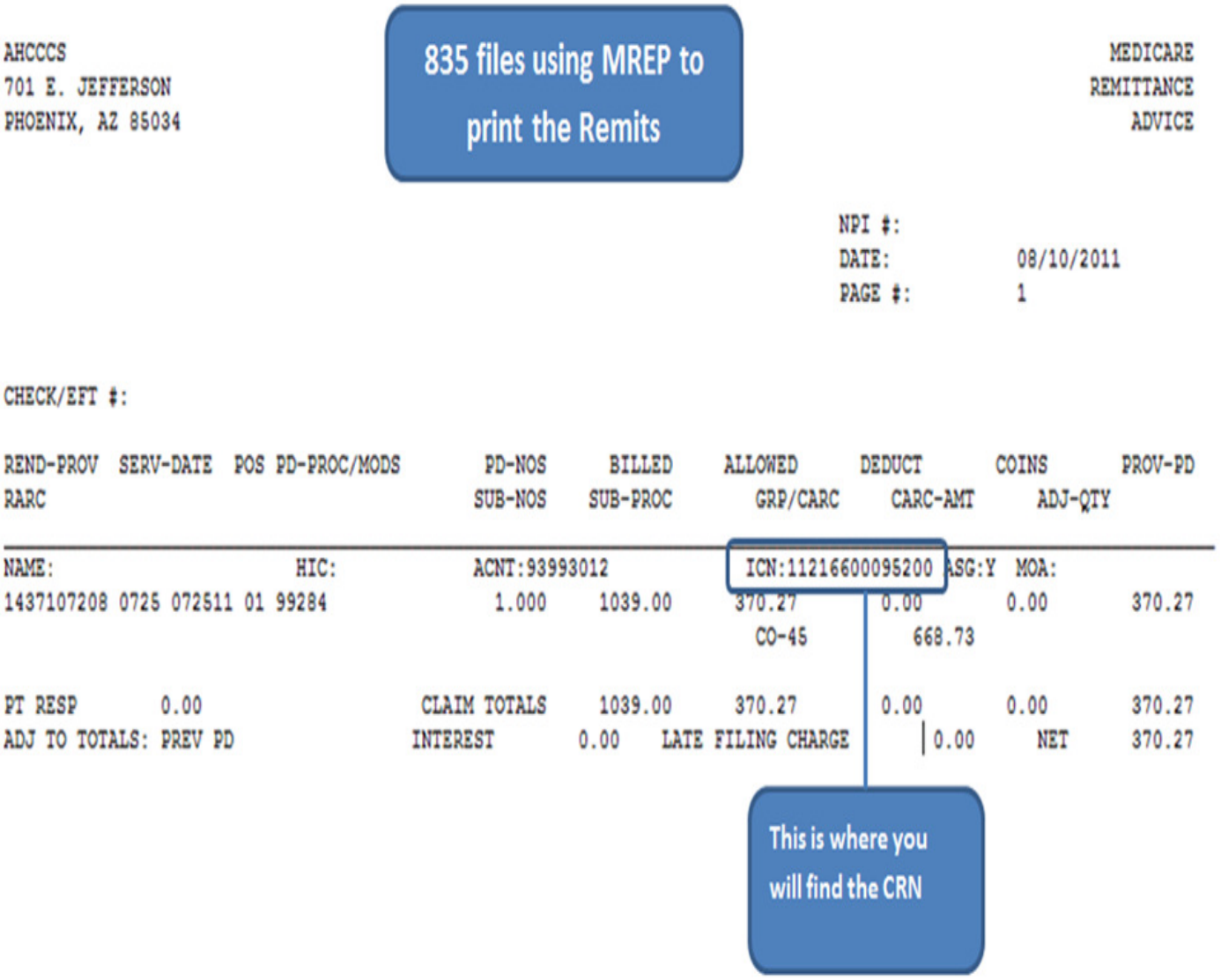
This is where you will find the CRN


835 files using MREP to print the Remits
AHCCCS
701 E. JEFFERSON
PHOENIX, AZ 85034
MEDICARE
REMITTANCE
ADVICE
NPI #:
DATE: 08/10/2011
PAGE #: 1
CHECK/EFT #:
REND-PROV SERV-DATE POS PD-PROC/MODS PD-NOS BILLED ALLOWED DEDUCT COINS PROV-PD
RARC SUB-NOS SUB-PROC GRP/CARC CARC-AMT ADJ-QTY
NAME: HIC: ACNT:93993012 ICN:11216600095200 ASG:Y MOA:
1437107208 0725 072511 01 99284 1.000 1039.00 370.27 0.00 0.00 370.27
CO-45 668.73
PT RESP 0.00 CLAIM TOTALS 1039.00 370.27 0.00 0.00 370.27
ADJ TO TOTALS: PREV PD INTEREST 0.00 LATE FILING CHARGE 0.00 NET 370.27
This is where you will find the CRN

Paper Remits

Exhibit 27-3

SAMPLE REMITTANCE ADVICE – PAID NON-FACILITY CLAIMS

```
REPORT ID:  FI04W400                    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                    PAGE:  9
PROGRAM ID: FI04L400                      NON-FACILITY REMITTANCE ADVICE - ACUTE                       RUN: 11/29/2003
001549                                    PAID CLAIMS - INVOICE DATE: 11/29/2003

BILLING PROVIDER:   654321  01   HOLLIDAY, DOC                    INVOICE NUMBER:  A9800000000001
SERVICE PROVIDER:   654321  01   HOLLIDAY, DOC                    CHECK NUMBER:    48746
                                                                  PAYMENT DATE:    12/02/2003

      TAX ID:     999999999
      FORM TYPE:  FORM 1500

AHCCCS ID     NAME                      CRN              SERVICE CD/   DATES OF    BILLED AMOUNT   ALLOWED
RECIPIENT     PATIENT ACCOUNT NUMBER    SCORE DATE        MODIFIER     SERVICE     BILLED UNITS      UNITS
-------------------------------------------------------------------------------------------------------------------
A12007007     BOND, JAMES               03310000100801    99223        10/09/2003      150.00      1.00   29.00  ALLOWED AMOUNT (*)
[illegible]   007                       11/26/2003                                      1.00                --------
                                                                                                          29.00  NET PAID AMOUNT
-------------------------------------------------------------------------------------------------------------------
                                        03310000103701    99233        10/10/2003      400.00      5.00   72.00  ALLOWED AMOUNT (*)
                                        11/26/2003                     10/14/2003        5.00                --------
                                                                                                          72.00  NET PAID AMOUNT
PRICE EXPL:   SUB   *MCC
-------------------------------------------------------------------------------------------------------------------
A61743893     HOLMES, SHERLOCK          03310000100801    99233        10/09/2003      300.00      3.00  222.00  ALLOWED AMOUNT (*)
A61743893     12714-350493              11/26/2003                     10/11/2003        3.00                --------
                                                                                                         222.00  NET PAID AMOUNT
 PRICE EXPL:  MAC   *AHA
-------------------------------------------------------------------------------------------------------------------
A21742813     KURIYAKIN, ILYA           03310000100801    90828        10/24/2003      800.00      5.00  680.00  ALLOWED AMOUNT (*)
A21742813     12224-489133              11/26/2003                     10/28/2003        5.00              270.00-  OTHER INSURANCE
                                                                                                          --------
                                                                                                          410.00  NET PAID AMOUNT
 PRICE EXPL:  SUB   MAC   *AHA
-------------------------------------------------------------------------------------------------------------------
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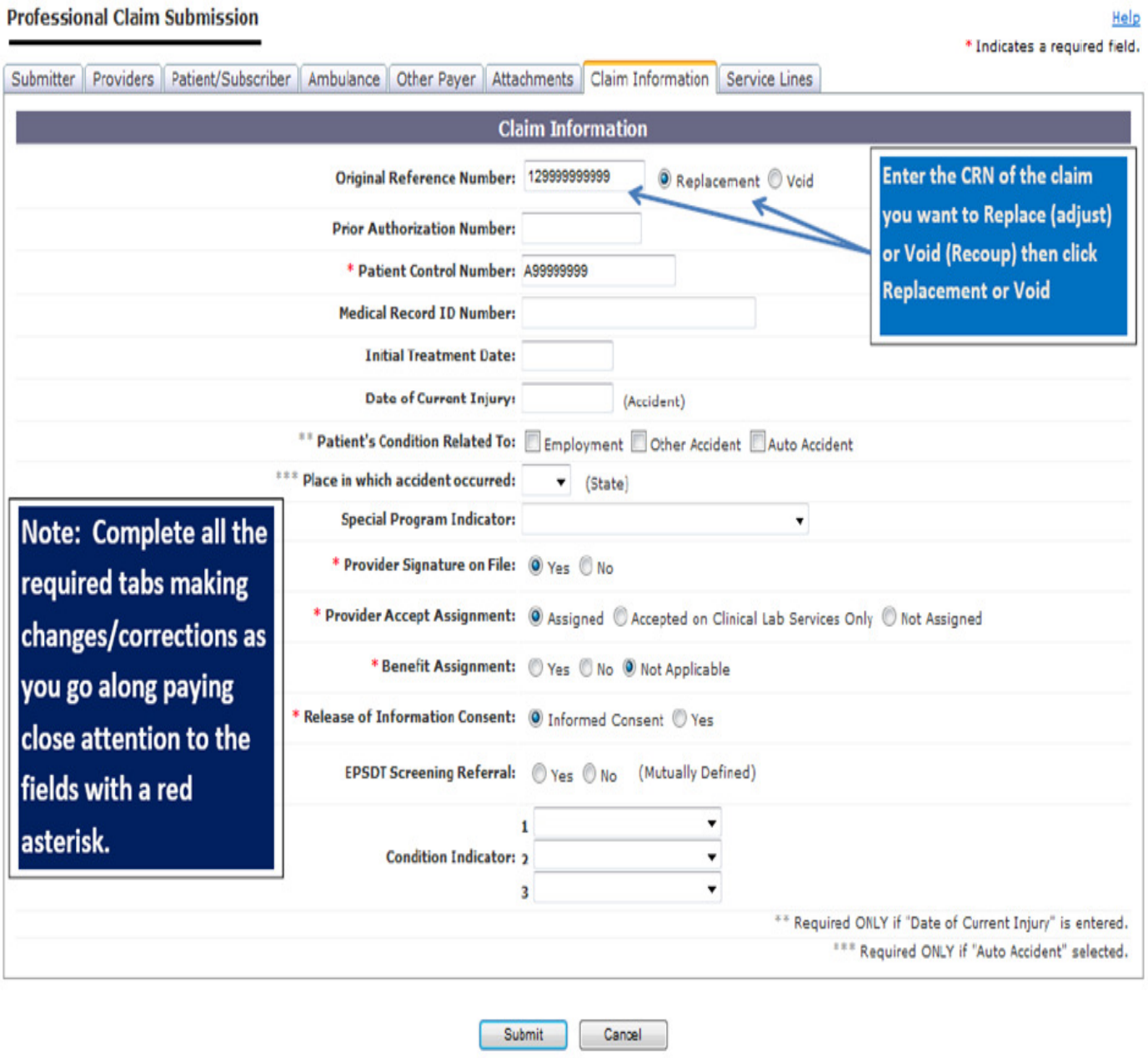
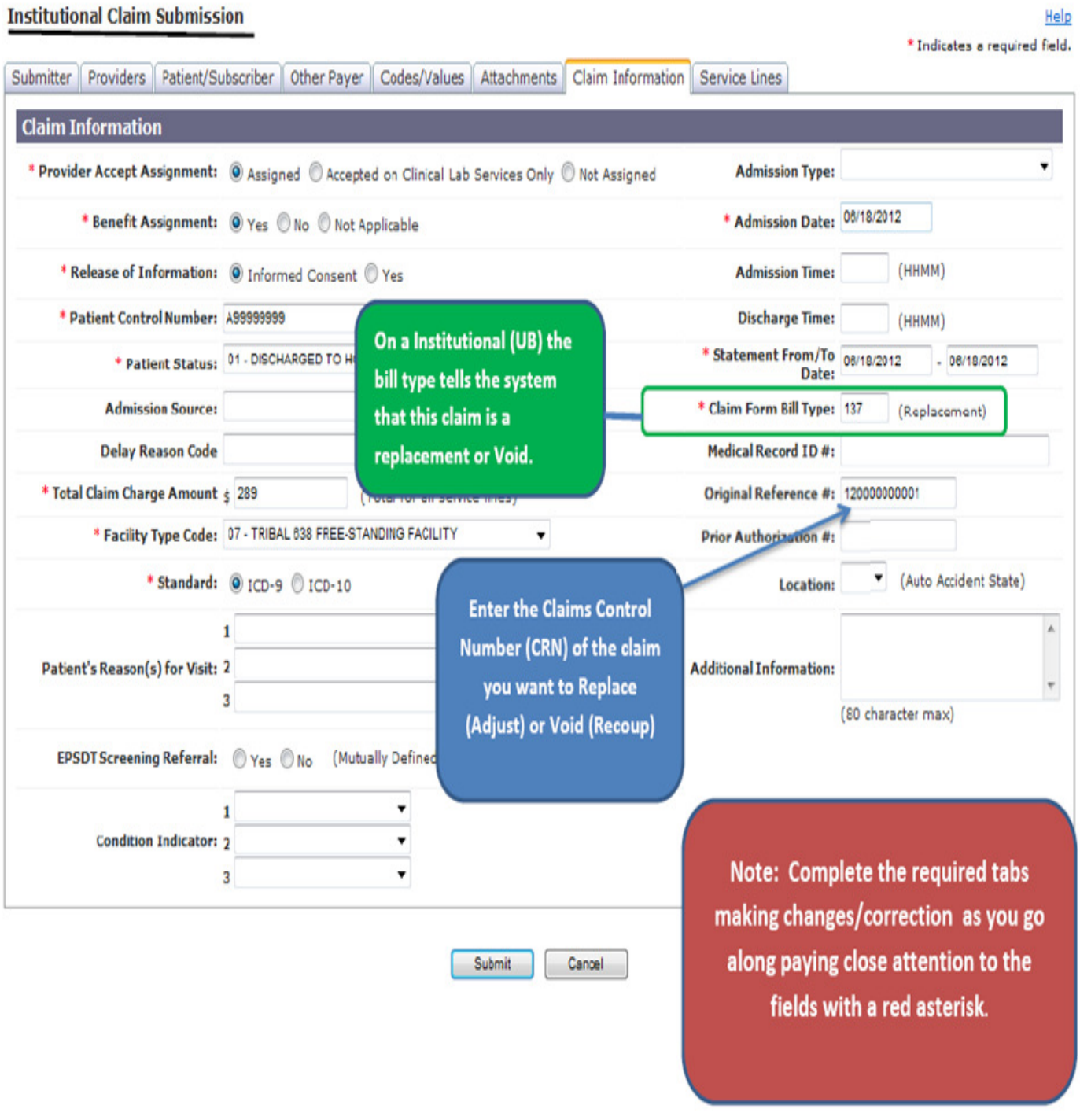
This is where you will find the CRN

Replacement/Voids

Correct the claim and resubmit the claim in its entirety, all original lines if the claim contained more than one line.

Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim

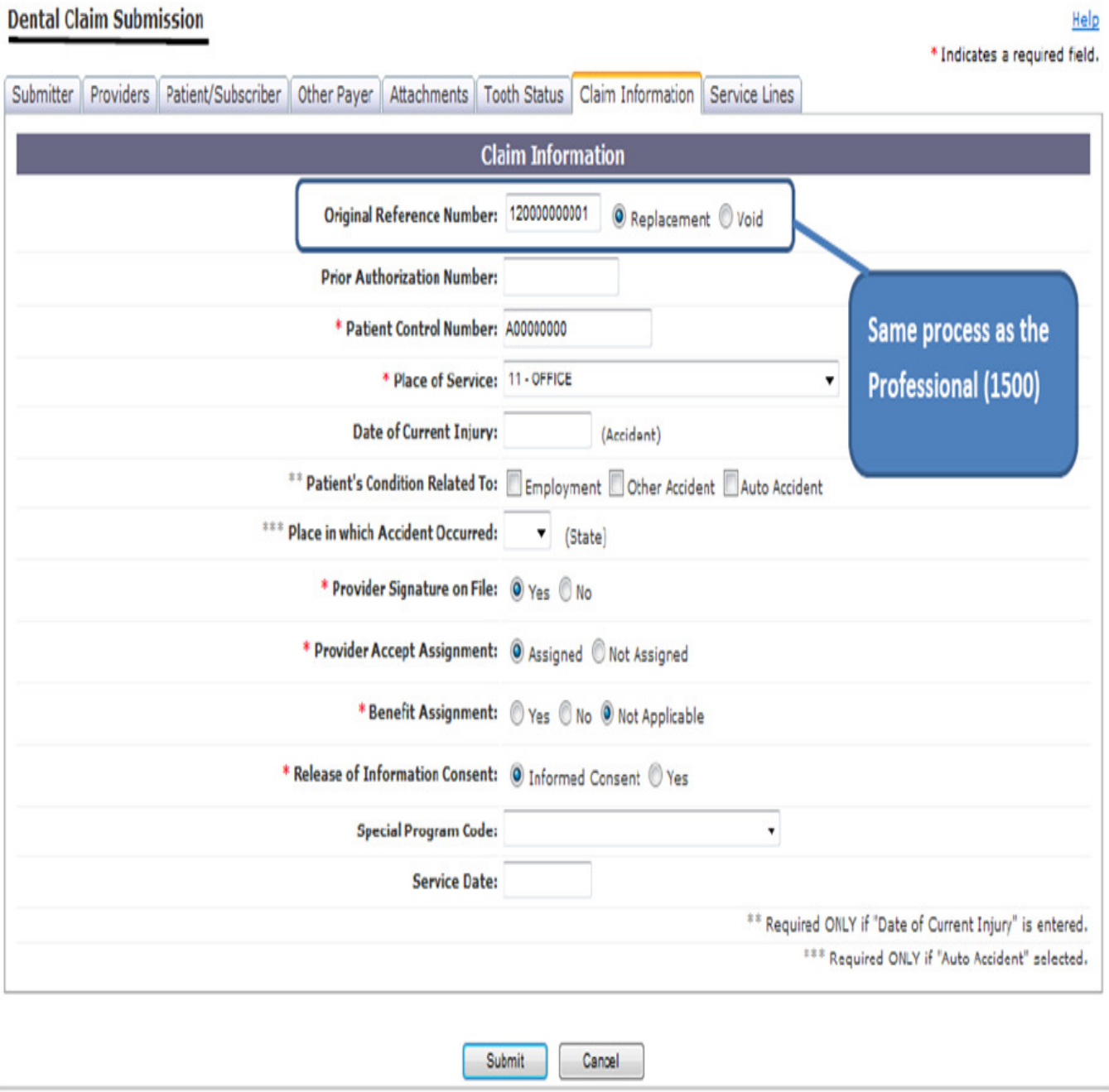



Institutional Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Claim Information
* Provider Accept Assignment: Assigned Accepted on Clinical Lab Services Only Not Assigned
Admission Type:
* Benefit Assignment: Yes No Not Applicable
* Admission Date: 08/18/2012
* Release of Information: Informed Consent Yes
Admission Time: (HHMM)
* Patient Control Number: A99999999
Discharge Time: (HHMM)
* Patient Status: 01 - DISCHARGED TO H
* Statement From/To Date: 08/18/2012 - 08/18/2012
Admission Source:
* Claim Form Bill Type: 137 (Replacement)
Delay Reason Code
Medical Record ID #:
* Total Claim Charge Amount $ 289
Original Reference #: 120000000001
* Facility Type Code: 07 - TRIBAL 638 FREE-STANDING FACILITY
Prior Authorization #:
* Standard: ICD-9 ICD-10
Location: (Auto Accident State)
Patient's Reason(s) for Visit: 1 2 3
Additional Information:
(80 character max)
EPSDT Screening Referral: Yes No (Mutually Defined
Condition Indicator: 1 2 3
Submit
Cancel
On a Institutional (UB) the bill type tells the system that this claim is a replacement or Void.
Enter the Claims Control Number (CRN) of the claim you want to Replace (Adjust) or Void (Recoup)
Note: Complete the required tabs making changes/correction as you go along paying close attention to the fields with a red asterisk.

UB's

This is a partial list of Bill Types for Replacement/Voids.

CODE	DESCRIPTION	BEG DATE	END DATE
117	HOSP,INP,REPLACEMENT OF PRIOR CLAIM	10/01/82	99/99/99
118	HOSP,INP,VOID/CANC PRIOR CLAIM	10/01/82	99/99/99
127	HOSP,INP,M/C B ONLY REPLACE OF PRIOR CLM	10/01/82	99/99/99
128	HOSP,INP,VOID/CANC PRIOR CLAIM,M/C B ONL	10/01/82	99/99/99
137	HOSP,OP,REPLACEMENT OF PRIOR CLAIM	10/01/82	99/99/99
138	HOSP,OP,VOID/CANC PRIOR CLAIM	10/01/82	99/99/99
147	HOSP,OP,REPLACEMENT OF PRIOR CLAIM	10/01/82	99/99/99
148	HOSP,OP,M/C B ONLY VOID/CANC PRIOR CLAIM	10/01/82	99/99/99
57	ICF1 (REPLACEMENT)	10/01/82	99/99/99
158	ICF1 (VOID/CANCEL)	10/01/94	99/99/99
187	HOSP, SWING BEDS,REPLACEMENT/PRIOR CLAIM	01/01/08	99/99/99
188	HOSP, SWING BEDS VOID/CANCEL PRIOR CLAIM	01/01/08	99/99/99
217	SNF,INP,REPLACEMENT OF PRIOR CLAIM	10/01/82	99/99/99
218	SNF,INP,VOID/CANC PRIOR CLAIM	10/01/82	99/99/99
227	SNF,INP,M/C B REPLACEMENT OF PRIOR CLAIM	10/01/82	99/99/99
228	SNF,INP,M/C B ONLY VOID/CANC PRIOR CLAIM	10/01/82	99/99/99
237	SNF, OUT PT, REPLACEMENT OF PRIOR CLAIM	01/01/08	99/99/99


Dental Claim Submission
Help
* Indicates a required field.
Submitter
Providers
Patient/Subscriber
Other Payer
Attachments
Tooth Status
Claim Information
Service Lines
Claim Information
Original Reference Number: 120000000001 Replacement Void
Prior Authorization Number:
* Patient Control Number: A00000000
* Place of Service: 11 - OFFICE
Date of Current Injury: (Accidant)
** Patient's Condition Related To: Employment Other Accident Auto Accident
*** Place in which Accident Occurred: (State)
* Provider Signature on File: Yes No
* Provider Accept Assignment: Assigned Not Assigned
* Benefit Assignment: Yes No Not Applicable
* Release of Information Consent: Informed Consent Yes
Special Program Code:
Service Date:
** Required ONLY if "Date of Current Injury" is entered.
*** Required ONLY if "Auto Accident" selected.
Same process as the Professional (1500)
Submit
Cancel