

**SECTION: 2 CHAPTER: 500**  
**POLICY: 501, Submitting Claims and Encounters**

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1. PURPOSE:

The purpose of this policy is to describe requirements for the submission of claims or encounters to a Regional Behavioral Health Authority (RBHA) and requirements for the submission of Tribal Regional Behavioral Health Authority (TRBHA) and TRBHA provider claims. This policy covers general requirements for submitting encounter data, procedures for submitting encounter data, procedures for submitting claims, and timelines for submitting billing information.

2. TERMS:

Definitions for terms are located online at <http://www.azdhs.gov/bhs/definitions/index.php>. The following terms are referenced in this section:

Claim  
Clean Claim  
Encounter  
Fee-for-Service  
Integrated RBHA  
Retro-eligibility Claim  
Sanction

3. PROCEDURES:

- a. Providers submit either claims or encounters to a RBHA. TRBHAs and TRBHA providers submit claims (see Attachment 501.2 for further information on where behavioral health service or physical health care service claims/encounters are to be submitted).
  - i. All copies of paper claims:
    - (1) Must be legible and submitted on the correct form; and
    - (2) May be returned to the provider without processing if they are illegible; incomplete, or not submitted on the correct form.
  - ii. Health Insurance Portability and Accountability Act (HIPAA) regulations specify the format for the submission of all electronic claims and encounters.
    - (1) HIPAA Format 837P is used to bill or encounter non-facility services, including professional services, transportation and independent laboratories.
    - (2) HIPAA Format 837I is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
    - (3) HIPAA Format NCPDP is used by pharmacies to bill or encounter pharmacy services using NDC codes
  - iii. Specific billing instructions on Medicare Part A and B, and Medicare Part D Prescription Drug Plan are outlined in the [Client Information System \(CIS\) File Layout and Specifications Manual](#) and the [ADHS/DBHS Office of Program Support Procedures Manual](#).

- b. Claims or encounters submitted to a RBHA:

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- i. The RBHA must submit all encounters including resubmissions or corrections to the Arizona Health Care Cost Containment System (AHCCCS) within 210 days from the end date of service.
- ii. The RBHA may be assessed sanctions for non-compliance with encounter submission requirements.
- iii. When crisis services are encountered, these services must be identified as such (see Attachment 501.1 for guidance).
- iv. A Trading Partner Agreement for Electronic Data Interchange (EDI) transactions must be in place between a RBHA and provider before a provider can submit electronic claim or encounter data to a RBHA.
- v. RBHAs must have policies that outline requirements for providers for the submission of claims and encounters, including where claims and encounters are to be submitted and the required timeframes for the submission of claims and encounters.
- vi. Submitted encounters for services delivered to eligible persons will result in one of the following dispositions:
  - (1) Rejected encounters: Encounters are typically rejected because of a discrepancy between submitted form field(s) and the RBHA's or AHCCCS' edit tables. A rejected encounter may be resubmitted as long as the encounter is submitted within the RBHA's established timeframe.
  - (2) Pended encounters: Encounters may pend at AHCCCS. The RBHA must resolve all pended encounters within 120 days of the original processing date. The RBHA must not delete pended encounters as a means to avoid sanctions for failure to correct encounters within the specified number of days.
  - (3) Adjudicated encounters: Adjudicated encounters have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.
- vii. Submitted encounters for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in this subsection.
  - (1) Rejected encounters for services delivered to Non-Title XIX/XXI enrolled persons will be returned to the RBHA with an explanation of the disallowance.
  - (2) A RBHA may resubmit the encounter within 210 days from the end date of service.
- viii. Encounters must be submitted to the RBHA within timeframes established in the RBHA's policy or as stipulated in the provider contract. Encounters received beyond the RBHA's timeframe may be subject to timeliness sanctions. Dates of service must not span a contract year. If a service spans a contract year, the claim must be split and submitted in two different date segments, with the appropriate number of units for each segment so the dates of service do not span a contract year.
- ix. Pseudo identification numbers are only applicable to behavioral health providers under contract with a RBHA.
  - (1) On very rare occasions, usually following a crisis episode, basic information about a behavioral health recipient may not be available. When the identity of a behavioral health recipient is unknown, a provider may use a pseudo identification number to register an unidentified person. This allows an

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- encounter to be submitted to AHCCCS, allowing the RBHA and the provider to be reimbursed for delivering certain covered services.
- (2) Covered services that can be encountered/billed using pseudo identification numbers are limited to Crisis Intervention Services (Mobile), Case Management, and Transportation.
  - (3) Pseudo identification numbers must only be used as a last option when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. Pseudo identification numbers:
    - (a) NR010115M0 Non-Registered GSA 1
    - (b) NR010103M0 Non-Registered GSA 2
    - (c) NR010127M0 Non-Registered GSA 3
    - (d) NR010123M0 Non-Registered GSA 4
    - (e) NR010126M0 Non-Registered GSA 5
    - (f) NR010208M0 Non-Registered GSA 6
- c. TRBHA and TRBHA provider claims:
- i. Specific billing instructions for tribal claims are included in the [AHCCCS Billing Manual for IHS/Tribal Providers](#). All paper claims must be submitted using the [CMS 1500](#), [UB-04](#) or the Universal Pharmacy Form.
    - (1) [The CMS 1500 \(formerly HCFA 1500\) Claim Form](#) is used to bill non-facility services, including professional services, transportation and independent laboratories.
    - (2) The [UB 04](#) (formerly HCFA 1450) Claim Form is used to bill all hospital inpatient, outpatient, emergency room, hospital-based clinic and residential treatment center services.
    - (3) The Universal Pharmacy Claim Form is used by pharmacists to bill pharmacy services using NDC codes.
    - (4) Paper claims are not considered legible if they contain highlighter or color marks, copy overexposure marks or dark edges.
  - ii. Submitted claims for services delivered to a Title XIX or Title XXI eligible person will result in one of the following dispositions:
    - (1) Claims are typically denied because of a discrepancy between form field(s) and AHCCCS' edit tables. A denied claim may be resubmitted as long as the claim is submitted within 12 months of the date of service. Tribal RBHA claims will be denied in the event the claim is untimely, illegible or incomplete.
    - (2) Approved claims have passed the timeliness, accuracy and completeness standards and have been successfully processed by AHCCCS.
  - iii. Behavioral health providers must submit accurate, timely and complete claims data to AHCCCS for all covered behavioral health services, either on paper or electronically.
    - (1) All paper claims must be mailed to AHCCCS Claims, P.O. Box 1700, Phoenix, Arizona 85002-1700.

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- (2) For submitting electronic claims, TRBHAs and TRBHA providers must contact the AHCCCS Electronic Claims Submission Unit at (602) 417-7670 #4.
  - iv. All initial claims must be received by AHCCCS no later than six months from the date of service, unless the behavioral health recipient has retro-eligibility. For hospital inpatient claims, “date of service” means the date of discharge of the behavioral health recipient. Claims initially received beyond the six-month timeframe, except retro-eligibility claims, will be denied. If a claim is originally received within the six-month timeframe, 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 correct a previously processed claim, unless the claim is a retro-eligibility claim. If a claim does not achieve clean claim status or is not corrected within 12 months, AHCCCS is not liable for payment.
  - v. A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system on 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 no later than six 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. Corrections to paid retro-eligibility claims must be received by AHCCCS no later than 12 months from the AHCCCS date of eligibility posting.
  - vi. Denied claims:
    - (1) AHCCCS will deny claims with errors that are identified during the editing process. These errors will be reported to the provider in the AHCCCS remittance advice. Providers must correct claim errors and resubmit claims to AHCCCS for processing within the 12-month clean claim timeframe.
    - (2) When resubmitting a denied claim, the provider must submit a new claim form containing all previously submitted lines. The original AHCCCS claim reference number (CRN) must be included on the claim to enable the AHCCCS system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied for being received beyond the initial submission timeframe.
4. REFERENCES:
- [45 CFR 162.1101](#)
  - [45 CFR 162.1102](#)
  - [A.R.S. § 36-2903](#)
  - [A.R.S. §36-2904](#)
  - [A.A.C. R9-22-705](#)
  - [9 A.A.C. 34, Article 4](#)
  - [9 A.A.C. 34](#)
  - [AHCCCS/ADHS Contract](#)
  - [ADHS/RBHA Contracts](#)
  - [ADHS/TRBHA IGAs](#)
  - [ICD-9-CM and ICD 10 Manual](#)
  - [First Data Bank](#)

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[Physicians' Current Procedural Terminology \(CPT\) Manual](#)  
[Health Care Procedure Coding System \(HCPCS\) Manual](#)  
[Medicare Claims Processing Manual](#)  
[CMS 1500](#)  
[UB 04](#)  
[AHCCCS Billing Manual for IHS/Tribal Providers](#)  
[AHCCCS Contractor Operations Manual, Chapter 432](#)  
[ADHS/DBHS Office of Program Support Operations and Procedures Manual](#)  
[Client Information System \(CIS\) File Layout and Specifications Manual](#)  
[ADHS/DBHS Covered Behavioral Health Services Guide](#)

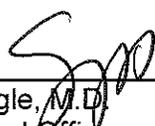
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5. APPROVED BY:

  
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