

REVISION DATES: 2/28/2019; 12/8/18; 12/30/2015; 04/26/2013; 05/31/2012

GENERAL INFORMATION

The *AHCCCS Fee-for-Service Remittance Advice* provides information about claims adjudicated by the AHCCCS Division of Fee For Service Management (DFSM), including claims paid or voided, claims which were denied, and in process and adjusted claims.

The Remittance Advice is generated weekly, and the paper Remittance Advice is mailed to the billing provider. If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each.

This chapter primarily addresses the Paper Remittance Advice. For providers interested in requesting Electronic Remittance Advice (ERA) setup (recommended), please see the below section on the 835 Remittance Advice.

For information related to the HIPAA-compliant 835 transaction, please consult the Implementation Guide and/or 835 Claim Remittance Advice Companion Document for the 835 transaction available on the AHCCCS website at:

<https://www.azahcccs.gov/Resources/EDI/EDITEchnicaldocuments.html>

835 REMITTANCE ADVICE

Please note that the AHCCCS Companion Document is intended to supplement, but not replace, the Implementation Guide for the 835 transaction. It can be found on the AHCCCS website at:

<https://www.azahcccs.gov/Resources/EDI/EDITEchnicaldocuments.html>

Providers who have completed the necessary registration and testing processes may download a HIPAA-compliant 835 electronic remittance advice for both paid and denied claims from a secure AHCCCS internet website, and may store the remittance in either electronic or hardcopy format on their internal systems.

Who may request ERA setup?

AHCCCS considers the provider their trading partner, and a request for electronic remittance advice (ERA) or 835 transaction setup must come from an authorized individual from within the provider's organization; **it cannot be initiated by the provider's clearinghouse, software vendor, or billing service.**

For clarification purposes, the authorized individual must be someone from within the provider's own organization that has the authority to accept the electronic Trading Partner Agreement (TPA) executed from the Community Manager (CM) web portal. Only the provider can accept the TPA as it is a contractual agreement between the provider and AHCCCS. **The provider's CM**

account activation cannot be done by the provider's clearinghouse, software vendor, or billing service.

How can a provider request ERA setup?

The AHCCCS Information Services Division, EDI Customer Support, is the first point of contact for questions related to electronic transactions or to request transaction setup. The preferred method of contact is email.

Note: If providing PHI data, please make sure your email is secured.

All inquiries will result in the assignment of a Service Request or Incident for AHCCCS reporting purposes. Contact information:

Email: EDICustomerSupport@azahcccs.gov
Telephone Number: (602) 417-4451
Hours: 7:00 AM – 5:00 PM Arizona Time, Monday through Friday

What information will AHCCCS need?

AHCCCS will require the following information from providers, in order to set them up for the Electronic Transaction Process:

- Customer Name
- Provider Name
- Customer Email Address
- AHCCCS 6 digit Provider ID and/or NPI
- Will the provider be retrieving their own ERA/835 or be using a clearinghouse to retrieve the ERA/835 on the provider's behalf?
- If a clearinghouse is to be used, provide the name of that clearinghouse.

Note: The remaining information in this Chapter applies only to the Paper Remittance Advice.

PAPER REMITTANCE ADVICE

The AHCCCS paper remittance advice is broken up into two general packages or sections.

- 1) The *Non-Facility Remittance Advice* section, which reports information related to services billed on the CMS 1500, UB ADA claim forms; and
- 2) The *Facility Remittance Advice* section, which reports information related to services billed on the UB claim form.

Providers may receive an Acute Remittance, a Long Term Care Remittance, a KidsCare Remittance or all three within a Remittance Advice package. The terms Acute, Long Term Care, and KidsCare designate the eligibility category of the members and do not refer to the type of provider. There will be only one payment issued for any combination of invoices paid.

REMITTANCE SECTIONS

Each Remittance Advice is divided into seven sections:

- Paid Claims
- Adjusted Claims
- Denied Claims
- Voided Claims
- Claims in Process
 - This section includes claims pending or reported on a previous Remittance and still in process.
- Processing Notes
 - This page provides an alphabetical listing of denial reason codes and pricing explanation codes.
 - Each is listed only once even if it applies to multiple claims.
- Grievance Process
 - This page informs providers of their grievance rights. (See Chapter 19, Claim Disputes)

Providers who would like to request a duplicate paper copy of the remittance advice may contact the Division of Business and Finance (DBF) at:

- **Metro Phoenix (602, 480, & 623 area codes): 602-417-5500**
- **Toll Free: 877-500-7010**

Please note that there is a charge for a duplicate remittance advice of \$4.00 per page. Duplicate paper copies are only available to providers receiving paper remittances, and not to providers receiving electronic 835s.

Providers receiving the electronic 835 remittance, who would like to request a duplicate 835, must contact the help desk at 602-417-4451 for assistance.

ADDRESS PAGE

The **Address Page** of the Remittance Advice (Exhibit 18-1) displays the billing provider's name, ID and pay-to mailing address, as well as the Invoice Date and Payment Date.

Information reported on the Address page includes:

- REPORT ID
- PROGRM ID
- BILLING PROVIDER ID number plus locator codes and name

- TAX ID of the billing provider.
- INVOICE DATE
- PAYMENT DATE
- BILLING PROVIDER NAME
- PAY-TO MAILING ADDRESS

FINANCIAL SUMMARY

The **Financial Summary** page (Exhibit 18-2) reports check and invoice data. If all claims are in process or denied, the page will indicate “No Active Invoices.”

Information reported on the Financial Summary page includes:

- REPORT ID
- PROGRM ID
- BILLING PROVIDER ID number plus locator codes and name
- TAX ID of the billing provider.
- PAYMENT DATE is the check date.
- PAY FOR CATEGORY.
 - Acute, Long Term Care, and KidsCare totals (as applicable) are printed on separate lines.
- CHECK NUMBER.
 - Providers receive separate checks for each Pay For Category
- INVOICE DATE is the date the invoice was created.
- INVOICE NUMBER links payments to the services that generated the payment.
 - A is for Acute services
 - L is for Long Term Care services
 - K is for Kids Care services
 - M is for FQMB
 - N is JDOC
 - J is MDOC
 - C is BKFS
 - B is BFFS
- TYPE column will indicate “CR” if the provider has a credit.
- GROSS AMOUNT is the total remitted for each Pay Category.
 - A negative Gross total on an invoice lines means it is a credit.
 - This may mean there is no payment on this remittance. However, there can still be a payment for the other invoices if there are more than one. The total payment will be the net of credits and debits.
 - When there is only one invoice: Gross Amount and Net Amount are usually equal unless there is a credit memo (negative invoices or recouped claims).

- When there is more than one invoice: When two invoices are submitted, the Net Amount reflects the total for both invoices.
- DISCOUNT is never used for AHCCCS fee-for-service providers.
- NET AMOUNT is the check/EFT amount for each Pay Category.

NON-FACILITY PAID CLAIMS

The ***Paid Claims*** section for non-facility claims (Exhibit 18-3) displays the following data:

- INVOICE DATE is the date AHCCCS processed the claims for payment.
- BILLING PROVIDER ID number plus locator codes and name.
- SERVICE PROVIDER ID number plus locator codes and name.
- NPI for both billing and servicing providers.
- INVOICE NUMBER matches the number on the Financial Summary.
- CHECK/EFT NUMBER matches the number on the Financial Summary.
- PAYMENT DATE is the date of the reimbursement check/EFT.
- TAX ID of the billing provider.
- FORM TYPE will be 1500 or Dental.
- AHCCCS ID of the member.
- NAME of the member as recorded in the AHCCCS system.
- PATIENT ACCOUNT NUMBER is the number entered on the claim in the patient account number field. At times this may be the same as the AHCCCS ID.
- CRN is the AHCCCS Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- STATUS DATE is the most recent date the claim was adjudicated (attained "Paid" status).
- SERVICE CD/MODIFIER is the CPT/HCPCS procedure code submitted on the claim.
 - Any procedure modifier would be printed below the procedure code.
- DATES OF SERVICE displays the From and Through dates of service submitted on the claim.
 - If dates are the same, only one date is displayed.
- BILLED AMOUNT submitted on the claim.
- BILLED UNITS reflects the number of units submitted on the claim.
- ALLOWED UNITS reflects the AHCCCS allowed number of units.
- ALLOWED AMOUNT may be based on the AHCCCS capped fee, a provider specific rate, Medicare Coinsurance and Deductible, etc.
- NET PAID AMOUNT is the ALLOWED AMOUNT minus any deductions.
- PRICE EXPL is the pricing explanation code.
- Definitions are printed on the Processing Notes page.
- An asterisk (*) next to a code denotes how the ALLOWED AMOUNT was determined (e.g., MCC = Medicare Coinsurance, MAX = maximum allowed charge/capped fee, etc.).

The following summary is listed at the end of each Non-facility Paid Claims section:

- NUMBER OF CLAIMS is the total number of claims in the Paid Claims section.

- TOTAL BILLED AMOUNT is the total amount for all claims in the Paid Claims section.
- TOTAL REMIT AMOUNT is the total paid amount for all claims in the Paid Claims section.

REPORT ID:	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM						PAGE:
PROGRAM ID:	NON-FACILITY REMITTANCE ADVICE						RUN:
	PAID CLAIMS - INVOICE DATE:						
BILLING PROVIDER:		NPI:		INVOICE NUMBER:			
SERVICE PROVIDER:		NPI:		CHECK NUMBER:			
				PAYMENT DATE:			
TAX ID:							
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	

A#####	Last Name, First Name	#####	99231		75.00	1.00	40.00 ALLOWED AMOUNT (*)
A#####	Patient Account #	MM/DD/YYYY			1.00		-----
							40.00 NET PAID AMOUNT

PRICE ENPL:	*AHA						

NUMBER OF CLAIMS:	1						
TOTAL BILLED AMOUNT:	75.00						
TOTAL REMIT AMOUNT:	40.00						

NON-FACILITY DENIED CLAIMS

The **Denied Claims** section for non-facility claims (Exhibit 18-4) displays much of the same data as the Paid Claims section.

Because no payment is made to the provider, the CHECK NUMBER, INVOICE DATE, INVOICE NUMBER, TYPE, GROSS AMOUNT, DISCOUNT, AND NET AMOUNT are not displayed on the Financial Summary page.

- Please note, if the remittance only has denied claims on it, the Financial Summary Page will show no active invoices and no other information on it.

Because no payment is made to the provider, the INVOICE NUMBER, CHECK NUMBER, AND PAYMENT DATE fields are not displayed in the Denied Claims section.

- Please note that the above holds true only if the remittance contains only denied claim information. However, if the same remittance has paid and denied claims on it, the PAYMENT NUMBER, INVOICE DATE, INVOICE NUMBER, AND GROSS and NET AMOUNTS will also appear.

The Denied Claim section adds a REASON CDS field that lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Providers should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Non-facility Denied Claims section:

- THE NUMBER OF CLAIMS in the Denied Claims section.



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- **TOTAL BILLED AMOUNT** for all claims in the Denied Claims section.

REPORT ID: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PAGE:
 PROGRAM ID: NON-FACILITY REMITTANCE ADVICE RUN:
 DENIED CLAIMS

BILLING PROVIDER: NPI:
 SERVICE PROVIDER: NPI:

TAX ID:
 FORM TYPE: FORM 1500

AHCCCS ID	RECIPIENT NAME	PATIENT ACCOUNT NBR	CRN	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT	BILLED UNITS
A#####	A##### Last Name, First Name	T#####CLAIM	#####	97110 GP	MM/DD/CCYY	30.00	1.00
REASON CDS: H001.7 L013.1							
A#####	A##### Last Name, First Name	T#####CLAIM	#####	97110 GP	MM/DD/CCYY	225.00	3.00
REASON CDS: H001.7							

NUMBER OF CLAIMS: 2
 TOTAL BILLED AMOUNT: 255.00

NON-FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for non-facility claims (Exhibit 18-5) displays much of the same data as the Paid Claims section.

The Adjusted Claims section adds a PREVIOUSLY PAID field that displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of each Non-facility Adjusted Claims section:

- **NUMBER OF CLAIMS** is the total number of claims in the Adjusted Claims section.
- **TOTAL BILLED AMOUNT** for all claims in the Adjusted Claims section.
- **TOTAL REMIT AMOUNT** for all claims in the Adjusted Claims section.

REPORT ID: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PAGE:
 PROGRAM ID: NON-FACILITY REMITTANCE ADVICE RUN:
 ADJUSTED CLAIMS - INVOICE DATE:

BILLING PROVIDER: Provider ID Billing Provider Name NPI: INVOICE NUMBER:
 SERVICE PROVIDER: Provider ID Servicing Provider Name NPI: CHECK NUMBER:
 PAYMENT DATE:

TAX ID:
 FORM TYPE: FORM 1500

AHCCCS ID	NAME	CRN	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT	ALLOWED UNITS		
RECIPIENT	PATIENT ACCOUNT NUMBER	SCORE DATE			BILLED UNITS			
A#####	Last Name, First Name	#####	Billed Code	MM/DD/CCYY	145.66	2.00	57.20	ALLOWED AMOUNT (*)
A#####	T#####CLAIM	MM/DD/CCYY	Modifier		2.00		57.20-	PREVIOUSLY PAID
							0.00	NET PAID AMOUNT

PRICE EXPL: *AHA

NON-FACILITY VOIDED CLAIMS

The *Voided Claims* section for non-facility claims (Exhibit 18-6) displays much of the same data as the Paid Claims section.

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than the amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are “backed out” and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

NOTE: The credit balance has not been recouped if there is no payment with the remittance and there are voided claims. Until there are further claims to recoup the credit balance from, the funds are not considered recouped. A provider will have an aging credit in the system if there were no claims paid or claims paid for less than what was voided. The funds will not be considered recouped until there is no longer an aging credit balance.

The following summary is listed at the end of each Non-facility Voided Claims section:

- NUMBER OF CLAIMS in the Voided Claims section.
- TOTAL BILLED AMOUNT for all claims in the Voided Claims section.
- TOTAL RECOUPED AMOUNT for all claims in the Voided Claims section.

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REPORT ID: ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PAGE:
PROGRAM ID: NON-FACILITY REMITTANCE ADVICE RUN:
          VOIDED CLAIMS - INVOICE DATE:

BILLING PROVIDER: NPI: INVOICE NUMBER:
SERVICE PROVIDER: NPI: CHECK NUMBER:
                    PAYMENT DATE:

TAX ID:
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
-----
##### Last Name, First Name CRN Number 00400 MMDDYYYY 2000.00 4.00 0.00 ALLOWED AMOUNT (*)
##### Account Number MMDDYYYY AA 4.00 200.00 PREVIOUSLY PAID
                    200.00- NET PAID AMOUNT

PRICE EXPL: *AHA
REASON CDS: MD034
COMMENTS: DENIED ADJUSTMENT OF PREVIOUS PAYMENT
-----

NUMBER OF CLAIMS: 1
TOTAL BILLED AMOUNT: 2000.00
TOTAL RECOUPED AMOUNT: 200.00-
  
```

NON-FACILITY CLAIMS IN PROCESS



The *Claims in Process* section (Exhibit 18-7) of the Remittance Advice for non-facility claims displays all claims that have not been adjudicated (as of that week’s invoice date). The Claims in Process section displays much of the same data described previously.

The Claims in Process section does not display any payment or edit information because the claims have not been adjudicated.

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of each Non-facility Claims in Process section:

- NUMBER OF CLAIMS is the total number of claims in process.
- TOTAL BILLED AMOUNT is for all the claims in process.
- **NOTE:** If there are multiple servicing providers with claims in process then the TOTAL BILLED AMOUNT will show under each service provider and not all combined.

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REPORT ID:                                ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM                                PAGE:
PROGRAM ID:                               NON-FACILITY REMITTANCE ADVICE                                             RUN:
                                           CLAIMS IN PROCESS

BILLING PROVIDER:                         NPI:
SERVICE PROVIDER:                       NPI:

TAX ID:
FORM TYPE: FORM 1500
  
```

AHCCCS ID	RECIPIENT NAME	PATIENT ACCOUNT NBR	CRN	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT	BILLED UNITS
A#####	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	2.00
A#####	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	2.00
A#####	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97010	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97110	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97140	MM/DD/YYYY	20.00	1.00
A#####	Last Name, First Name	Account Number	CRN	97530	MM/DD/YYYY	20.00	2.00
A#####	Last Name, First Name	Account Number	CRN	G0283	MM/DD/YYYY	20.00	1.00

```

NUMBER OF CLAIMS:           15
TOTAL BILLED AMOUNT:       300.00
  
```

NON-FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* (Exhibit 18-8) section displays the following data:

- BILLING PROVIDER ID number plus locator codes and name.
- TAX ID number of the billing provider.

- NPI of the billing provider.
- NOTE is an alphabetical listing of processing codes (denial or void reason codes, pricing method codes, etc.).
 - Each code is listed only once even if applicable to multiple claims.
- TYPE lists the type of code.
 - M = Pricing Method
 - P = Pricing Type
 - R = Reason Code
 - T = Tier
 - X = Modifier
- DESCRIPTION is the description of a processing note code.
Examples:
 - H199.4 R CLAIM RECEIVED PAST 6 MONTH LIMIT
 - H079.7 R BILLING PROVIDER ID NOT VALID FOR PROVIDER
 - AHA P AHCCCS ALLOWED
 - SUB M SUBMITTED AMOUNT FROM CLAIM

FACILITY PAID CLAIMS/INPATIENT

The *Paid Claims* section for inpatient facility claims (Exhibit 18-9) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- BILLING PROVIDER ID number plus locator codes and name.
- SERVICE PROVIDER ID number plus locator codes and name.
- NPI of the billing and servicing provider IDs.
- INVOICE NUMBER matches the number on the Financial Summary .
- CHECK NUMBER matches the number on the Financial Summary.
- PAYMENT DATE is the date of the reimbursement check.
- TAX ID of the billing provider.
- The FORM TYPE will be Inpatient (includes inpatient hospital and nursing home).
- AHCCCS ID of the member.
- NAME of the recipient as recorded in the AHCCCS system.
- PATIENT ACCOUNT NUMBER is the number you entered on the claim in the patient account number field.
- PRICE EXPL is the pricing explanation code.
 - Definitions are printed on the Processing Notes page.
 - An asterisk (*) next to a code denotes how the ALLOWED AMOUNT was determined (e.g., MCC = Medicare Coinsurance, MAX = maximum allowed charge/capped fee, etc.).
- CRN is the AHCCCS Claim Reference Number that is unique to each claim and remains the same over the life of the claim.
- STATUS DATE is the most recent date the claim was adjudicated (attained “Paid” status).

- DATES OF SERVICE displays the From and Through dates of service submitted on the claim.
 - If dates are the same, only one date is displayed.
- BILLED AMOUNT submitted on the claim.
- BILLED UNITS reflects the number of units submitted on the claim.
- ALLOWED UNITS reflects the AHCCCS allowed number of units.
- ALLOWED AMOUNT may be based on the AHCCCS capped fee, Medicare Coinsurance and Deductible, etc.
- NET PAID AMOUNT is the ALLOWED AMOUNT minus any deductions.
- The PRICE EXPL field will display:
 - For hospital inpatient claims, tier(s) into which the claim was classified are displayed (e.g., MAT = Maternity tier).
 - For hospital claims, discount and penalty percentages also are displayed.
 - For nursing home claims, codes may indicate PDM (per diem) or MCC (Medicare Coinsurance).
- TIER DATA displays the inpatient tier classification(s), number of accommodation days billed, AHCCCS allowed days for tier(s), and reason codes for any disallowed and cutback days.
- BILLED UNITS reflects accommodation days for inpatient claims.
- ALLOWED UNITS reflects accommodation days for inpatient claims.

The following summary is at the end of each Paid Claims section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.
- TOTAL REMIT AMOUNT for all claims in the section.

BILLING PROVIDER:		NPI:	INVOICE NUMBER:					
SERVICE PROVIDER:		NPI:	CHECK NUMBER:					
TAX ID:			PAYMENT DATE:					
FORM TYPE: INPATIENT								

AHCCCS ID	NAME	CRN	DATES OF	BILLED AMOUNT	ALLOWED		
RECIPIENT	PATIENT ACCOUNT NUMBER	STATUS	SERVICE	BILLED UNITS	UNITS		
-----	-----	-----	-----	-----	-----	-----	-----
A#####	Last Name, First Name	CRN	MM/DD/YYYY	54,000.00	3.00	10,000.00	ALLOWED AMOUNT (*)
A#####	Account Number	MM/DD/YYYY	MM/DD/YYYY	3.00		300.00-	DISCOUNT

						9,700.00	NET PAID AMOUNT

PRICE EXPL: *AHA (Q5 - 1%)

FACILITY PAID CLAIMS/OUTPATIENT

The *Paid Claims* section for outpatient facility claims (Exhibit 18-10) displays much of the same data displayed in the Paid Claims section for non-facility claims.

- BILLING PROVIDER ID number plus locator codes and name.
- SERVICE PROVIDER ID number plus locator codes and name.
- NPI of the billing and servicing provider IDs.
- INVOICE NUMBER matches the number on the Financial Summary .

- CHECK NUMBER matches the number on the Financial Summary.
- PAYMENT DATE is the date of the reimbursement check.
- TAX ID of the billing provider.
- The FORM TYPE will be Outpatient (includes outpatient hospital, dialysis facilities, hospice, and birthing centers).
- The PRICE EXPL field will display:
 - For hospital claims, discount and penalty percentages also are displayed at the claim level.
 - Definitions are printed on the Processing Notes page.
- BILLED UNITS reflects actual line billed units for each revenue code line for outpatient claims with dates of service on or after 7/1/2005.
- ALLOWED UNITS reflects actual line allowed units for outpatient claims with dates of service on or after 7/1/2005.

BILLING PROVIDER:		NPI:		INVOICE NUMBER:			
SERVICE PROVIDER:		NPI:		CHECK NUMBER:			
TAX ID:				PAYMENT DATE:			
FORM TYPE: OUTPATIENT							

AHCCCS ID RECIPIENT	NAME PATIENT ACCOUNT NUMBER	CRN STATUS DATE	DATES OF SERVICE	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS		
A#####	Last Name, First Name	CRN	MM/DD/YYYY	4200.00	5.00	450.00	ALLOWED AMOUNT (*)
A#####	Account Number	MM/DD/YYYY	MM/DD/YYYY	5.00		2.50	DISCOUNT
						447.50	NET PAID AMOUNT

FACILITY DENIED CLAIMS

The *Denied Claims* section for facility claims (Exhibit 18-11) displays much of the same data as the Paid Claims section.

Because no payment is made to the provider, the INVOICE DATE, INVOICE NUMBER, PAYMENT DATE, and CHECK NUMBER fields are not displayed in the Denied Claims section.

- NOTE: If the remittance only has denied claims on it, the Financial Summary Page will show no active invoices and no other information on it.
- NOTE: The above holds true only if the remittance contains only denied claim information. However, if the same remittance has paid and denied claims on it, the PAYMENT NUMBER, INVOICE DATE, INVOICE NUMBER, AND GROSS and NET AMOUNTS will also appear.

The REASON CDS field lists the denial reason code(s). The code definitions are printed on the Processing Notes page.

Providers should make note of the AHCCCS Claim Reference Number printed in the CRN field. This number must be referenced when the denied claim is resubmitted.

The following summary is listed at the end of each Denied Claims section:

- NUMBER OF CLAIMS in the Denied Claims section.
- TOTAL BILLED AMOUNT for all claims in the Denied Claims section.

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REPORT ID:
PROGRAM ID:
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
FACILITY REMITTANCE ADVICE
DENIED CLAIMS
PAGE:
RUN:

BILLING PROVIDER: Provider ID#
SERVICE PROVIDER: Provider ID#
Billing Provider Name
Service Provider Name
NPI:
NPI:

TAX ID:
FORM TYPE: INPATIENT

AHCCCS ID  RECIPIENT  NAME  PATIENT ACCOUNT NBR  CRN  DATES OF SERVICE  BILLED AMOUNT  BILLED UNITS
-----
A#####  A#####  Last Name, First Name  #####  #####  MM/DD/CCYY  MM/DD/CCYY  $4,000.00  4.00
REASON CDS: H210.9  H229.1  H258.1
-----

NUMBER OF CLAIMS: 1
TOTAL BILLED AMOUNT: 4,000.00
  
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FACILITY ADJUSTED CLAIMS

The *Adjusted Claims* section for facility claims (Exhibit 18-12) displays much of the same data as the Paid Claims section.

The PREVIOUSLY PAID field displays the previously paid amount as a negative number. The NET PAID AMOUNT is the difference between the new ALLOWED AMOUNT and the PREVIOUSLY PAID amount. The net paid amount could be negative if the adjusted Allowed Amount is less than the original Allowed Amount.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original claim. The claim retains this number regardless of the number of times it is adjusted.

The following summary is listed at the end of the Adjusted Claims section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.
- TOTAL REMIT AMOUNT for all claims in the section.

FACILITY VOIDED CLAIMS

The *Voided Claims* section for facility claims (Exhibit 18-13) displays much of the same data as the Paid Claims section.

The Voided Claims section will only display CHECK NUMBER and PAYMENT DATE fields if the paid and adjusted claims during the payment cycle total more than amount being recouped as voids.

The AHCCCS Claim Reference Number displayed in the CRN field is the CRN of the original

claim. The claim retains this number when it is voided.

The ALLOWED AMOUNT is displayed as a negative amount, and any previous deductions are “backed out” and displayed as a positive number. The NET PAID AMOUNT is a negative number showing the amount recouped.

The following summary is listed at the end of each Voided Claims section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.
- TOTAL RECOUPED AMOUNT for all claims in the section.

REPORT ID:	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM	PAGE:
PROGRAM ID:	FACILITY REMITTANCE ADVICE - MDOC FEE FOR SERVICE	RUN:
	VOIDED CLAIMS - INVOICE DATE:	
BILLING PROVIDER:	NPI:	INVOICE NUMBER:
SERVICE PROVIDER:	NPI:	CHECK NUMBER:
		PAYMENT DATE:
TAX ID:		
FORM TYPE:	OUTPATIENT	

AHCCCS ID	NAME	CRN	DATES OF	BILLED AMOUNT	ALLOWED		
RECIPIENT	PATIENT ACCOUNT NUMBER	STATUS DATE	SERVICE	BILLED UNITS	UNITS		
A#####	Last Name, First Name	CRN Number	MM/DD/YYYY	30,000.00	1.00	10,000.00-	ALLOWED AMOUNT (*)
A#####	Account Number	MM/DD/YYYY	MM/DD/YYYY	1.00		500.00	DISCOUNT

						9500.00-	NET PAID AMOUNT

PRICE EXPL: *AHA (Q5 - 1%)

REASON CDS: EV100 --LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE00, LINE01, LINE01, LINE01, LINE01, LINE

REASON CDS: EV100 --LINE01, LINE01, LINE01, LINE01, LINE02, LINE02, LINE02, LINE02, LINE02, LINE02

Number of Claims: 1
 Total Billed Amount: 30000.00
 Total Recouped Amount: 9500.00

FACILITY CLAIMS IN PROCESS

The *Claims in Process* section (Exhibit 18-14) of the Remittance Advice for facility claims displays all claims that have not been adjudicated. The Claims in Process section displays much of the same data described previously.

Inquiries about a claim in process should reference the AHCCCS Claim Reference Number of the claim displayed in the CRN field.

The following summary is listed at the end of the Claims in Process section:

- NUMBER OF CLAIMS, both inpatient and outpatient, in the section.
- TOTAL BILLED AMOUNT for all claims in the section.



REPORT ID: PROGRAM ID:	ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM FACILITY REMITTANCE ADVICE CLAIMS IN PROCESS	PAGE: RUN:
BILLING PROVIDER: SERVICE PROVIDER:	NPI: NPI:	
TAX ID: FORM TYPE: INPATIENT		

AHCCCS ID	RECIPIENT	NAME	PATIENT ACCOUNT NBR	CRN	DATES OF SERVICE		BILLED AMOUNT	BILLED UNITS
A#####	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	30,000.00	3.00
A#####	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	78,900.00	7.00
COMMENTS: OUTLIER REQUESTED, NOT QUALIFIED								
A#####	Recipient ID	Last Name, First Name	Patient Account Number	CRN	MM/DD/YYYY	MM/DD/YYYY	50,000.00	2.00

Number of Claims: 3
Total Billed Amount: 158,900.00

FACILITY CLAIMS PROCESSING NOTES

The *Processing Notes* section for both Acute and Long Term Care claims displays the same type of information as does the Processing Notes section for non-facility claims (Exhibit 18-8).

GUIDANCE ON REVIEWING THE REMITTANCE ADVICE

Here are some suggestions for working the AHCCCS Remittance Advice to reconcile claims billed to the AHCCCS Administration and the status of those claims.

1. Review the Paid Claims section of the Remittance Advice to determine which claims have been paid and if those claims were paid correctly. Any errors, such as claims that have not paid the correct number of units, should be resubmitted (if within timely filing guidelines), noting **the original** CRN. (See Chapter 4, General Billing Rules, for information on resubmitting a paid claim.)

NOTE: The CRN on the originally submitted claim is REQUIRED on resubmissions.

2. Review the Adjusted Claims section of the Remittance Advice. This section will report any claims submitted by the provider as adjustments because they were not paid correctly. If problems still exist with a claim, it may be submitted again if within the timely filing guidelines. This section also will report any claims that were adjusted by AHCCCS as a result of an audit or review.

NOTE: AHCCCS highly recommends that resubmissions should be done using the [AHCCCS Online Provider Portal](https://azweb.statemedicaid.us). (<https://azweb.statemedicaid.us>)

3. Review the Voided Claims section of the Remittance Advice. This section will report any claims submitted by the provider as a voided transaction. There are many reasons a claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that AHCCCS can recoup its payment. This section also will report any

claims that were voided by AHCCCS as a result of an audit or medical review recoupment.

4. Review the Denied Claims section of the Remittance Advice. Review each denial reason and determine the action necessary to correct the claim. (See Chapter 4, General Billing Rules, for information on resubmitting a denied claim.)

Providers who have questions about the status of their claim should contact the AHCCCS Claims Customer Service Unit:

- (602) 417-7670 (Phoenix Area)
- (800) 794-6862 (In state)
- (800) 523-0231 (Out of state)**

**Customer Service Agents cannot provide billing guidance.

Providers who have questions on delayed payments, checks, or the remittance advice may contact the Division of Business and Finance (DBF) at:

- Metro Phoenix (602, 480, & 623 area codes): 602-417-5500
- Toll Free: 877-500-7010

References

835 Claim Remittance Advice Companion Guide:

<https://www.azahcccs.gov/Resources/EDI/EDITEchnicaldocuments.html>

Revision History

Date	Description of Changes	Page(s)
2/28/2019	General Information Section – Clarifications added and link to the 835 Claim Remittance Advice Companion Document updated.	1
	Link added for 835 AHCCCS Companion Documents	1
	FAQs added regarding the Electronic Remittance Advice	
	<ul style="list-style-type: none"> • Who may request ERA setup? 	1
	<ul style="list-style-type: none"> • How can a provider request ERA setup? 	2
	<ul style="list-style-type: none"> • What information does AHCCCS require to set up the Electronic Transaction Process? 	2
	Clarification added to the paper remittance advice section reading as, “There will be only one payment issued for any combination of invoices paid.”	3
Remittance Sections list added	3	
Contact information (to request a duplicate paper remittance advice) for the Division of Business and Finance added.	3	

	Address Page section updated	4
	Financial Summary section updated	4-5
	Non-Facility Paid Claims section updated	5-6
	Non-Facility Denied Claims section updated	6-7
	Non-Facility Adjusted Claims section updated with an example	7-8
	Non-Facility Voided Claims section updated with an example	8-9
	Non-Facility Claims in Process section updated	9-10
	Non-Facility Claims Processing Notes section updated	10-11
	Facility Paid Claims/Inpatient section updated	11-12
	Facility Paid Claims/Outpatient section added and updated	12-13
	Facility Denied Claims section updated	13-14
	Facility Voided Claims section updated	14-15
	Facility Claims In Process section updated	15-16
	Guidance on Reviewing the Remittance Advice section updated	16-17
12/8/18	References Section Added	10
	Formatting	All