REPLACEMENTS AND VOIDS

June 8, 2017
HRD Room
2:00 p.m. – 3:30 p.m.
Please Welcome

Arcelia Velazquez
Provider Training Officer
Please refer questions to:
ProviderTrainingFFS@azahcccs.gov
Claims Customer Service Line 602-417-7670
Timely Claim Submission

- **Timelines for claim submissions:**
  - Fee-for-Service claims are considered timely if the initial claim is received by AHCCCS no later than 6 months from the date of service.
    - DOS 6/1/17
    - Timely Filing Date 12/1/17

  - IHS/638 claims should be submitted within 12 months from the date of service.
    - DOS 6/1/17
    - Timely Filing Date 6/1/18
Retro-Eligibility & Hospital Inpatient Submission

- **Timelines for retro eligibility claim submissions:**
  - Retro-eligibility claims should be submitted 6 months from the eligibility posted date.
  - For hospital inpatient claims, “date of service” means the date of discharge.

DOS 6/1/17

Eligibility Posted Date 7/1/17

Timely Filing Date 1/1/18

Date of **Discharge** 6/1/17

Timely Filing Date 12/1/17
Timely Claim Submission

- Originally received within 6 months
  Provider has **up to 12 months** from the date of service to achieve a clean claim status by submitting a replacement.

- 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 recoupments, which would decrease the original AHCCCS payment.

**Note:** As defined by ARS §36-2904 (G)(1) a “clean claim” is:
A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
**Reconsideration**

Reconsideration - a request for a review of a claim that a provider feels was incorrectly paid or denied because of processing errors, with no changes (as it was originally submitted).

AHCCCS will correct any AHCCCS system errors and re-process the original claim.

**No changes will be accepted on the copy of the original claim coming in as a reconsideration.**

You can mail the claim to AHCCCS with the following information:

✓ A copy of the original claim (reprint or copy is acceptable)

**Reconsiderations for CLAIMS are mailed to:**

**AHCCCS Claims Department**

Attn: Resubmission & Reconsideration

701 E. Jefferson MD 8200, Phoenix, AZ 85034
Resubmission - a claim originally denied because of missing documentation, incorrect coding, etc., which is now being resubmitted with the required information or after appropriate changes have been made to the claim and the claim still meets the submission timeliness guidelines.

Note: The original claim has been denied. Option, submit a brand new claim with corrections as long as the claim meets timely filing guidelines.
**Void** – only used to recoup an entire claim submitted in error. This option is for a claim that should not have been submitted.

When a claim is voided, all paid lines are recouped.

- This process should only be used when there is **no other alternative**.
- Only the provider who submitted the original claim can void the claim.
- The claim becomes completely voided in the system.
- If you want to void individual lines, you must use the replacement process by omitting the lines you want recouped.

If a provider received overpayment, the provider must notify AHCCCS and must initiate recoupment.
Replacement

**Replacement** - an adjustment to a denied or paid claim, in order to achieve a clean claim status (denied: correct typos. Paid: correct codes, units, etc.)

A Replacement can be submitted in the following manner:
1. Online AHCCCS web portal,
   Below is the link to the AHCCCS web portal:
   https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f
2. As an 837 transaction or
3. Mailing the paper claim.

**Note:** When submitting the replacement, it’s important to remember to use the Claim Reference Number (CRN) associated with the original claim you want to replace. Otherwise, the system will not be able to link the claim you are replacing and deny the replacement claim.
DENIED CLAIMS:
✓ Correct the claim.
✓ Resubmit the claim in its entirety, including all lines of the original claim. Failure to include all lines in a multi-line claim will result in a recoupment on paid lines not accounted for on resubmitted claims.
✓ If the original claim denied anything on the claim can be changed.

**RULE OF THUMB** – Bill as you originally intended to bill.

PAID CLAIMS:
✓ Make changes and or add lines to the new claim.
✓ Resubmit all lines from the original claim for which you are requesting reimbursement, even if they contain no changes.
✓ 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.
✓ Anything can be changed except the provider.
✓ For Inpatient claims the Bill Type can not be changed.
Non-IHS/638 Paid Claims

PAID CLAIMS:

If the claim was paid and it is now over six (6) months, if the claim is adjusted DO NOT VOID the claim.

Voiding the claim will result in the recoupment of the payment.
If a replacement denies for “unmatched key field”, the replacement failed. The original claim has not been replaced.

Correct the errors, and submit a new replacement claim and reference the original CRN number.

If replacement denies for any other reason, the replacement was successful and the original is now voided. If the replacement needs subsequent corrections, the replacement becomes the original claim.

Use the CRN of the replacement claim.
Reaching across Arizona to provide comprehensive quality health care for those in need

**How the Replacement process works**

The original claim comes in and is assigned a CRN (i.e. 130000000000), the claim has two service lines, line 1 paid and line 2 denied for invalid procedure code.

<table>
<thead>
<tr>
<th>CRN</th>
<th>Status</th>
<th>Service Code</th>
<th>Amount</th>
<th>Adjusted Amount</th>
<th>Payment Status</th>
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<tr>
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<td>$14.54</td>
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<td>$14.54 Paid</td>
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<td>130000000000</td>
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<td>A0215</td>
<td>$70.38</td>
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<td>$0.00 Denied</td>
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</table>

**Replacement Claim**

Key the replacement claim as a new claim with corrections, mark the claim as a replacement and enter the original CRN of the claim you want to replace (adjust) (i.e. 130000000000). Make sure you enter both lines from the original claim, any omitted lines will result in the recoupment of those line/s.

If billing online

When the replacement claim is submitted the system will assign it a new CRN (i.e 1300000000033) and will void the original claim (130000000000). You will no longer be able to adjust or add attachments to the original claim (130000000000). If another adjustment is needed, you must adjust the Replacement claim (1300000000033).

<table>
<thead>
<tr>
<th>CRN</th>
<th>Status</th>
<th>Service Code</th>
<th>Amount</th>
<th>Adjusted Amount</th>
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<td>S0215</td>
<td>$70.38</td>
<td>46</td>
<td>$70.38</td>
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</table>
Replacements/Void
Online AHCCCS Web-Portal.
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.

**Note:** Complete all the required tabs making changes/corrections as you go along paying close attention to the fields with a red asterisk.
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ADA (Dental) Claim

Same process as the Professional (1500)
Institutional (UB’s) Claims

Enter the Claims Control Number (CRN) of the claim you want to Replace (Adjust) or Void (Recoup)

On a Institutional (UB) the bill type tells the system that this claim is a replacement or Void.

Note: Complete the required tabs making changes/corrections as you go along paying close attention to the fields with a red asterisk.
Must use a Bill type when doing a replacement/void on an Institutional UB Claim

<table>
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<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>BEG DATE</th>
<th>END DATE</th>
<th>LAST MOD</th>
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<td>03/20/07</td>
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<td>HOSP, OP INTERIM, 1ST CLAIM</td>
<td>10/01/82</td>
<td>99/99/99</td>
<td>03/20/90</td>
</tr>
</tbody>
</table>
G. The administration shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later, except for claims submitted for reinsurance pursuant to section 36-2906, subsection C, paragraph 6. The administration shall not pay claims for system covered services that are submitted by contractors for reinsurance after the time period specified in the contract. The director may adopt rules or require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims. Notwithstanding any other provision of this article, if a claim that gives rise to a contractor's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the contractor shall have at least sixty days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability. Contractors that contract with the administration pursuant to subsection A of this section shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

For the purposes of this subsection:
1. "Clean claims" means claims that may be processed without obtaining additional information from the subcontracted provider of care, from a non-contracting provider or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.
2. "Date of service" for a hospital inpatient means the date of discharge of the patient.
3. "Submitted" means the date the claim is received by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt.
Please submit all questions to
ProviderTrainingFFS@azahcccs.gov
Thank You.