AHCCCS Encounters - Allowed and Net Allowed (Approved) Amount Matrix for Non-BHS Plans

#	Amount Field	Form Type	837 Location	Rules/Notes
1	COB Allowed AMT	I/P/D	2320/AMT01 = 'B6' 2320/AMT02 = $	4010 Institutional & Professional & Dental
2	COB Approved AMT	P/D	2320/AMT01 = 'AAE' 2320/AMT02 = $	4010 Professional & Dental
3				Background: With v5010, the 2320 COB Approved and 2320 COB Allowed Amount segments were removed from the 837 Transactions. 5010 Includes guidance to calculate the Approved amount. The process with which to select the appropriate values for AHCCCS to calculate the Health plan Approved amount has been challenging. It was identified that the calculation would only work for some plans and not others. As a result, AHCCCS will require that Health plans submit the amounts Definitions: **Allowed Amount** What would have paid under FFS before other payer **Final Net Allowed Amount (Approved Amount)** Final value of the encounter if paid as FFS after all other payments have been considered Allowed Amount and Net Allowed Amount does not apply for Denied Encounters Non-BHS Plans will continue to determine the applicable CN101 code to use as was done under v4010 **9/19/12 update:** Please note that it is not necessary to report the difference between the Line charge (SV102) and the HP Allowed amount (CN102) in a CAS segment. The CN1 segment is used for reporting purposes and is not used for Claim or line balancing. The Line charge, Payer paid amount and applicable adjustments are factors for balancing. (#13366) **9/25/12 update:** For a "fee schedule reimbursement arrangement", plans may use the CN101 Contract type code of '03' (Variable per diem). This does not

#	Amount Field	Form Type	837 Location	Rules/Notes
				affect Encounter processing. (#13531)
4a	HP Paid Amount	Inst	2320/AMT01 = 'D' 2320/AMT02 = $	Institutional **FFS Claim:** HP Paid Amount = Final Net Allowed Amount **CAP Claim:** HP Paid Amount = $0
4b	HP Paid Amount	Prof Dental	2320/AMT01 = 'D' 2320/AMT02 = $ 2430/SVD01 = Payer ID 2430/SVD02 = $	Institutional & Professional &Dental **FFS Claim:** HP Paid Amount = Final Net Allowed Amount **CAP Claim:** HP Paid Amount = $0
5a	Billed Charges (Total Claim Charge Amt)	Inst	2300/CLM01 = Patient Acct # 2300/CLM02 = $	Institutional
5b	Billed Charges (Line Item Charge Amt)	Prof	2400/**SV1** (service info) 2400/**SV102** = $	Professional
5c	Billed Charges (Line Item Charge Amt)	Dental	2400/**SV3** (service info) 2400/**SV302** = $	Dental
6a	Allowed	Inst	2300/CN102 = $	Institutional - Claim Level - report for each encounter - Line Level segment does not exist for 837I (2400/CN1) Example: CLM*01234567*31676.50***11|A|1**A*Y*I**********3 DTP*435*DT*201107020700 DTP*096*TM*1130 DTP*434*RD8*20110702-20110725 DTP*050*D8*20110701 CL1*3*4*03 PWK*OZ*BM***AC*DMN0012 **CN1*##*<ALLOWED AMOUNT$>**
6b	Allowed	Prof Dental	**2400**/CN102 = $	Professional & Dental - Report for each service line in the encounter Example: LX*1 SV1*HC|T1016|HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708

#	Amount Field	Form Type	837 Location	Rules/Notes
				CN1*##*<ALLOWED AMOUNT$>** SVD*PLANID0812*0*HC\|T1016\|HN**1 **CAS*CO*24*<FINAL NET ALLOWED$> DTP*573*D8*20110727

7a	Final Net Allowed (Approved)	Inst **(Cap)**	2320/CAS01 = 'CO' 2320/CAS02/05/08/11/14/17 (Trio) = '24' 2300/CAS03/06/09/12/15/18 (Trio) = $	Institutional - Claim Level – **Capitated** **Capitated = Amount Paid $0, use CAS*CO*24 segment** CAS01 = Group code - 'CO' = contractual obligation CAS02 (trio) – CARC – '24' = Capitated Agreement Example: CLM*50210121739*6422.95***11\|A\|1**A*Y*Y DTP*096*TM*1600 DTP*434*RD8*20120210-20120214 DTP*435*DT*201202100100 CL1*1*1*01 **CN1*##*<Allowed Amount$>** REF*EA*AC062796M0 HI*BK|29622 HI*BJ|2989 HI*BH|42|D8|20120214 NM1*71*1*PROVIDERLAST*PROVIDERFIRST****XX*1437194109 SBR*P*18*******MC **CAS*CO*24*<Final Net Allowed$>** **AMT*D*0 (Plan paid $0)**
7b	Final Net Allowed (Approved)	Inst **(FFS)**		Institutional - **FFS** FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported Example: CLM*50214120841*11190.26***11|A|1**A*Y*Y DTP*096*TM*1200 DTP*434*RD8*20120214-20120221 DTP*435*DT*201202142000 CL1*1*1*01 **CN1*##*<Allowed Amount$>** REF*EA*1101071528 HI*BK|29690 HI*BJ|2989 HI*BH|42|D8|20120221 NM1*71*1*PROVIDERLAST*PROVIDERFIRST****XX*1538201779 SBR*P*18*******MC CAS*CO*45*5412.6 **<CO*24 Final Net Allowed not used for FFS** **AMT*D*5777.66 (Plan paid)**

7c	Final Net Allowed (Approved)	Prof Dental **(CAP)**	2430/CAS01 = 'CO' 2430/CAS02/05/08/11/14/17 (Trio) = '24' 2430/CAS03/06/09/12/15/18 (Trio) = $	Professional & Dental - Line Level - Capitated **Capitated = Amount Paid $0, use CAS*CO*24 segment** CAS01 = Group code - 'CO' = contractual obligation CAS02(trio) – CARC – '24' = Capitated Agreement Example: LX*1 SV1*HC\|T1016\|HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708 CN1***##*<Allowed Amount$>** SVD*PLANID0812***0***HC|T1016|HN**1 **(Plan paid $0)** **CAS*CO*24*<Final Net Allowed$>** DTP*573*D8*20110727
7d	Final Net Allowed (Approved)	Prof Dental **(FFS)**		Professional & Dental - **FFS** FFS - Final Net Allowed Amount would not be sent; it is the same as the HP Paid Amount which was already reported LX*1 SV1*HC|T1016|HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708 **CN1***##*<Allowed Amount$>** SVD*PLANID0812***21***HC|T1016|HN**1 **(Plan Paid $21)** **CAS*CO*45*5.25 (CO*24 Final Net Allowed not used for FFS)** DTP*573*D8*20110727

8a	Denied Encounter example	Prof Dental	Allowed and Net Allowed amount does not apply	Professional & Dental - Line Level CAS01 = Group code - 'CO' = contractual obligation CAS02(trio) – CARC – '24' = Capitated Agreement, not used Use applicable Claim adjustment reason code for denial Example: LX*1 SV1*HC|T1016|HN*26.25*UN*1***1**Y DTP*472*RD8*20110708-20110708 SVD*PLANID0812***0***HC|T1016|HN**1 **(Plan paid $0 (denied))** **CAS*CO*45*26.25 (Use of CO*24 does not apply)** DTP*573*D8*20110727
8b	Denied Encounter example	Inst	Allowed and Net Allowed amount does not apply	Institutional - Claim Level CAS01 = Group code - 'CO' = contractual obligation CAS02(trio) – CARC – '24' = Capitated Agreement, not used Use applicable Claim adjustment reason code for denial Example: CLM*50210121739*6422.95***11|A|1**A*Y*Y DTP*096*TM*1600 DTP*434*RD8*20120210-20120214 DTP*435*DT*201202100100 CL1*1*1*01 REF*EA*AC062796M0 HI*BK|29622 HI*BJ|2989 HI*BH|42|D8|20120214 NM1*71*1*PROVIDERLAST*PROVIDERFIRST****XX*1437194109 SBR*P*18*******MC **CAS*CO*45*6422.95 (Use of CO*24 does not apply)** **AMT*D*0 (Plan paid $0 (denied))**
9				**Claim Adjustment Group Codes and common CARC usage:** 'PR' Patient Responsibility – Includes '3' Co-pay 'OA' Other Adjustment – Includes '23' Other Payer paid amounts 'CO' Contractual Obligations – Includes '45' Charge exceeds fee schedule, '24' Charges covered under a Capitation agreement

10	**Scenario: Medicare (or other payer) paid more than the HP Allowed amount.** **9/19/12** RE: #13366	837P CAP	In the scenario where Medicare (or other payer) paid more than the HP Allowed amount, it would be appropriate for the plan to only report the difference between the Line charge and other payer payments with a group code 'CO' (Contractual Obligations) and an adjustment code of '45' (Charge exceeds) in order to balance the line since there are no further payments to be made. See example below. Although this is a capitated encounter, the HP paid amount is $0 and therefore, the CO*24 (Capitated agreement) to report the Final Net Allowed Amount would not apply. *This scenario would be treated the same as a FFS and Denied encounter per the matrix.* We will include this scenario in the next version of the HP Approved Amount matrix. AHCCCS also expects that plans report this type of scenario in a paid encounter file and not in a denied file.	Example: CLM{111181162{126.5{{{11|B|1{Y{A{Y{Y{P <Claim charge $126.50 SBR{P{18{{MEDICARE PART B{{{{{MB AMT{D{100.98 <Medicare Paid $100.98 SBR{S{18{{AZ HEALTH PLAN{{{{{MC AMT{D{0 <HP Paid $0 LX{1 SV1{HC|99214{126.5{UN{1{{{1|2|3|4 <Line charge $126.50 DTP{472{RD8{20120301-20120301 CN1{05{83.57 <CN102=HP Allowed amount REF{6R{54567420 **Medicare Line adjudication loop:** SVD{MEDICARE PART B{100.98{HC|99214{{1 <Line Paid $100.98 CAS{CO{45{25.52 <45-Charge exceeds (126.50 charge - 100.98 paid = 25.52) DTP{573{D8{20110506 **Health Plan Line adjudication loop:** SVD{AZ HEALTH PLAN{0{HC|99214{{1 <Line paid $0 CAS{CO{45{25.52 <45-Charge exceeds (126.50-100.98=25.52) CAS{OA{22{100.98 <22-Covered by another payer DTP{573{D8{20110506 (Note: The CO*24 to report the HP Final Net Allowed Amount does not apply due to $0 payment. Additional lines followed but not shown.)