ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
DIVISION OF FEE FOR SERVICE MANAGEMENT

CLAIMS CLUES

A Publication of the AHCCCS DFSM Claims Department

March 2025

Importance of Reviewing The Behavioral Health Documentation Prior To Submission

Behavioral health documentation errors can include inconsistent documentation, incorrect diagnoses, treatments, and charting of services and duration. Creating and maintaining accurate records can reduce these types of errors.

It is critical for clinical and billing staff to review the documentation and claim specifics before submitting the claim to prevent any discrepancies in the information provided.

For example the denial reason code MD418 "Claim Mismatch Units/ Code Documented" indicates that there is a discrepancy between the CPT code, the recorded start and end times of the services, and the units reported on the claim.

Provider Claims Dispute Education: Claims Disputes Cannot Be Filed With An Invalid Claim Number

The Office of the General Counsel (OGC) has experienced an increase in dispute requests that cite or refer to a claim reference number (CRN or ICN) that is in a *Void* status.

A void claim is a claim that has been canceled in the AHCCCS processing system based on the actions of the submitter and no longer exists as an active claim.

The AHCCCS Online Provider Portal allows users to log in and view a list of their submitted claims with their current status.

When submitting a valid claims dispute, the submitter is required to specify the accurate claim reference number associated with the *disputed claim.* Should an incorrect or void claim number be referenced; the dispute will be returned to the submitter.

EDI Solutions Upload Attachment Process

When using the AHCCCS Claim Reference Number (CRN) as your document attachment number or Payer Claim Control Number, enter only the first 12-digits of the CRN. It is important to exclude the service line number, such as 001 or 002, as this information is not part of the claim number and will result in documents not linked to the associated claim.

The DFSM Claims Clues is a monthly newsletter that provides information about changes to the program, system changes/updates, billing and FFS policies.

Claims, Prior Authorization and Provider Enrollment inquires: The Division of Member and Provider Services (DMPS) manages the service calls for AHCCCS Feefor-Service. DMPS can assist providers with prior authorizations, claim inquires and status and provider registration (APEP) questions and processes.

The hours of operation are Monday – Friday, 8:00am-5:00pm (602-417-7670).

AHCCCS Provider Enrollment Portal (APEP): Questions regarding providerrelated enrollment, policy, or APEP user issues email APEPTrainingQuestions@ azahcccs.gov . Your email will automatically create a service ticket to Provider Enrollment for assistance.

AHCCCS Warrents - For questions about Warrants, paper EOBs or Electronic Fund Transfers (EFT), contact the Division of Business & Finance (DBF) at (602) 4175500.

835 Electronic Remittance Payment Sign Up (Remittance Advice Sign Up/835) Contact: ServiceDesk@azahcccs.gov or call (602) 417-4451

To upload documents to the new EDI Solutions portal ServiceNow, users will need to have access. If you do not have an account, please follow the instructions outlined in the EDI Portal Provider Signup and Login Guide.

Training materials for FFS Providers and upcoming Provider Training Sessions can be found on the DFSM Provider Training Web Page .

For provider training questions please outreach the Provider Training Team via email at ServiceDesk@azahcccs.gov
COVID FAQ: FAQ COVID Fact Sheet

Reminder: Fee-for-Service Prior Authorization Process

Starting your request: There are three steps that must be completed to successfully submit a prior authorization request.

Step 01. Initiating the Case Creation. If there is no case on file that meets the search criteria, the system will automatically create a new case number for you to complete steps two and three.

Step 02. Completing the Event Tab. The event type provides details in regards to the type of authorization that you are requesting, for example MD for surgery, IP for inpatient facility medical stay, BP for BHRF.

Quick Training Guide PA Submission-Selecting The Correct Event Type.pdf

Step 03. Completing the Activity Tab is the last step in the PA submission process and is most commonly missed or not completed. On the activity tab, you must enter the CPT/HCPCS/Revenue code and or modifier for the PA request and make sure to include the appropriate date span and units.

Accurate PA Details Matter

The standard required information is the member's AHCCCS ID, Date(s) of service, Service, provider NPI, CPT/ HCPCS code, Revenue code, units of service, Modifier (if applicable).

The AHCCCS Fee-for-Service prior Authorization Guide is a master list of CPT and HCPCS

codes that may or may not require an authorization.

Timely Follow-Up:

Prioritize authorizations and work through them in a systematic and organized manner. Track the status of the PA request. Many requests remain incomplete for several months without follow-up by the submitter.

Making Corrections to Your PA Request - Status is Pend, Approved, Denied

Pend Status: If the PA case is in a Pend status, providers can make a correction via the PA Submission tab, for example changing the date of service, CPT/HCPCS, revenue code, units. If the service provider NPI needs to be changed, the Prior Authorization Correction form must be completed and submitted via the PA attachment tool.

Approved and Denied authorizations are handled differently, please review the guidance below.

Approved Authorizations PA cases that are in an Approved status cannot be changed via the Online portal. To request an update or modification to an existing approved case, providers must complete the Prior Authorization Correction Form (PAC). Any additional medical documentation for this request should be submitted with the request. The PAC form must be completed in its entirety and can be uploaded using the PA attachment tool located on the Event tab.

Prior Authorization Correction Form

DD-THP Tribal Health Program Authorization Correction Form

Create A Paper Work Number (PWK) To Submit Documentation Electronically (2/7/2025)

Did You Know submitting claims via the AHCCCS Online Provider portal, providers can create a Paper Work (PWK) number at the time of submission. Creating a PWK number facilitates the electronic attachment of the documents.

The primary advantage of creating a PWK number is it enables providers to submit "unsolicited" documents while the claim is in the initial process phase.

Pros of Using Paper Work Number to Attach Documents:

- Claims submitted with an PWK number will process routinely.
- Enhanced efficiency and speed of documents received and linkage.
- Facilitates a faster review process.
- Adjudication of a "clean claim" is expedited.

Claim Attachment Tab - PWK Format:

The standard format for the PWK Attachment number consists of the AHCCCS member ID number (capital A), followed by the first date of service entered on the claim submission, formatted as a two-digit month and twodigit year in the format shown below.

The PWK number must be entered on the EDI Solutions upload portal as an "exact" match that was created on the claim attachment tab.

Example PWK Format: A12345678MMDDYY

The utilization of the **claim reference number** triggers a manual process. This process affects the time required to associate and link the documents with the claim and complete the processing.

How To Request A Copy of a 835 Electronic Remittance Advice File

Providers can obtain a copy or reload of a missing 835 Electronic Remittance file by submitting a service desk ticket. It is important to request that the ticket be assigned to ISD Finance. The service ticket request must include the following information:

- Provider Identification number (6-digit number or NPI)
- Payment Reference Number (check number),
- Pay Date and;
- Check Amount.

NCCI Edit Denial Code L119.1 Providers should check with their billing department first with questions regarding claim denials.

Reimbursed At The Outpatient Fee Schedule

If a member is admitted (example 10/1/2024) and discharged on the same day (10/1/2024), the hospital charges do not meet the criteria to be reimbursed as a DRG claim. Inpatient claims with an admission date equal to the date of the discharge will be paid using the AHCCCS Outpatient Fee Schedule (OPFS) methodology, including same day admission and discharge claims for maternity and nursery.

The Outpatient Hospital Fee Schedule will provide rates at the procedure code level, and Surgery/Emergency Department (ED) services will be bundled similar to Medicare for payment purposes. A replacement claim is required for processing.

Allowable HCPCS Codes for a Provider with a Counseling Facility License

Impacted Providers

- Providers licensed with ADHS solely as a **"counseling facility"** *and*

- providers submitting claims to the American Indian Health Program (AIHP) *and*
- Providers submitting claims to AIHP behavioral health services with a HCPC code

Requirements

As defined in A.A.C. R9-10-101.60, a "Counseling facility" means a health care institution that **only** provides counseling, which may also include:

1. DUI screening, education, or treatment according to the requirements in 9 A.A.C. 20, Article 1; or
2. Misdemeanor domestic violence offender treatment according to the requirements in 9 A.A.C. 20, Article 2.

A provider with a counseling facility license with Arizona Department of Health Services (ADHS), is limited to billing from the list of following HCPC codes below. Claims submitted for services that fall outside the HCPCS codes listed below will be denied.

Codes	Description
H0001	Alcohol and/or drug assessment
H0002	Behavioral health screening to determine eligibility
H0004	Behavioral health counseling and therapy, per 15 minutes
H0023	Behavioral health outreach service
H0031	Mental health assessment, by non-physician
H2011	Crisis intervention service, per 15 minutes

Inpatient Facility Claims Submitted With The Same Admit and Discharge Day Will Be Reimbursed At The Outpatient Fee Schedule

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Consumer Notice: Marketplace Plan Enrollment Without Permission (2/7/2025)

The Centers for Medicare and Medicaid Services (CMS) and US Department of Health and Human Services (HHS) have issued several public notices about unauthorized activity by health insurance agents and brokers. These agents and brokers have been enrolling consumers into Accountable Care Act (ACA) Marketplace health plans without their knowledge or consent. These notices were issued by CMS in April, May, July, and October of 2024, highlighting that unauthorized Marketplace enrollment is a nationwide issue that authorities are committed to addressing.

AHCCCS has also received multiple reports of members unknowingly enrolled and/or coerced to enroll in an ACA Marketplace plan. While there may be valid reasons for an AHCCCS member to opt for dual enrollment in Medicaid and the Marketplace, it's important to be aware of the significant trade-offs.

One key consideration is that Medicaid will become the secondary payor. Additionally, the member will not be eligible for Marketplace savings (i.e., subsidies) to help make a Marketplace plan more affordable. For these reasons, HHS encourages Marketplace members to end Marketplace coverage if they qualify for Medicaid. See AHCCCS eligibility: www.azahcccs.gov/Members/GetCovered/

Consumers who believe they may have been the victim of unauthorized agent or broker activity should call the Marketplace Call Center at 1.800.318.2596 (TTY: 1.855.889.4325) to resolve any coverage issues. More information about changing insurance plans from Marketplace to Medicaid can be found on Healthcare.gov.

AHCCCS is proactively reaching out to members to raise awareness of this issue, inform consumers of the warning signs, and share how to report any unauthorized activity to the Marketplace Call Center. AHCCCS continues to monitor its data for concerning trends. Any AHCCCS members who have experienced a barrier to health care services due to being enrolled in a Marketplace plan without their consent can contact the AHCCCS Clinical Resolutions Unit (CRU) to help find a resolution: 602.364.4558 or 1.800.867.5808.

For more information, please read the CMS infographic and AHCCCS webpage