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Fee-for-Service (FFS) Claims Denial Edit Resolution Guide

The Claims Denial Edit Resolution Guide was created to help providers understand the denial edits, descriptions, and actionable next steps. New denial edits will be added periodically to the guide. Providers maintain the responsibility to ensure all claims are billed appropriately.

The codes associated with the denials offer clarifications regarding why the claim could not be fully processed or paid in full and may not cover every possible scenario. This guide is intended to assist providers in addressing denied claims. Please examine the resolution instructions below for the edit code(s) associated with the claim. When necessary or applicable, submit a new claim with the corrected information and include the required documentation when necessary to facilitate the processing of the claims.

Provider Resources:

Provider Training Information: The DFSM Provider Training Web Page offers E-Learning training by related topics, quarterly provider training schedules, DFSM Claims Clues, quick training guides and more. For more information, visit https://www.azahcccs.gov/Resources/Training/DFSM_Training.html

AHCCCS Billing and Policy Manuals: The AHCCCS FFS Provider Billing Manuals are available on the AHCCCS website. To view the complete list https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html

AHCCCS Online Provider Portal: AHCCCS offers a free online provider based portal for FFS providers. Providers can Submit and status claims and prior authorizations, verify member eligibility, electronic fund transfer (EFT), provider verification and more. To initiate an access account to AHCCCS Online Provider Portal select "Register for an AHCCCS Online Account.

Staying In Contact: Provider News and Alerts - Sign up for the DFSM Email News Alerts to receive important notifications regarding policy and program changes, authorizations, billing related changes, provider training notifications, and more.

EDI Solutions Portal: The EDI Solutions portal has succeeded the 275 Transaction Insight Portal, while continuing to offer the same functionalities for uploading and attaching necessary documentation for the review of claims. To request an access account email: Servicedesk@azahcccs.gov

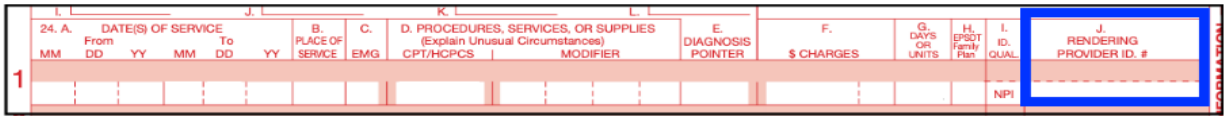
AHCCCS Provider Enrollment Portal (APEP) is an online application-based enrollment process for provider credentialing. If you do not

have an APEP account, go to https://www.AZAHCCCS.gov/APEP. Select the option “User Registration” and complete the form. For APEP questions, providers can email APEPTrainingQuestions@azahcccs.gov.

Disclaimer: Please be aware there may have been updates to information since the original posting or publication date. Therefore, when reviewing an older article or publication on the AHCCCS website, please check for any available updates by using the search tool.

AHCCCS | azahcccs.gov

Edit	Description	Resolution

H001.1	Service Provider ID Field is missing.	**The service provider NPI field may contain the following errors: service field is blank, provider's NPI is either not registered or active for the date of service or at the time the claim was processed.** 1. Verify the provider's status using the Provider Verification tab on the Online portal or review your remittance advice to confirm the NPI entered is valid. 2. Providers who are not registered with AHCCCS, must enroll via APEP. After the provider's enrollment is approved, the provider must resubmit a corrected claim referencing the original CRN. 3. EDI data entry errors must be corrected by the provider. 4. Paper claim submissions, if it is an AHCCCS **data entry error**, contact Provider Services at **(602) 417-7670 or submit a Service Ticket.**
H001.5	Service Provider ID Cannot Be Group – Payment ID.	**This denial edit is prompted by incorrect claim billing information entered in the "service provider" ID field.** Service provider refers to a AHCCCS registered provider type, for example physicians, nurse practitioners, chiropractors, physical therapists, dentist, anesthesiologist, and others offering specialized health care services must be listed as the service/rendering provider in field 24J on the claim form. Box 24J on the CMS-1500 claim form is used to enter the rendering provider's National Provider Identifier (NPI).  1. The submitter must review the billing details and submit a correction claim for processing.
H001.7	Service Provider ID Not Valid for Provider.	**The provider NPI listed on the claim was either not registered or active with AHCCCS on the date of service listed on the respective claim.** 1. Verify if the service provider was an AHCCCS registered provider on the date of service (DOS) listed on the claim. 2. EDI / WEB submissions, If the NPI # was entered incorrectly by the submitter; a replacement/correction claim is required and must reference the original claim record number (CRN). 3. Paper submission, If the NPI # was entered incorrectly by AHCCCS; providers should contact Customer Service to have the data entry error corrected (602) 417-7670 or submit a service ticket.

H002.1	Recipient ID Field is Missing	**Field 1a on the CMS 1500 Field is blank or completed incorrectly. AHCCCS FFS and MCO recipient IDs begin with the letter "A" followed by 8 numeric characters. It is not the responsibility of the call center to verify enrollment.** Paper claims, the submitter must review the claim submission (Paper/WEB/EDI) to verify the correct information was entered in field 1A. If field 1A was not completed or had incorrect information the submitter must submit a correction claim for processing. The following errors can be corrected by contacting Customer Service (602-417-7670) or submit a Service Ticket to request a reprocessing of the claim. • Paper claim submission - if the error is the result of a data entry error by the payer, EDI and Web submissions it is the responsibility of the submitter to correct the information and submit a correction claim as the program does not make changes to a WEB or EDI submission.
H002.2	Recipient ID Field Is Invalid Format.	**This edit will present when there is an error with the Medicaid (AHCCCS) member (recipient) ID listed on the claim. AHCCCS only accepts the Medicaid member ID number that begins with "A" or ADOC assigned ID numbers.** 1. If the member's name field is "blank" on the remittance advice or on the AHCCCS Online Provider Portal), this indicates an error with the member ID number. 2. Verify if the recipient (member) ID was entered in the correct format (A12345678) 3. In the field was not completed correctly, a correction claim is required for processing.
H002.3	Recipient ID Field is Not on File.	**This denial will appear on a claim if the Member ID is not on file with AHCCCS.** 1. Verify if the AHCCCS Medicaid ID was entered correctly (A12345678) or is in an incorrect for example due to a data entry error, etc. (A11XX2345). The following errors can be corrected by contacting Customer Service (602-417-7670) or submit a Service Ticket to request a reprocessing of the claim. • Paper claim submission - if the error is the result of a data entry error by the payer, EDI and Web submissions: it is the responsibility of the submitter to correct the information and submit a correction claim as the program does not correct WEB / EDI submission. 2. The replacement claim must include the claim reference number of the claim that is being replaced to ensure the replacement claim meets the timely filing criteria.

H012.1	Admission Type code is missing	This denial indicates that an admission type code is missing from the claim submission. The admit type code is entered in Box 14 of the UB-04 claim submission. Providers should refer to their EDI companion guide for the appropriate EDI loop. The type of admission identities if the admit was 1**= Emergency. 2 = Urgent. 3 = Elective. 4 = Newborn. 5= Trauma.** Action: If the admit type code is not present on the claim, the provider must submit a replacement/correction claim.
H012.2	Admission type code is invalid	This denial edit indicates that an "invalid admission type code" error was used to describe how a patient was admitted to a facility is incorrect. If the admission type is invalid, determine the appropriate type based on the patient's treatment and circumstances of admission, correct the claim and resubmit. Do not use admit type 9.
H079.2	Billing provider ID field is in invalid format.	**This edit points to the group billing information entered on the claim submission.** 1. Verify if the provider ID was active on the date of service listed on the claim. 2. For paper claim submissions, the provider should first review the claim details for any errors. If the NPI was entered incorrectly by the submitter, a correction claim is required. 3. If the NPI was entered incorrectly by AHCCCS; the provider can call Customer Service (602-417-7670) or submit a service ticket to request a correction of the error. 4. If the claim was submitted on the WEB or by EDI; the provider must submit a corrected claim and reference the original CRN.
H079.3	Billing Provider ID Field is not on file.	This edit identifies an error with the group billing information entered on the claim. EDI/WEB and Paper submissions, the provider should first confirm the effective date of the provider's enrollment. Access the AHCCCS Online Provider portal and navigate to the Menu and select the **Provider Verification** tab and enter the NPI number. If the NPI was not active on the date of service, the denial is correct. In some instances, a retroactive request for a modification of the Enrollment Effective date may be requested. Refer to the APEP website (https://www.azahcccs.gov/APEP) for complete information. The following errors can be corrected by contacting Customer Service (602-417-7670) or submit a Service Ticket to request a reprocessing of the claim. • Paper claim submission - if the error is the result of a data entry error by the payer, • The NPI has been updated and now shows active enrollment for the service date.

H097.7	Billing Provider Id Not Valid for Provider	This edit is set to deny the claim. Key fields to review are the group billing NPI field. Is the group NPI valid for the date of service billed? Second is the service provider linked to the group billing provider for the date of service billed. If this information has been updated after the processing of the claim, the provider can contact the provider service line to request reprocessing of the claim. If the information has not been updated or is not a match, corrections or modifications can be submitted using the APEP enrollment portal.
H103.1	Admission Diagnosis Code Field is Missing	This denial edit indicates a admission diagnosis code field has not been reported on the UB-04 claim. An "admission diagnosis" is the initial, preliminary diagnosis made by a physician when a patient is admitted to a hospital or healthcare facility. Action: The provider must submit a replacement/correction claim.
H105.1	Admit Date vs Service Begin Date, Date #2 is Prior to Date #1.	**This edit will present when the service is billed on a UB-04 and is for an Inpatient facility stay.** 1. The claim's processing system is reading the Service Covered dates field on the claim. 2. This error will occur when the Admit date is after the first date entered in the covered dates field. **3.** If the member was admitted on an inpatient basis from ER or Observation, the edit may be overridden to allow the claim to proceed for review.
H140.3	Primary Diagnosis Code Not Covered for Contract Type	This denial edit refers to the primary/principal diagnosis code entered on the claim is not covered under the specific contract type, for example the Federal Emergency Services (FES) program. Any services billed must meet the federal definition of emergency services as defined in federal law within section 1903(v)(3) of the Social Security Act and 42 CFR 440.255 in order for a claim to be considered for reimbursement. "Emergency medical or behavioral health condition" for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including extreme pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1. Placing the member's health in serious jeopardy; 2. Serious impairment to bodily functions; 3. Serious dysfunction of any bodily organ or part; or 4. Serious physical harm to self or another person (for behavioral health conditions). Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary, but may not meet this definition for FESP.

H151.1	Accommodation days greater than service date span.	This claim denial will present when the units of service on an Inpatient or SNF claim with covered days is greater than the number of days billed. The FFS program does not reimburse the day of discharge (for example, the member is admitted on 7/1/2024 and discharged on 7/7/2024, the total units or number of days billed should be 6 not 7, as the program does not reimburse the discharge day. **1. A replacement/correction claim is required for processing.**
H154.3	ICD PROCEDURE CODE #1 NOT COVERED FOR CONTRACT TYPE	**This edit will identify a non-covered ICD 10 procedure performed in the same inpatient stay. The denial identifies a specific procedure code that is excluded under the member's contract (plan) type.** 1. The provider may request to have the claim reviewed by the medical review team. 2. Documentation must be provided for the review process.
H154.5	ICD-10 Procedure code #1 requires a prior auth, none found.	**This edit is set to deny the claim when the ICD-10 procedure code reported on the claim requires prior authorization and none is found and if the admission type is not "1" for emergency.** 1. The provider should review the claim details to determine if the claim was submitted incorrectly. **2.** Request a prior authorization if the service meets the PA requirements.
H166.2	Trauma Diagnosis Code is Invalid	**This edit denial is triggered by the information entered in box 72 External Cause of Injury Code.** 1. The provider must review the claim details to determine if the information entered in this field is correct or if a correction claim is required. **2.** Electronically submitted claims must be corrected by the provider.
H179.1	Recipient Enrolled in Plan for Entire Service Date Span.	**This edit will present when the claim has been submitted to the incorrect Medicaid plan for processing. The denial will also provide the name of the member's health plan enrollment.** 1. The submitter should verify the member's health plan enrollment and submit the claim to the appropriate health plan for processing. 2. Enrollment can be verified via the AHCCCS Online Provider Portal.

H179.3	Recipient enrolled in a plan that does not allow payment.	**This edit will set if the member has a lapse in coverage or may be enrolled in a non-payment program for specific dates of services.** 1. Providers should verify the member's eligibility prior to rendering the service and prior to submitting the claim for payment. 2. The provider must verify the member's eligibility/enrollment for the date of service, and this can be done via the AHCCCS Online Provider Portal. **3.** If there is an eligibility line that shows "NO PAYMENT with a specific date reflected, no action can be taken on the claim.
H185.1	Value code inconsistent with bill type claim, inconsistency.	**This edit will present if there are coding inconsistencies on the original or replacement claim. Value codes A1 / A2 cannot be billed with an outpatient bill type code. See examples:** 1. The original claim was submitted as an outpatient claim with (Bill Type Code 131) with the value code "A2" Medicare inpatient coinsurance. A correction claim was submitted to correct the bill type to reflect an inpatient stay (Bill Type Code 117). 2. The processing system is reading the original bill type code in error. The provider should contact provider services to have the claim reprocessed.
H188.1	Invalid discharge data on final bill; claim inconsistency.	This edit will present on a UB-04 claim form if the Bill Type code indicates an inpatient claim; but the biller omitted entering the discharge hour. 1. The biller should review the claim to determine if a correction claim is required. Relevant fields may be the discharge hour, bill type, patient status fields.
H189.1	Recipient has Medicare, the Medicare payment information must be indicated and is missing.	**This edit will be presented when the member has Medicare coverage as the primary payer, but the claim was submitted to AHCCCS without the Medicare explanation of benefits included or attached for processing.** 1. If there are no changes required to the claim details information, providers must submit a copy of the MEOB for processing and this can be done via the transaction insight portal.
H191.3	UB summary line charges do not match details.	**This edit will set if the Sum of line-item charges does not equal the total billed charge on the summary (0001) line.** 1. The provider is responsible for reviewing each line of service by total charges and verifying that the claim lines total the summary line total. **2.** If there is a data error by the provider, it is the provider's responsibility to review and make any corrections to the claim line details and submit a replacement/correction claim.

H192.1	Recipient has other insurance; Third Party Liability, TPL data must be indicated, is missing.	1. This edit identifies that the member has a primary payer other than AHCCCS Medicaid. AHCCCS Medicaid is always the "payer of last resort". 2. To verify the member's TPL/Medicare information, utilize the Online Provider Portal. 3. In cases where a primary payer is indicated and active during the service period, providers must directly submit the claim to the primary payer for review. 4. Upon receipt of M/EOB details, providers can upload the determination of the primary payer to the claim. If no changes are necessary to the claim information, please avoid resubmitting the claim. Instead, providers can upload a copy of the EOB via EDI Solutions portal.
H194.1	Occurrence code indicates Medicare exhausted; claim must be split.	**This edit will be set when the claim submission includes a UB-04 occurrence code that indicates some portion of the member's Medicare inpatient days are exhausted.** 1. The provider must review the Medicare EOB (Explanation of Benefits) and split bill the claim; billing the dates of services that were covered by Medicare on a single claim and include a copy of the MEOB. 2. Bill, the remaining days not covered by Medicare on a separate claim, billing the dates of services not covered by Medicare due to the inpatient days were exhausted and include a copy of the MEOB. **3.** If the claim is a direct Medicare Crossover claim the same process listed in steps 1 and 2 will apply.
H199.4	Claim received past 6-month limit.	**This edit is set to Hold the correction/replacement claim for review to allow the processing team to confirm the original claim receipt date and replacement claim receipt date meets the timely filing period. Providers should submit correction claims as soon as possible to avoid untimely claim denials.** 1. If the original claim was received within the 6-month period, and the replacement claim was submitted within the 12 months of the clean claim date, edit H199.4 is the only denial on the claim contact provider services (602-417-7670) for assistance. **2.** If there are other denial codes that resulted in the denial of the claim, if the provider believes the untimely denial is in error, contact provider services (602-417-7670) for assistance.
H204.2	Duplicate check failed; duplicate claim.	**This edit will be presented on a UB-04 claim submission when an AHCCCS paid claim is on file for the same date or overlapping dates of service, billing codes and provider ID number.** 1. Review your prior remittances or Online portal to identify the paid claim against the denied claim. 2. If both claims match no action is required. If the provider is billing missed or late charges, this must be submitted as a replacement claim by the provider. 3. If the provider intended to submit a corrected claim but failed to include the original claim number, please submit a corrected claim with the correct claim number.

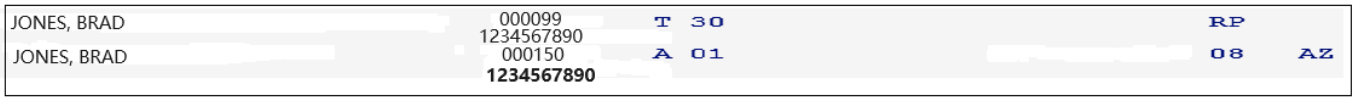
H204.3	Duplicate check failed; date crossover duplicate claim.	**This edit will be presented if there is a paid claim on file for the same provider, dates of services and charge amount.** 1.The provider must check their payment details either using their Remittance advice or AHCCCS Online Portal.
H205.1	Inpatient Claim Overlaps Outpatient Claim: Service Excluded by Previous claim service.	**This edit will be presented on a UB-04 claim submission when there is another paid facility (UB-04) claim on file billed with service date(s) that covers at least one date of service that is approved for payment on another UB-04 claim submission.** 1. Denial edit H205.1 is set to Hold the claim for review by the claims adjudication team. 2. If the claim is verified as a non-duplicate claim, the claim will be released for payment. 3. If the claim is manually denied as a duplicate and the provider disagrees with the processing of the claim, contact the call center 602-417-7670 for assistance.
H209.1	UB-04 Late Bill Has Accommodation Codes; Claim Inconsistency.	**This edit will be presented when the Bill Type code identifies "Hospital, inpatient, late charge(s) only claim.** 1. AHCCCS Fee-for-Service accepts corrected claims to report services rendered in addition to the services listed on the original claim. AHCCCS FFS does not accept UB-04 claims that are for late/missed charges only. 2. The provider must rebill the corrected UB-04 claim with the correct Bill Type code. 3. On the corrected claim, include both the original charges and the additional charges. 4. Do not use the Late Charges bill type (i.e., Type 115 or type 135) when submitting corrected claims in this context.
H210.9 **H229.1** **H258.1**	Intentionally left blank, refer to the resolution panel.	**Billing for inpatient services:** PER A.A.C. R9-22-204 (A)(1) advises that providers shall obtain PA from AHCCCS for the following inpatient services: • Nonemergency and elective admission, including psychiatric hospitalization; • **H210.9** Not Entitled To Behavioral Health Srv; PA Required; Level I & II Provider type indicates the provider type must have an authorization on file for the service.. • **H229.1** Non-Emg Hospital Admission Requires P/A; Prior Authorization Not Found, identifies the claim contains an non- emergency admit type billed and per AHCCCS billing guidelines a prior authorization would be required for all **non-emergency inpatient hospital admissions. Admit type "1" identifies "emergency admission".** • **H258.1** Inpatient BHS Service Requires P/A; Prior Authorization Not Found; this indicates that a PA is not on file for the member, dates of services and NPI number. If the facility has not submitted a prior authorization via the AHCCCS Online provider portal, this must be done first before the claim can be considered for reimbursement. The PA request must be approved before the claim can be reconsidered for reimbursement. Once the above steps are completed and the PA approved, the provider can contact Customer Service (602-417-7670) or submit a Service Ticket to request a reprocessing of the claim.

H216.1	Recipient Not Eligible/Enrolled for Entire DOS; Invalid Eligibility.	**This edit will present if the member was not enrolled Fee for Service (FFS) for the entire dates of service.** 1. Verify the member's enrollment for the dates of services. 2. If it is determined that the member had eligibility for specific dates only, submit a corrected claim with only the dates of service that the member has eligibility with FFS.
H218.4	Service not covered for ESP (Federal Emergency Services) must be an emergency.	**Members enrolled in the FES program; prior authorization cannot be required for emergency services. Each time emergency services are delivered to an FESP member, the federal criteria for an emergency medical condition must be met for the claim to be considered for payment.** 1. If the emergency indicator field on the CMS 1500 or the Admit type on the UB-04 is not billed as an "emergency" the claim will be denied. 2. Providers must check the emergency indicator or admit type information. If these fields are not billed correctly, the provider must submit a replacement/correction claim and reference the original claim number.
H219.1	Admit Date versus Service End Date, Date #2 is prior to Date #1.	**This edit reviews on the UB-04 the dates entered in field #6 Statement Covered Period and the date of Admit entered in field #12.** 1. If the admit date is after the begin date of service and you have verified the information is correct, providers can contact Provider Services 602-417-7670 to request the claim be forwarded to the processing team for review. 2. A correction claim will only be required if the data listed is incorrect.
H220.2	Prior authorization is pended	To resolve a denied claim with a "pended" prior authorization, first check the reason for the denial. This can be done using the AHCCCS Online Provider portal to identify any missing information and ensure all necessary supporting documentation, such as medical records and clinical justifications, is on file. In addition, review any comments made by the PA team and take the necessary actions as needed. The claim cannot be completed until the authorization is approved.

H220.3	Prior authorization mismatch.	**This edit will present if the information on the claim submission does not match the details of the approved prior authorization.** 1. The provider must check the claim details and the prior authorization to determine what is prompting the discrepancy which may be but not limited to the dates authorized, CPT/HCPCS, Provider id, etc.
H221.1	Provider TAX ID Field is Missing	**This edit will check for accuracy of the provider's Tax Identification number entered in field #25 on CMS 1500 and Box #5 on the UB-04. This edit may also be triggered if the Tax ID number was not active for the date of service billed.** 1. Paper Claim Submission, the provider must verify the information in field 25. If field 25 is blank, you must submit a corrected claim. 2. If there is a data entry error (paper claim only) by AHCCCS, contact provider services at 602-417-7670 to request the claim to be sent to the processing team. 3. EDI submissions, the provider must verify the data (effective date of the TAX id against the date of service billed. If the TAX ID information was corrected by the provider after the claim was submitted contact provider services at 602-417-7670 to request the claim to be sent to the processing team.
H221.7	Provider TAX ID not valid for provider	**This denial edit points to the Tax ID number and the Pay to location entered on the claim.** Some providers may have multiple pay-to-locations associated with a specific tax ID number. The biller/coder must verify that the correct matching information was entered into the claim. Ensure your billing software uses the correct NPI, pay-to-location, and Tax ID combinations. The begin or effective dates of the provider's enrollment can impact on the processing of the claim. For example, the Tax id 998877665 has an effective date of 5/1/2025 with Medicaid. The date of service billed is 4/29/2025, this will cause the claim to deny. Second example, the biller entered tax ID 123456789 and selected pay location 01. However, pay location 01 is associated with tax id 112233445 not 123456789, this will result in a denial of the claim. The **Provider Verification tab** available on the AHCCCS Online provider portal is used to verify provider details. Check if the TAX ID is active for the date of service and if the correct pay to location was selected. If this information is not a match or incorrect, the provider must submit a correction claim. **Other Check Points:** • Pay-to-location associated with the tax ID may be invalid or closed. • The pay to location associated with the TAX id number may not match the TAX ID billed for the date of service.

H229.1	Non-Emergency Hospital Admission Requires Prior Authorization, Prior Authorization Not Found.	**This edit will be set when the claim contains an admit type other than "1" that identifies "Emergency Admission".** 1. Non-emergency admit type billed and per AHCCCS billing guidelines prior authorization would be required for all non-emergency inpatient hospital admissions**. Admit type "1" identifies "emergency admission".** 2. All non-emergency and elective admissions, including all organ and tissue transplantation services require prior authorization. Notification to DFSM must be provided within 72 hours of a behavioral health emergency hospitalization. (This does not apply to FES inpatient admissions.) **Refer to the Chapter 8 FFS Prior Authorization Guide**
H253.1	Category of service providers is not authorized to bill.	**This edit will set if the CPT/HCPCS/Revenue code billed is not covered under the provider's assigned Category of Services (COS). All CPT/HCPCS/Revenue codes are assigned a COS in the AHCCCS processing system. If a service code falls under a COS that is not listed under the provider's profile, this will result in a denial of the claim.** 1. The provider should check the assigned category of services under their NPI number, this can be done using the AHCCCS Online Provider Portal > select the Provider Verification tab > COS to view the list of categories assigned to the provider. 2. If the COS is present, check the effective date to confirm if the COS was effective for the date of service and if yes, contact provider services 602-417-7670 to have the claim reprocessed. 3. If the COS is not listed, the provider must submit a request via APEP to add the required COS to the provider's profile.
H253.4	Category Of Service (COS) Not Valid for Bill Type	The error message "COS NOT VALID FOR BILL TYPE" indicates a mismatch between the type of skilled nursing facility claim submitted and the specific revenue codes billed. Medicaid will not accept the combination of revenue **code(s)** with the **bill type**. • LTC Medicare claims should not be submitted to AHCCCS with revenue code 0022. This revenue code will result in a reduction in available authorized days. • Provider type 22 "nursing home", claims should be submitted with the appropriate revenue code that matches the authorized days for the member with the exception of Medicare paid secondary claims to AHCCCS.
H210.9 **H229.1** **H258.1**	Intentionally left blank, refer to the resolution panel. Non-Emergency Hospital Admission Requires Prior Authorization, Prior Authorization Not Found. Inpatient BHS Service requires prior authorization	**Billing for inpatient services:** PER A.A.C. R9-22-204 (A)(1) advises that providers shall obtain PA from AHCCCS for the following inpatient services: • Nonemergency and elective admission, including psychiatric hospitalization. • **H210.9** Not Entitled to Behavioral Health Service; PA Required; Level I & II Provider type indicates the provider type must have an authorization on file for the service. • **H229.1** Non-Emergent Hospital Admission Requires P/A; Prior Authorization Not Found, identifies the claim contains a non- emergency admit type billed and per AHCCCS billing guidelines a prior authorization would be required for all **non-emergency inpatient hospital admissions. Admit type "1" indicates an "emergency admission".** • **H258.1** Inpatient BHS Service Requires P/A; Prior Authorization Not Found; this indicates that a PA is not on file for the member, dates of services and NPI number.

		If the facility has not submitted a prior authorization via the AHCCCS Online provider portal, this must be done first before the claim can be considered for reimbursement. The PA request must be approved before the claim can be reconsidered for reimbursement. Once the above steps are completed and the PA approved, the provider can contact Customer Service (602-417-7670) or submit a Service Ticket to request a reprocessing of the claim.
H304.1	Dental Claim Error, Total Billed Amount > $1,500.	**This edit will present when the total billed dental services exceed $1,500 and the claim will require dental review**. 1. Complete dental notes including x-ray must be submitted with the claim. This information can be attached to the paper submission or attached using the EDI Solutions Portal. 2. When submitting multiple-page paper ADA2024 dental claims indicate the total amount billed for the entire claim on the last page of the claim. The Total Fee element should be left blank on all other pages. 3. Incorrect billing of a multiple page paper dental claim: If multiple ADA 2024 claim **forms** are **submitted** with totals on each claim **form**, the claims will be scanned as separate claims and not as **multi**-**page** claims in error. In this scenario only enter the total of all the dental services performed on the single date on the very last page of the claim submission.
H309.2	DRG Processing edits II; criteria not met for any DRG.	This means that the diagnosis-related group (DRG) assigned to claim cannot be categorized or grouped into a specific payment category. The provider will need to review and resubmit the claim with accurate coding or additional documentation to support the assignment of a valid DRG code.
H309.6	DRG Processing edits II, invalid birth weight.	This edit will set on an inpatient newborn claim only. For claims submitted related to newborns, providers should include the birth weight of the newborn on all claims in which the age of the newborn is fourteen (14) days or less. Birth weight should be communicated in a value amount field with an **associated value code equal to 54.** Birth weight should be billed as a **number of grams. If the weight is listed in pounds/ ounces the claim will deny, and a correction claim must be submitted.** For claims submitted related to newborns under the following additional circumstances, the provider should include the birth weight of the newborn: • Age at admission = 15-28 days and principal diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures. • Age at admission = 15-28 days with a secondary diagnosis of a specific perinatal complication with certain operating room or non-operating room procedures. Refer to the relevant list of principal and secondary diagnoses contained in the 3M APR-DRG documentation.

H310.4	DRG Processing edits III; DRG IS ungroupable.	This edit will set on an inpatient claim only. This edit identifies that there was some information on the claim submission that prohibits the claim for qualifying for a specific APR-DRG. The term "ungroupable" is typically used to identify this as an APR-DRG pricing issue. The DRG field will indicate "956" ungroupable. APR-DRG claims that are denied as "ungroupable" will require the provider to review the details of the claim and submit a correction claim, correcting any fields that are in error.
H310.5	DRG Processing Edits III; Principal Diagnosis (PDX) Invalid as Discharge diagnosis.	This edit will present if there is a coding error All Patient Refined DRGs (APR-DRG) which results in failure to assign an APR-DRG value for newborn claim processing and reimbursement. 1. This claim Edit may be prompted by other denial errors identified on the claim and cannot be reprocessed. 2. The provider must review all denial edits on the claim and make the appropriate corrections and submit a correction/replacement claim.
H313.2	Attending provider ID test; Provider type cannot be attending.	In some instances, a provider may be enrolled as a referring/ordering provider (PT=RP). Per AHCCCS guidelines a RP provider type cannot be an **"attending provider".** If the provider becomes fully credentialled or enrolled with the program the enrollment under provider type RP will be terminated = T by provider enrollment services and a new AHCCCS assigned 6-digit provider number and provider type will be assigned to the provider under their NPI number. Submitters should make sure the correct 6-digit under the valid provider type and corresponding NPI number is selected when submitting the claim.  1. The submitter will need to submit a correction claim making sure to select the current enrollment under the fully credentialled AHCCCS assigned provider ID.
H482.1	NPI missing or invalid, field is missing.	**The participating provider reporting information was not entered on the claim.** 1. Providers must review the claim submission and submit a correction/replacement claim.
H482.7	NPI missing or invalid, not valid for provider.	**The participating provider reporting information was entered incorrectly or is in an invalid format. The biller must review the claim and resubmit a replacement/correction claim.** **Examples:** 1. The participating provider information was not entered. 2. Erroneous entry - NTE:XX1234567890, NTE should not be added to field 19 (invalid format). 3. The qualifier code XX and NPI was entered but the provider is not registered with AHCCCS. 4. The XX qualifier code was entered for a non-registrable provider type with (9999999999). 5. The group NPI was entered incorrectly as the participating provider.

L001.1	Procedure Code Field is Missing.	**This edit will be presented on the CMS 1500 and outpatient UB-04 if the CPT/HCPCS code field was not entered on the claim.** 1. Providers must review their claim submission to verify if the CPT/HCPCS code was entered on the claim, in the correct format, and is a valid five-digit CPT or HCPCS code. 2. AHCCCS data entry errors, providers can contact Provider Services 602-417-7670. 3. Provider billing errors, submit a replacement / correction claim with the correct/valid five-digit CPT or HCPCS code.
L002.2	Revenue code field is invalid format.	**This edit will present if the revenue code field is in an invalid format, for example 0192 was entered as 192.** **Providers must review their claim and submit a correction claim if required.** Providers may use the AHCCCS Online Provider portal to view the claim line details.
L005.4	The service end date is in the future.	**Upon receipt of a paper, EDI or web claim submission, the AHCCCS processing system automatically assigns a claim number based on the receipt date of the claim. The begin and "end dates of services" listed on the claim cannot be before the date the service was rendered/performed.** No action can be taken on a claim with the denial edit L005.4. The submitter must review the claim information / details and submit a correction/replacement claim if applicable.
L010.1	(1) Service End Date Vs (2) Claim Receipt Date, Date #2 Is Prior To Date #1.	**This edit indicates that the claim submitted was received before the date of service billed on the claim. All claims received by AHCCCS are assigned a Julian date.** 1. This denial edit is set to track the date the claim was received (Julian date) by the program with the date of service billed on the claim form. 2. If the receipt date is before the actual date the service was rendered, this would constitute improper billing. 3. A replacement claim would be required for consideration. 4. If the claim was a paper submission and the provider has verified that the claim was submitted after the date of service, the provider should contact the call center for assistance.
L013.1	Claim Service Not Covered by AHCCCS.	**This edit checks for verification of benefits and will present if the service billed is not covered under the recipient's contract / plan that is in effect on the date of service.** 1. No claims resubmission is required as the service billed is not an AHCCCS Medicaid reimbursable service.

L013.3	Claim Service Not Covered for Contract Type	Edit code L013.3 is set to deny the claim. Providers should check the member health plan enrollment. If the member is enrolled in the Federal Emergency Services program (FES) and the service was deemed non-emergent for example services provided in a skilled nursing facility are not covered under the FES program and the denial is valid.
L013.5	Claim Service Requires prior authorization (PA), no PA found.	**This edit will present when prior authorization is required, and no PA is on file or there is a discrepancy between the services authorized on the PA and the services billed on the claim.** 1. Providers must verify that a PA is on file and is a match for the CPT/HCPCS, Revenue codes, dates of service (DOS), and provider ID number. If the prior authorization was entered after the processing of the claim, resubmit the claim for processing. 2. If there are discrepancies on the PA details or the claim, the provider will need to submit a PA Correction Form or corrected claim depending on what the provider deems appropriate. 3. If submitting a PA Correction Form- upload and attach the document to the PA case number using the AHCCCS online provider portal.
L013.7	Claim service requires Prior Authorization, Prior authorization not APPROVED.	This edit has identified (1) the service billed requires prior authorization, (2) a PA case is on file, however (3) the authorization is not approved. Providers must review the denial reason code appended to the case. A common PA denial reason code is PD900 “medical documentation not received”. 1. Check the current status of the PA case, review any comments entered by the PA team to determine next action steps. 2. If documentation is requested, only upload the requested documentation using the “PA attachment tool” located on the Event list tab.
L016.3	Category of Service Provider is Not Authorized.	**All CPT/HCPCS/Revenue codes are assigned a specific Category of Service (COS) in addition to TH provider type. Providers can verify the assigned COS using the AHCCCS Online Provider Portal > Provider Verification tab.** 1. Check which code is denied for COS, by reviewing the claim details on the remit or via the AHCCCS Online Provider Portal. 2. If you verify the coding is accurate, contact Provider Enrollment to update the Category of Service (COS) to have the COS added to the provider profile. 3. Upon updating the Category of Service listed in the provider profile you can resubmit the claim, please note all claim corrections must be submitted within timely filing period

L017.1	Place of Service Code is Missing	**This edit sets on the CMS 1500 field #24 is left blank.** 1. Paper submissions the provider must check their claim submission to verify if the POS was entered. If the field is blank, the provider must submit a correction claim. 2. The provider must check their claim first, if there is a data entry error by AHCCCS, the provider can contact provider services 602-417-7670 to request reprocessing of the claim. **3.** EDI claims the provider must verify the Place of Service code loop was populated with this information. If the details are missing the provider must submit a replacement claim.
L018.1	HCPCS Procedure /Place of Service Invalid Combination of Codes.	**This edit sets if the provider has entered a place of service code that is not valid with the CPT/HCPCS code billed.** **1.** The provider can review the details of the claim via the AHCCCS Online Provider Portal or the remittance advice. **2.** Review the claim details with your coder/biller and submit a correction/replacement claim.
L019.5	Diagnosis code #1 Is not on file.	**The diagnosis code entered may be invalid or may require additional characters.** 1. Paper claim submission, check to verify if the DX code was data entered correctly, if not the CS must send the claim for correction. 2. If the provider entered an invalid diagnosis code, the provider must review their records to determine what the correct diagnosis code should be and then submit a correction claim.
L020.5	Diagnosis #2 is not on file	Possible OCR/Scanning error for paper claim submissions. Review the claim submission, if a scanning error is found, contact provider services to request correction of the data/scanning error.
L023.1	Diagnosis code #1 invalid for recipient age & gender.	The diagnosis "pointers" connect the medical diagnosis made by the provider to each CPT® code that is billed with the first pointer being the primary diagnosis. Some claims are billed with multiple diagnosis codes, and the diagnosis code pointers play a key role with the assignment of the diagnosis code with the specific CPT/HCPCS and line of service billed. The biller should review the diagnosis code entered on the specific line of service that denied. 1. The biller must review the claim and submit a correction claim if appropriate.
L023.2	Diagnosis code #1 invalid for recipient age	The diagnosis billed on the claim is not compatible with the recipient's age. 1. The biller must review the claim and submit a correction claim if appropriate.
L024.2	Diagnosis code #2 is invalid for recipient age.	In the ICD-10-CM system, some diagnosis codes specify age ranges. These age banded diagnosis codes must match the patient's age at the time of care. Providers should review the ICD-CM coding book for billing details and submit a replacement claim that meets the coding details. 1. The biller must review the claim and submit a correction claim if appropriate.

L025.2	Diagnosis code #3 is invalid for recipient age.	In the ICD-10-CM system, some diagnosis codes specify age ranges. These age banded diagnosis codes must match the patient's age at the time of care. Providers should review the ICD-CM coding book for billing details and submit a replacement claim that meets the coding details. 1. The biller must review the claim and submit a correction claim if appropriate.
L026.2	Diagnosis code #4 is invalid for recipient age	In the ICD-10-CM system, some diagnosis codes specify age ranges. These age banded diagnosis codes must match the patient's age at the time of care. Providers should review the ICD-CM coding book for billing details and submit a replacement claim that meets the coding details. 1. The biller must review the claim and submit a correction claim if appropriate.
L028.1	Diagnosis reference #1 not covered by AHCCCS.	**The diagnosis code entered is not covered by AHCCCS.** 1. Paper claim submission, check to verify if the diagnosis code was data entered correctly, if there was a keying error by AHCCCS, contact the call center to have the claim forwarded for correction. 2. If the provider entered an invalid diagnosis code, the provider must review their records to determine what the correct diagnosis code should be and then submit a correction claim if applicable.
L028.3	Diagnosis #1 Not Covered for Contract Type.	**This edit will present if the ICD-10 Diagnosis code in Field #1 is not covered by AHCCCS.** 1. Every procedure or diagnosis code is not covered by the program. Review the diagnosis code(s) to identify any errors, refer the claim to the biller/coder for review. 2. Submit a correction/replacement claim if appropriate.
L029.1	Diagnosis reference #2 not covered by AHCCCS.	**This edit will present if the ICD-10 Diagnosis code in Field #2 is not covered by AHCCCS.** 1.Every procedure or diagnosis code is not covered by the program. Review the diagnosis code(s) to identify any errors, refer the claim to the biller/coder for review. 2. Submit a correction/replacement claim if appropriate.
L030.1	Diagnosis Reference #3 Not covered by AHCCCS	Any reference to an invalid diagnosis code will prompt the biller to review the specific diagnosis reference pointer listed on the claim submission. This edit; the provider must review the 3rd diagnosis code entered on the claim submission to determine if an additional character(s) should be added to the diagnosis code. Please review the BH Diagnosis code list that is published on the Medical Coding Resources web page. https://www.azahcccs.gov/Resources/Downloads/BHDiagnosisListApproved.pdf 1. Resubmit the claim with the correct coding details.

L031.3	Diagnosis Reference **#4** Not Covered for Contract Type	The contract type refers to the health plan the member is enrolled with on the date of service. 1. Confirm the claim was submitted to the correct health plan of enrollment for the date of service. 2. If the claim was submitted to the incorrect plan, the provider must resubmit the claim to the correct MCO plan.
L032.2	Procedure Code Is Invalid for Recipient Age	The most common cause is that the CPT/HCPCS procedure code has specific age restrictions, and the patient's age falls outside of those parameters. The provider should verify the patient's age and confirm the billing code used. If it is determined the code billed is incorrect, refer the claim to the appropriate coding staff to find the appropriate code that is valid for the patient's age and service provided. Next submit a correction claim.
L042.1	Health Plan Paid Amount Field is missing.	This edit identifies the member is enrolled with an AHCCCS Complete Care Plan that is the primary payer. To confirm this information providers can use the AHCCCS Online Provider portal to verify the health plan that is in effect for the date(s) of service.
L046.1	Non-Emergency Dental for Recipients Over 20 years Not Covered by AHCCCS.	**This edit will set when the dental service is for a member over the age of 21 years and the dental service is not identified as an emergency dental care and emergency extractions per policy.** **Benefit details:** For adult members (21 years of age and older), effective date of service 10/1/17, in accordance with A.R.S. 36-2907, an emergency dental benefit has been granted in an annual amount not to exceed $1,000 per member per contract year (October 1st to September 30th) for **emergency dental care and emergency extractions.** A dental emergency covered by this benefit is defined as an acute disorder of oral health resulting in severe pain and/or infection from pathology or trauma. 1. If the claim service meets the above criteria, the provider must review the claim to determine if the services were billed as an emergency services claim. 2. The provider must correct any claim submission errors and resubmit the claim with the required documentation for review.
L050.1	Recipient Enrolled in Plan for Entire Service Date Span.	**This edit will present if the claim was submitted to AHCCCS FFS in error. The edit denial will also indicate the name of the plan the member is enrolled in.** 1. Verify the members' health plan enrollment on the dates of services billed. Also check if the member's enrollment was changed during the DOS span billed on the claim or after the claim was processed. 2. Submit the claim to the appropriate health plan for consideration.
L050.3	Recipient Enrolled in Plan That Does Not Allow Payment.	**This edit will present if the member is enrolled in a Medicare Savings Program. AHCCCS SLMB-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. No claim payments are made by AHCCCS Administration.** Providers should not submit claims to AHCCCS Fee for Service (FFS) on behalf of Specified Low-Income Medicare Beneficiary (SLMB) and OR QI1-PART B BUY-IN (QI1) members.

L054.1	Non- FFS reimbursement type; provider not authorized to bill for service.	**This edit will set if the provider has a service restriction or may not be fully enrolled with AHCCCS.** 1. The AHCCCS assigned 6-digit provider number indicates the provider is enrolled as a Referring Provider (RP) type only and is listed on the claim as a service/rendering provider in error. 2. If the RP/OP enrollment status has been updated to reflect the provider is a fully enrolled provider and is assigned a provider type other than RP/OP. 3. Check the effective date of the provider's enrollment change to full status with the date of service billed on the claim. If the service date is on or after the provider's status changes, the claim can be reprocessed. This information can be verified using the AHCCCS Online Provider portal – Provider Verification tab. 4. If the date of service is prior to the provider becoming fully credentialed, no action can be taken. 5. If the provider disagrees with the date change, have your provider credentialing team check the information that was submitted to APEP and if a correction is needed, modification can be submitted via APEP.
L064.1	Critical Care Procedure code over $50.00 billed.	**This edit will present when a critical care procedure code is billed. This service will require medical review.** **The provider must submit documentation with the claim submission.** **1.** The documentation can be uploaded via the EDI solutions portal.
L067.1	Recipient has Medicare Part B coverage, Medicare data missing.	**This edit will present if the member has Medicare Part B coverage only, and the required MEOB was not submitted with or attached to the claim for processing.** 1. Check the claim details, verify if the MEOB was submitted with the claim. 2. If the MEOB was not included with the initial submission, and there are no changes to the billing/charges, simply attach a copy of the MEOB using the claim reference number via the EDI Solutions portal.
L069.1	Recipient Has Other Insurance; TPL Data Must Be Indicated, Is Missing.	**This edit will present if the AHCCCS system indicates the member has a primary payer (TPL) which needs to be billed prior to AHCCCS. Providers should always do benefits eligibility checks before appointments to reduce denials.** 1. Verify if the claim was submitted with the TPL payment information on each line of service (CMS 1500/ADA). 2. If the EOB was not included with the initial submission, and there are no changes to the billing/charges, simply attach a copy of the primary payer's EOB for processing. 3. Use the AHCCCS claim reference number as your attachment number via the EDI Solutions portal.

L076.1	Claim received past 9 Month limit.	**This edit will be presented if the receipt date is after the 6-month timely filing period and is triggered by the date of service entered on the claim form. An initial claim for services provided to an AHCCCS member must be received by AHCCCS no later than 6 months after the date of service unless the claim involves retro-eligibility.** 1. Review the date of service(s), if there is a typo, i.e., date of service or year, submit a correction claim. 2. If the dates of services are correct and the claim was submitted past the timely filing, no action can be taken at the claims level.
L076.2	Claim received past 12-month limit, deny	Claims must initially meet the 6-month timely filing period to be considered by AHCCCS FFS. The receipt date of the claim and the date of service triggers this edit. If a claim is originally received within the 6-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status. • If the submission is the first claim submitted for consideration, the denial is correct, and the claim will be denied. • If the submission is a replacement claim, it must reference the original claim number and date of service that met the 6-month timely filing period.
L076.4	Claim received past 6-month limit.	**This is a timely claim submission edit that is triggered by the date of service and the date the claim was received.** 1. If the claim is a replacement/correction claim and the submitter failed to reference the original claim number, this will cause the claim to fail with this edit. 2. The submitter must verify if there is an original claim on file and if so, submit a correction claim referencing the original claim number to avoid untimely claim submission denial.
L077.1	Service provider status not Active; Not authorized to bill.	**The edit will be set if the provider is Terminated, or the date of service billed is prior to the provider's effective or begin date with the program.** 1. The provider must verify the provider's effective date billed on the claim; this can be done via the AHCCCS Online Provider portal. 2. If the provider determines the provider's effective date is incorrect, the provider must submit a modification request via the APEP system. **3.** No action can be taken on the claim until the provider's information is corrected.

L078.1	Billing provider status, not active; not authorized to bill for service.	**This edit will be presented when the Billing Provider NPI listed on the claim is not active for the date of service. The provider should check the following information for the group NPI ID and if needed complete the revalidation process and provide the required information via AHCCCS Provider Enrollment Portal (APEP).** The provider must revalidate their enrollment every four years to maintain Medicaid billing privileges. AHCCCS reserves the right to request off-cycle revalidations. **During the revalidation process the provider is subject to the same screening and disclosures captured during the initial enrollment. Based on provider type the screening requirements could include an enrollment fee, site visit, and fingerprint criminal background check.** 1. The Group Billing provider (NPI) has failed to re-enroll or revalidate their enrollment. 2. The Group Billing provider NPI was not active on the date of service billed.
L079.1	Provider has service restrictions; claim disallowed.	**This edit may be set for multiple reasons based on the provider's enrollment status.** 1. If the provider failed to re-enroll/revalidate. 2. If the provider has a service restriction based on the CPT/HCPCS code submitted on the claim. Customer service can view the restricted codes on the reference table (PR055) (602-417-7670)
L081.1	Duplicate Check Failed; Near Duplicate Claim.	**This edit will be presented when the AHCCCS system has identified a claim paid for similar services.** 1. The AHCCCS claims system has an approved/paid claim on file with the same member ID, procedure code and date of service on file. 2. Verify if another claim was submitted on behalf of the member with the same codes, same date of service (DOS) or by the same service provider. Any of these will trigger this denial. 3. This is a valid denial unless a distinct service was provided to the member and was billed with a different modifier. 4. If duplicate services are billed on multiple lines/claims, then a corrected claim will be required. If the same procedure is provided multiple times on the same date of service, enter the procedure only once. Use the Units field to indicate the number of times the procedure was performed. 5. Please review the claim information and resubmit the claim if appropriate.
L081.2	Duplicate Check Failed, duplicate claim.	**This edit will be presented when the AHCCCS system has identified a paid claim for the same or similar date.** 1. If there is another claim which has been approved and paid by AHCCCS with the same procedure code or date of service, and/or member information. 2. Verify if another claim was submitted on behalf of the member with the same codes, same date of service (DOS) or by the same service provider. This is a valid denial unless a distinct service has a different modifier. 3. If duplicate services are billed on multiple lines/claims, then a corrected claim will be required. 4. Please review the claim information and resubmit it as appropriate if it is within timely filing guidelines.

L081.5	Duplicate check failed; duplicate MCO claim on file.	**This edit will be presented when the provider has submitted the claim to the MCO plan and payment was issued by the MCO plan.** 1. The provider must contact the MCO plan and request to have the payment adjusted (recouped) from the MCO's payment system. 2. After the MCO recoups the payment, the provider can follow up with AHCCCS for reprocessing of the claim.
L083.2	Prior Auth is Pended.	**This edit will present if there is a prior authorization on file in a Pend status at the time the claim was processed.** 1. If the PA has been approved, resubmit the claim for processing. 2. If the PA is in a Pend status, review the comments section on the PA portal to confirm if the PA team requires additional documentation to finalize the PA request. Use the "attachment" tab on the PA case number to upload the necessary documents for PA review. 3. If the PA was submitted in error and is not required for the services, the Pended authorization must be **Revoked** by the provider before the claim can be processed.
L084.1	DME service requires prior authorization, prior authorization not found.	**This edit will present when the provider has failed to submit a PA request and or if the prior authorization case is incomplete, for example missing the Activity information.** 1. Initiate a PA case search using the Prior Authorization Inquiry tab. 2. If a PA case number is on file, but the PA Event or Activity tabs have not been completed this information can be completed using the Prior Authorization Submission tab. Provider training resources: https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2023/QuickGuideHowtoAddtheMissingActivityInformationonthePriorAuthorization.pdf https://www.azahcccs.gov/Resources/Downloads/DFSMTraining/2024/QuickGuide_PASubmission-SelectingTheCorrectEventType.pdf
L086.1	Home Health service requires prior authorization; prior authorization not found.	**This edit will present for outpatient behavioral health claims when the total units exceed . Medical documentation is required for review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via EDI Solutions portal. 3. The 12-digit AHCCCS claim number is used as the attachment/linking control number.

L088.1	Non-Emergent transportation requires prior authorization, prior authorization not found.	**This edit will be presented if the service / CPT (Current Procedural Terminology) code billed requires prior authorization and the system was unable to find a prior auth that matched the details of the claim at the time the claim was processed.** 1. The provider should use the AHCCCS Online Provider portal to verify if a PA is on file that is a match for the claim details, member, date of service, CPT/HCPCS codes and units to include mileage. **2.** If the provider submitted the claim before the approval of the PA, they must resubmit it to include the AHCCCS daily trip report.
L096.1	Out of State (Non-IHS) provider not authorized to bill.	**This edit will be presented when the provider's street address is either missing or out of state. Excluding those listed below in step #3.** 1. Check if the provider has a valid in-state service address on file in PMMIS. **2.** Is the provider service address within **AZ, CA, CO, NV, or UT.** 3. a. If the service address listed on the claim submission is outside of one of the 5 states listed above then the service must be an "emergency" or have an accompanying Prior Authorization.
L099.1	Recipient Not Eligible /enrolled For Entire DOS; Invalid Eligibility.	**This edit is set to check the members' eligibility for the date of service span listed on the claim form.** 1. Verify the member's eligibility and the dates of service billed on the claim. 2. If the member is not enrolled for the entire date of service billed on the claim, then submit a corrected claim and only bill for the dates of service that the member is enrolled.
L101.4	Service not covered for Emergency Services Program (FES) recipients, service must be an emergency claim or PA.	**This edit will be presented when the member is enrolled in the Federal Emergency Services program, and the claim was not marked as "emergent."** 1. The provider must check the claim form to verify if the claim was billed with the appropriate emergency indicators. (a). CMS1500, ensure there is a **"Y"** in EMG field #23 if appropriate. 2. Submit a corrected claim as necessary upon reviewing the original submission and mark the appropriate indicator. All claims must be submitted within the timely filing guidelines. 3. Medical documentation is required for review of all claim services for FES members.

L101.5	Service not covered for Emergency Services Program (ESP) recipient, secondary maternity diagnosis.	This edit is set to **HOLD** the claim for medical review. Medical documentation is required for review. If records were not submitted with the original claim, it is recommended that they do not resubmit the claim. Providers can use the EDI Solutions Portal to upload documents for review. Users will need to have access in order to use the EDI Solutions Portal. If you do not have an account, please follow the instructions outlined in the: **EDI Portal Provider Signup and Login Guide**. Additional information related to the EDI platform can be found **AHCCCS EDI Portal Upload Medical Records or NEMT Trip Reports.** *(09/03/2025*
L103.5	Not entitled to behavioral health service; Inappropriate Contract type.	**This edit will be presented when the member is enrolled in an ACC (AHCCCS Complete Care) plan, the services are for behavioral health, and the claim was submitted to Fee-for-Service in error.** 1. Use the AHCCCS Online Provider Portal to verify which plan the member is enrolled with for the date of service. **2.** If the member is enrolled with an AHCCCS Complete Care plan, verify the behavioral health site the member is enrolled with by selecting the BHS site tab at the top of the web page and submit the claim to the correct payer listed on the BHS site tab.
L103.9	Not Entitled to Behavioral Health Service; Prior Authorization Required; level I and II provider type.	**This edit will present if a professional service code is billed on the CMS 1500 claim form and the facility's NPI number is used as the service/rendering provider.** 1. This is a billing error and must be corrected by the submitter.
L106.1	Therapy Requires Prior Authorization; Prior Authorization Not Found	**Claim edit L106.1 will set when the member is over 21 and has exceeded the limit for the therapy service. AHCCCS covers physical, occupational, speech and respiratory therapy services that are ordered by a primary care provider (PCP), or attending physician for FFS members. Providers and billing staff should refer to AHCCCS Medical Policy 310-X Occupational, Physical And Speech Therapy Services** **Occupational services identified with the GO modifier:** Outpatient OT services are an AHCCCS covered benefit as specified below: Outpatient OT services are covered for ALTCS members and members under the age of 21, b. Outpatient OT services are covered for Acute members, 21 years of age and older as follows: **i**. 15 OT visits per benefit year for the purpose of restoring a skill or level of function and maintaining that skill or level of function once restored, and ii. 15 OT visits per benefit year for the purpose of acquiring a new skill or a new level of function and maintaining that skill or level of function once acquired**.**
L108.1	Observation Requires Prior Authorization Prior Authorization Not Found	Edit L108.1 is set to deny the observation line item for observation services billed under revenue code 0762 on an outpatient UB-04 claim for under bill type 0131. The AHCCCS claim processing system is programmed to place the claim in a HOLD status for medical review. No additional action is required by the provider until the medical review process is finalized.

L112.1	Modifier #1 is not Valid for Procedure; Invalid Combination of codes.	**This edit will present if the CPT/HCPCS and Modifier #1 is not a valid billing combination. As coding and billing guidelines change, providers should be familiar with coding changes and their impact on billing.** 1. The biller/coder should review the claim details CPT/HCPCS codes with their coding team to determine the correct action to take to correct the claim. 2. Providers can view the claim details via the AHCCCS Online Provider portal or their remittance advice. 3. The provider may be required to submit a correction/replacement claim using the correct modifier and resubmit the claim.
L113.1	Modifier #2 Not Valid for Procedure; Invalid Combination	"Modifier not valid for procedure code" is a medical billing denial reason indicating that the modifier submitted with a specific procedure code is incorrect, inconsistent, or missing. While both the procedure code and the modifier may be valid on their own, they are not allowed to be billed together. The provider should verify the procedure code and modifier: The claim should be referred to the provider's coding team for review and a correction claim submitted if appropriate.
L119.1	No rate schedule found for provider type; not authorized to bill for service.	**This denial may appear in a claim if the practitioner billed a CPT code that is not covered or listed for their specific provider type.** 1. Review the claim to identify the CPT/HCPCS code that failed. 2. If an incorrect code was billed, submit a corrected claim. 3. Providers can submit a request to add a code to their provider type by completing the Reference Table Review. 4. Update (RTRU) form if the code is valid for their respective provider type. 5. Providers can submit a request to add a code to their provider type by completing the Reference Table Review Update (RTRU) form if the code is valid for their respective provider type. A. https://www.azahcccs.gov/PlansProviders/Downloads /MedicalCodingResources/RTRU.docx
L120.1	Non-IHS provider with revenue code 100-101; Not authorized to bill for service.	**This edit will present if the provider is not a recognized/designated IHS/638 tribal provider, and the incorrect revenue code was billed.** 1. The provider must review the claim and submit a correction/replacement claim with the appropriate revenue code for consideration. 2. This claim cannot be sent back for reprocessing.
L125.1	Diagnosis Code Indicates Abortion; Medical Review Required	This edit is set to **HOLD** the claim for medical review. Medical documentation is required for review. If medical records are required for review, we recommend that providers Do Not resubmit the claim but instead to upload documents using the EDI Solutions portal.

L126.2 L125.1	**HCPCS Procedure** indicates Abortion; Prior authorization required but not found **Diagnosis code** indicates abortion; medical review required	AHCCCS requires all claims that include a HCPCS or diagnosis related to missed/incomplete/ spontaneous abortion will require medical review. Documents required are the history and physical, ultrasound report, operative report, pathology report. The medical reviewer may request additional records as needed. Documents may be attached to the claim using the EDI Solutions portal.
L127.1	Billing provider not valid Group ID; Invalid combination of codes referring to the (Service provider NPI and Group NPI numbers).	**This denial edit will be presented when the service provider's NPI is not linked to the group billing provider's NPI listed on the claim.** 1. Verify If the service provider's NPI and the group billing NPI numbers are linked (must be linked since at least the date of service on the claim). 2. Verify If the service provider's NPI and the group billing NPI numbers are linked (must be linked since at least the date of service on the claim). a. If they are linked, but not as early as the date of service listed on the claim then the provider will need to request the effective begin date to be backdated to the date of service via AHCCCS Provider Enrollment Portal (APEP) using a "Modification Request." 3. If the service provider's NPI and the group billing NPI number are not linked in the AHCCCS Provider Enrollment Portal (APEP) system, then the provider must update this information with the Provider Enrollment Unit. A service ticket will need to be submitted with the request to link the IDs. To submit this ticket email: servicedesk@azahcccs.gov
L136.1	Emergency Services Recipient: Service Requires Med Review	Edit L136.1 will Hold the claim for medical review team. No additional action is required from the provider until the completion of the review process. Documentation must be submitted with the claim for review or can be attached to the claim using the EDI Solutions portal.
L137.1	Recipient is QMB ONLY; Invalid eligibility.	**QMB Only – a Qualified Medicare Beneficiary under the Federal QMB program. This is a person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.** 1.AHCCCS can reimburse the provider for the Medicare deductible, coinsurance, and copay. 2. A copy of the Medicare Explanation of Benefits is required for consideration of the cost-sharing portion. 3. If Medicare denies the service and upholds the denial upon the provider's appeal, then AHCCCS makes no payment. Refer to Arizona Administrative Code (A.A.C.) R9-29-301. **Balance billing of QMBs is prohibited by Federal Law. Section 1902(n)(3)(B) of the Social Security Act, as modified by Section 4714 of the Balanced Budget Act of 1997, prohibits Medicare providers from balance billing QMBs for Medicare cost sharing.**

L140.9	Practitioner NCCI Edit Correct Coding Col 1 Code paid.	**This is a National Correct Coding Initiative Edit (NCCI) denial. The NCCI edits are based on claims with the same date of service, same provider, and same recipient.** **Each edit has a "Column One" and "Column Two" for HCPCS and/or CPT codes. If a provider reports the two codes in an edit pair on a claim or on separate claims, the Column Two code is denied and the Column One code is eligible for payment.** 1. This type of error will require review by the provider's professional coder/biller.
L141.1	Modifiers 25, 59, 76, 77 or 79 is present service requires medical review.	If either of these modifiers is included in the claim submission, the claim may require medical review to ensure the modifiers are used correctly and are applicable to the date of service billed. Documentation must support the use of the modifier(s). Questions concerning proper coding of the claim should be directed to your coding/billing team. **Modifier 25** significant, separately identifiable evaluation and management (E/M) service provided by the same physician or qualified health care professional on the same day as another procedure or service**,** **Modifier 59** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M [Evaluation/Management] services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances, **Modifier 76** defines a repeat procedure or service, on the same day, by the same physician or other qualified healthcare professional. Use modifier 76 to indicate a procedure or service was repeated subsequent to the original procedure or service. Bill all services performed on one day on the same claim, to avoid duplicate claim denials. **Modifier 77**, this modifier is used to indicate a procedure, or service was repeated by another physician or other qualified healthcare professional in a separate encounter on the same day. **Modifier 79** is present on the claim medical documentation must be submitted to support the use of these modifiers. 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The clinical documentation can be uploaded via EDI Solutions portal 3. The AHCCCS 12-digit CRN/ICN number is used as the attachment/linking control number in the EDI Solutions portal.
L141.2	Modifiers 25, 59, 76, 77 or 79 Is present; requires adjudication review.	Claim adjudication is the process by which AHCCCS reviews and evaluates claims to determine approval of services. Medical documentation must be on file with the claim to initiate this review process. If documentation was not submitted with the initial claim submission, providers can use the EDI solutions portal to upload documents to the claim using the claim reference number, it is not recommended to submit a new claim if there are no changes to the data elements.

L144.1	Please Contact Tribal Regional Behavioral Health Authority (TRBHA); Possible Subvention.	**This edit will present if the CPT/HCPCS codes billed on the claim may be covered by a TRBHA/RBHA.** 1. The provider must contact the member's assigned TRBHA to verify if the service is covered by the TRBHA/RHBA. 2. Submit a corrected claim if required to the TRBHA for consideration.
L159.3	Tooth number field is not on file.	**Dental tooth numbers are a system used by dentists to identify teeth in a patient's mouth. This information is required for paper, EDI and Web based claim submissions.** If the tooth number field is entered with a single character, **(i.e. 5 and not 05)** or is left blank, the line item will be denied, and a correction/replacement claim is required for processing. Dental billers and coders should refer to the Current Dental Terminology, commonly known as CDT, is published by the American Dental Association (ADA) for billing instructions.
L183.1	HCPCS & POS Not Allowed for Contract Type, Unacceptable with AHCCCS Policy	**This edit will be presented when the HCPCS or Place of Service code listed on the claim are not allowed.** 1. Per the AHCCCS Fee-For-Service Provider billing manual Chapter 18, only emergency services are covered. Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary but may not meet this definition for FESP. 2. Per AHCCCS claim submission guidelines, all FES (Federal Emergency Services) claims must be submitted with the appropriate "emergency" indicator and place of service.
L199.1	Outpatient Facility Services (OPFS) National Correct Coding Initiative (NCCI) Edit Correct Coding Column 1 Code paid.	**The Medicare National Correct Coding Initiative (NCCI) is a program that helps ensure correct coding for outpatient facility claims and other services. CMS develops its coding policies based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.** The column 1/column 2 correct coding edit table contains two types of code pair edits, as follows: • The code in column 1, which usually represents the more significant (comprehensive) procedure. • The code in column 2, which is considered a subpart (component) of the service in column 1. • Claims submitted for reimbursement of both codes without justification will be denied because the service represented by the code in column 1 includes the service represented by the code in column 2. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment, but the Column Two code is denied unless a clinically appropriate NCCI associated modifier is also reported. This claim cannot be reprocessed as submitted and should be referred to the coder / biller for review.

L207.1	Failed MUE Edit, MUE units of service.	**This edit will present when a Medically Unlikely Edit for a HCPCS / CPT code exceeds the maximum units of service that a provider would report under most circumstances on a single date of service.** Billers/Coders should review the claim to determine appropriate coding and can also refer to the CMS NCCI Medically Unlikely Edits website for additional information.
L208.1	Ordering provider ID invalid provider / type qualifier.	If a billed service requires an ordering provider, the claim will not be paid if the ordering provider is not listed on the claim. The claim will also be denied if the ordering provider is not enrolled in the program.
L210.2	Trip report required, trip report missing.	**This edit will be presented when the AHCCCS Daily Trip Report is not attached to the initial claim submission.** 1. Upload the missing trip report via TIBCO. Select Set Purpose Code 11 and reference the 12-digit claim number as the attachment number to attach the trip report to the existing claim.
L210.3	Trip report required, holding for trip report.	**This is a system programmed edit to advise the provider to submit the required AHCCCS Daily Trip Report.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
L210.4	Trip Report Required, Trip Report Not Received.	**This edit will be presented for NEMT (Non-Emergency Medical Transportation) transportation services and the AHCCCS Daily Trip Report is not attached to the claim.** 1. Upload the missing trip report using the EDI Solutions portal. 2. Select Set Purpose Code 11 and reference the 12-digit CRN/ICN as the attachment number to attach the trip report to the existing claim number.

L217.7	T1015 Check, provider type invalid or not Multi-Specialty Interdisciplinary Clinic (MSIC) provider.	HCPCS code T1015 is billed for encounter services. MSICs may submit claims as follows: • Claims must be submitted using the NPI for the MSIC as the rendering provider for the claim. • Reimbursement for T1015 and MSIC rate will only apply when the MSIC is the rendering provider on the claim. • CMS 1500 Claim Form (or the 837P) • ADA 2024 Claim Form (or the 837D) Only these form types will permit reimbursement using the MSIC fee schedule, including reimbursement of the T1015 procedure code.
L226.1	No visit was found for claim line, and field is missing.	**The claim details must match the Aggregator visit details and the visit must be in Verified status.** **The provider must review the details in the EVV system.** **The error originates in the provider's EVV system, the provider must review their data to determine the error.** ● Review visits in Aggregator for accuracy. ● If the visit is not in Verified status, review the exception, and send a visit update, correcting appropriate value or acknowledging the appropriate exception. ● If the visit is in Verified status, but the visit details do not match the claim details, either the claim must be changed, or the visit must be updated. ● After the visit is updated, and in Verified status, the claim can be resent.
L227.1	Claim line failed for unmatched unit field is missing.	This edit will present an Electronic Visit Verification (EVV) service. The claim details must match the Aggregator visit details and the visit must be in a **'Verified'** status. 1. Check units in the EVV system before submitting your claim. 2. Claims will only get approved if the units shown in the EVV system match the units billed on the individual claim line. 3. If this information is not a match, you will get an "unmatched units" error message which must be resolved by the provider. **The provider must review the details in the EVV system, here are some examples of data to review.** 1. Review the visit in Aggregator, to confirm the units match the units claimed. 2. If the Aggregator visit has incorrect units, confirm the In and Out times are correct. 3. Update the visit or claim accordingly.
L231.2	Must Bill Regional Behavioral Health Authority (RHBA).	**This edit will present when the diagnosis code billed is for behavioral health, the member is enrolled with a RHBA, and the service may be covered by the RBHA.** 1. Verify member's behavioral health site enrollment throughout the dates of service (DOS) span listed on the claim. 2. If the member is enrolled with a RHBA, please submit the claim to the RHBA for processing.

L232.1	Invalid provider; invalid provider type qualifier	Beginning July 1, 2025, claims submitted by fee-for-service providers that include a Referring, Ordering, or Attending provider (referred to as ROA) who is **NOT** registered with AHCCCS will be denied with edit L232.1. The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require that all health care providers who refer AHCCCS members for an item or service, who order non-physician services for members, who prescribe medications to members, and who attend/certify medical necessity for services and/or who take primary responsibility for members' medical care must be registered as AHCCCS providers. 1. To begin the ROPA enrollment process, visit AHCCCS Provider Enrollment Portal (APEP). Note: Fee-for-service claims that include an unregistered prescribing provider are not subject to this deadline. For more details refer to https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html
L236.4	Each Date of Service (DOS) Must Be on A Separate Service Line.	This denial edit identifies a provider billing/coding error which overlaps multiple dates of services. 1. The biller cannot overlap multiple dates of services on a single claim line on the CMS 1500 and ADA 2024 dental claim forms. 2. The biller must review the claim, correct any errors, and submit a correction/replacement claim.
L237.4	Similar Services Not Allowed Same Day Per Diem, Not Allowed.	This edit is set to identify when a claim billed with a **Per Diem (per day)** code is billed in addition with a "**timed based"** HCPCS code on the same date of service, subsequent claims submitted for the member for the same date of service and provider NPI will be automatically denied. **CMS 1500 Claim Submission - All services rendered for the member, for the same date of service, by the same provider NPI, must be billed on the same claim submission. Claims are processed in the order they are received.** AHCCCS for purposes of consideration for behavioral health services, per billing and policy may use American Medical Association Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definition purposes only and do not imply any right to reimbursement.
L238.9	Exceeds HCPCS 5 Hour Max Per Day Behavioral health HCPCS Exceed 5-hour daily limit.	**When five or more hours of behavioral health services are provided on a single day, behavioral health documentation is required for review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal.. 2. The AHCCCS 12-digit CRN/ICN is used as the attachment/linking control number.

P001.5	Tier Based Edit (Header level); Psych Tier – Service covered under DH.	**This edit will present if the inpatient facility claim is billed with a mental health diagnosis code and the member is enrolled in the Federal Emergency Services program and the member has a Serious Mental Illness (SMI) designation.** 1. The provider must check the member's behavioral health enrollment via the AHCCCS Online provider portal. 2. Search steps: Select Member Verification > Behavioral Health Services. Under the heading Behavioral Health Services category, if **SMI** is listed, submit the claim to the RHBA / TRBHA on record.
V002.1	Service Limit Edit; Frequency Limit Exceeded – Lifetime Maximum	***The edit V002.1 will set on the claim if the code billed has a daily, weekly, monthly and or lifetime limit and the service has been reimbursed for the member.*** 1. Once this lifetime limit is reached, the program will deny any further claims submitted for the same service. Note: This limit is not set per provider. ***On the Medical Coding Resources Web page*** providers can view different coding information to include various Reference extracts that are updated periodically. AHCCCS will be developing and rolling out various Reference Extracts and will place the completed information here upon completion. To view the lifetime limits select the HCPCS-CPT Procedures daily limits link below. Crisis, COE, COT, MABG and SABG Billing Indicators/Modifiers HCPCS – CPT Procedures Daily Limits Guidelines OPFS Related Extracts Telehealth Code Set Pay and Chase EPSDT Diagnosis Extract Multiple Surgery Codes Extract OPFS Allowed Modifiers Extract FFS Prior Authorization Guidelines
V002.2	Service Limit Edit; Frequency Limit Exceeded - Other	**This Edit tests the frequency of a service and the dates of services billed. This denial edit will require manual review. Provider can submit a service ticket request for review of the claim/denial.**
V003.5	Valuation / Pricing edit; No rate schedule found – mandatory.	**This edit will present if the claim service does not meet certain billing criteria.** For example, if the provider does not have the CPT/HCPCS code listed for their specific provider type, or if the facility or provider type is not allowed to bill for the service.
V004.2	Valuation / Pricing edit; Date of Services spans multiple rate schedules	AHCCCS Fee-for-Service rates are updated annually beginning 10/1 of each year. Dates of services that overlap multiple rates schedules may set with this edit. In this example, the beginning date of service billed is 9/25/2024 and the end date of service is 10/5/2024, would overlap multiple rate periods. Providers should review the current FFS rate guides when submitting claims and prior authorization requests.

		For IHS/638 tribal facilities, Inpatient hospital rates are updated effective January 1, of each year. If the claim is a Medicare cross-over claim or a direct billing and the inpatient Medicare deductible is due only, the edit V004.2 may be overridden to allow reimbursement of the inpatient Medicare deductible. (see example below) In this example, the claim is a Medicare crossover claim, and the inpatient Medicare deductible is due only. The begin date of service for the inpatient stay is 12/29/2023 through 01/01/2024. ***AHCCCS FFS does not reimburse the date of discharge (January 01),** so in this example the edit may be overrode to allow payment of the covered days. The provider can contact provider services (602) 417-7670 for assistance.
V009.3	Service limits edit: By Report line limit exceeded.	**This edit is a frequency edit and will present when the total service units billed exceed the daily, weekly, or monthly limits.** 1. Providers should review the HCPCS/CPT Procedures Daily Limits Guidelines if the total units billed exceed the limit, a correction claim may be required not to exceed the approved limits.
AD015	Explanation of Medicare Benefits does not match claim	**This is a manual claim denial edit.** If the information on the Explanation of Benefits (EOB) does not match the billing information, for example, CPT/HCPCS/ Provider NPI/ Units of service. 1. The provider must review the codes/descriptions of services from your EOB and your medical bill and confirm that the coding details match. 2. If you believe the details match, providers can contact DMPS call center 602-417-7670 or submit a service ticket request for further review.
AD021	Federal Consent Form Required	AHCCCS requires a completed copy of the federal consent for covered sterilization services apply to Contractors and FFS providers as specified in 42 CFR 441.250 et seq. Attachment A Consent to Sterilization
AD035	No Coinsurance/Deductible Due on Service.	**This is a manual claim denial and is used to identify if the individual claim line does not show a coinsurance, deductible or copay amount due.** 1. If the claim is a Medicare crossover claim or a direct claim submission by the provider and the line item does not show a cost sharing amount due no action can be taken at the claims level. 2. The provider must review the details of the Medicare Explanation of Benefits (MEOB) to determine their next step. The provider is responsible for submitting documentation that warrants reprocessing of the claim, a copy of the MEOB is required and must include a copy of the Medicare remark codes summary page. If this information is not on file, the provider can upload the documents via the Transaction Insight portal. 3. The provider must review AHCCCS guidelines (FFS Provider Billing Manual – Chapter 8 Medicare) for secondary Medicare claims processing based on the member's Medicare plan enrollment. This can be done via the AHCCCS Online Provider Portal. 4. If the CPT/HCPCS code requires prior authorization, verify that an approved authorization is on file for the service. 5. After completing these steps the claim now meets the criteria for reconsideration.

AD067	Prior authorization is in a Pend status.	**This is a manual claim denial edit and suggests that at the time of the claim submission the PA is Pended.** 1. Review the current status of the PA using the AHCCCS Online Provider Portal. 2. If the PA status has been updated from Pend to Approve, the provider can submit a service ticket to request to have the claim reprocessed. To submit this ticket please email servicedesk@azahcccs.gov 3. Include the member's name, Medicaid ID, PA case number and provider NPI.
AD073	No documents to support medical necessity	The documentation submitted for review does not support the medical necessity of some or all of the services billed. If there is no change in the coding information it is not required to resubmit the claim. Providers can upload the necessary documentation to the claim using the EDI Solutions portal.
AD075	Document does not support services /charges.	**This edit is a manual claim review denial.** Check the claim details to ensure that services outlined in the documentation match the code that is being billed. The number of units and any modifiers must also match the claim and documentation. The provider can upload the documents (within a timely filing time frame) and notify the claims department using EDI Solutions. The claims review team will reopen the claim and forward the claim for clinical review.
AD087	Non-covered Service, court ordered.	**This is a manual claim denial edit. This denial code identifies the service is court ordered, and it is not covered by AHCCCS.**
AD090	Resubmit with Anesthesia Records	**This is a manual claim denial edit and requests a copy of the anesthesia report for review.** 1.The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD091	Resubmit the Progress Notes	**This is a manual claim denial edit and requests a copy of the progress notes for review.** 1.The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD092	Resubmit with Lab test results	**This is a manual claim denial edit and requests a copy of the laboratory report(s) for review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.

AD093	Resubmit with Physician's Orders	**This is a manual claim denial edit and requests a copy of the Physician's Orders for review.** 1.The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD094	Resubmit with History and Physical	**This is a manual claim denial edit and requests a copy of the History and Physical report for review.** 1.The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD095	Resubmit With Itemized Statement	**This is a manual claim denial edit and requests a copy of the Itemized Statement for review.** 1.The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD097	Medicare Denial/Decision Upheld	This edit is triggered by the Medicare denial edit CO-16 "Claim lacks modifier", indicating a lack of necessary information needed to process the claim properly. 1.Review the Denial Notice to identify the specific reasons for the CO-16 denial. 2.Examine the claim for missing or incorrect information, including patient details, service dates, coding, and required documentation. Discuss with your biller if needed. 3. Always check with the payer to understand their specific guidelines for correcting CO16 denials. 4. Correct any errors and resubmit the claim with the necessary corrections to Medicare;
AD101	Incorrect Procedure Code for Service	This edit is a manual claim review denial. 1. NEMT claims the vehicle type identified on the AHCCCS Daily Trip report must match the HCPCS base code billed. 2. The provider must review the claim and coding to determine if a correction claim is required for processing.

AD102	IHS/KIDSCARE must bill on the CMS 1500, ADA 2024, or Point of Sale (POS)	**Claims for Title XXI (KidsCare) members must be submitted to the member's enrolled health plan.** ● If the KidsCare member is enrolled in an AHCCCS Complete Care (ACC) health plan, submit the claim to that plan. ● If the KidsCare member is enrolled as FFS or AIHP, then submit the claim to AHCCCS FFS. ● Medical services provided to Title XXI (KidsCare) members must be billed on the CMS 1500 (02/12) claim form using appropriate CPT and HCPCS codes and procedure modifiers, if applicable. ● Dental claims for services provided to Title XXI (KidsCare) members must be billed on the ADA 2024 form using CDT-4 codes. ● The All-Inclusive Rate (AIR) may not be billed for Title XXI (KidsCare) members. ● Claims for Title XXI (KidsCare) members are reimbursed at the fee schedule.
AD209	Inmate is Medicaid eligible	**This is a manual adjudication denial edit for Department of Correction claims.** Resource: Inpatient Claims For AHCCCS Eligible Inmates When a detainee is released from custody temporarily to an inpatient hospital setting, designated staff assists the detainee with completing an application for AHCCCS Health Insurance. Providers should submit claims for AHCCCS eligible inmate's for hospital inpatient claims and related inpatient physician services directly to AHCCCS. Inmates enrolled under this process will be given an AHCCCS ID number that begins with the **letter (A)** for the period of time they are eligible. • Claims submitted for these inmates must have the AHCCCS ID number on each claim in order for the claim to process correctly. Providers should validate the AHCCCS ID number on our website at azahcccs.gov • Claims should be submitted to AHCCCS *only after an AHCCCS ID number has been issued* to avoid claim denials. **Action Step: If a claim has been submitted with a department of correction member ID number that may begin with the letter (P), the provider must resubmit the claim with the appropriate Medicaid member ID number that begins with the letter (A).** **AHCCCS' Role:** • Process claims on behalf of the contracted DOC agencies • Each County Contract has its own unique branding (criteria code and recipient exception code) • DOC agencies are responsible for state share of the costs. • Claims follow AHCCCS guidelines.
AD211	Bill Medicare Part B charges to Medicare Part A - EOB required.	**This edit is a manual claim review denial**. **The provider must submit the claim to Medicare Part A for consideration and provide a forward copy of Part A determination to AHCCCS for consideration of the claim.**
AD219	Number of Trips Must Be Billed with Miles	**NEMT claim submissions must contain the total number of miles.** ● If the total miles are missing, a replacement claim is required for processing.

AD220	Required signature(s) missing	**This edit is a manual claim review denial**. **The provider must review the AHCCCS daily trip report and complete any missing fields and resubmit the trip report.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2.The updated/corrected trip report can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD221	Odometer Readings Missing/Incomplete	**This edit is a manual claim review denial**. **The provider must review the AHCCCS daily trip report and complete any missing fields and resubmit the trip report.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2.The updated/corrected trip report can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD222	Incomplete trip report	**This edit is a manual claim review denial**. **The provider must review the AHCCCS daily trip report and complete any missing fields and resubmit the trip report.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD223	Destination service not covered.	**This edit is a manual claim review denial.** 1. AHCCCS only covers NEMT transport that is to and from an AHCCCS covered service provided by an AHCCCS registered provider.
AD224	Trip Report Not Received.	**This edit is a manual claim review denial and identifies the AHCCCS Daily Trip Report is not on file for review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 2. The AHCCCS 12-digit claim number is used as the attachment/linking control number in TIBCO.

AD225	The driver is not registered with the company.	**This edit is a manual claim review denial. Specific employee/driver information must be reported to AHCCCS.** As part of the application process, including the initial, revalidation and company change applications, the Owner/Provider is required to disclose each Employee/Driver's full legal name, employment begin date, employment end date (if applicable), date of birth, and social security number directly in the AHCCCS Provider Enrollment Portal (APEP). Any changes regarding the Employee/Driver must be reported within 30 days by submitting a modification in APEP. As the Owner/Provider, you are responsible for maintaining and providing upon request a valid Arizona driver's license for each Employee/Driver.
AD281	Invalid Provider Signature AMPM Policy 940 III)(A)(3); Arizona Revised Statutes 18-106	**AHCCCS conducts prepayment and post payment reviews of claims and provider records to ensure claims and payment accuracy as well as to identify potential fraud, waste, and abuse. This edit is a manual claim denial.** Based on the review of the claim, the required Provider signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information. This may mean that the electronic signature used does not meet the specific requirements or standards per AMPM 940 are not met. Per ARS 18-106, "An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated." 1. The submitter must take corrective action by obtaining a signature that meets all necessary criteria. https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/940.pdf
AD282	Missing Provider Signature	**AHCCCS conducts prepayment and post payment reviews of claims and provider records to ensure claims and payment accuracy as well as to identify potential fraud, waste, and abuse. This edit is a manual claim denial.** Based on the review of the claim, the required provider signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information. The submitter must secure the correct signature, resubmit the appropriate documentation. Providers should implement a process of checking this information prior to the billing process to include training for staff on the importance of provider signatures in the claim process. **https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/940.pdf**
AD283	Invalid Member Identification Information AMPM Policy 940 section: (III)(A)(1)(B)	**AHCCCS conducts prepayment and post payment reviews of claims and provider records to ensure claims and payment accuracy as well as to identify potential fraud, waste, and abuse. This edit is a manual claim denial.** Based on the review of the claim, the required member signature requirements have not been met as outlined in the AHCCCS Medical Policy 940 Medical Records and Communication of Clinical Information. Unable to verify if the signature meets the state law Arizona Revised Statute 18-106. Per ARS 18-106, "An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated." 1. The submitter must take corrective action by obtaining an electronic signature that meets all necessary criteria.

		https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/940.pdf
AD295	Questionnaire, (Boxes) page 2 Incomplete	**The AHCCCS daily trip report requires all applicable fields to be completed. If any fields are not completed the claim will be denied with this edit. The provider must review the Daily Trip Report and make any necessary corrections.**
AD348	Participating Provider Name/NPI Required	**This edit identifies that the claim requires the participating provider information, and this information was not included / omitted on the claim submission.** 1. The provider must review the claim and resubmit with the correct information to include any documents that are required for review. 2. Providers can refer to the Quick Training Guide: How to complete the participating provider information. The training tool can be found on the https://www.azahcccs.gov/Resources/Training/DFSM_Training.html
AD352	Invalid Trip Report Form	AHCCCS requires the use of the AHCCCS standard Daily Trip Report, which is Exhibit 14-1 in the Fee-For-Service Provider Billing Manual. The attachment in Exhibit 14-1 is the **only version that may be used and submitted to AHCCCS FFS**.
AD353	Trip Report Does Not Match Claim	**This is a manual claim denial edit.** 1. The provider must review the claim, AHCCCS daily trip report and make any necessary corrections and resubmit the information.
AD354	Modifier - TN Not Appropriate	**This edit will present when the provider has billed with the TN Modifier in error.** ● Urban transports are those that originate within the Phoenix and Tucson metropolitan areas. ● All other transports, outside of the Phoenix and Tucson metropolitan areas, are defined as rural and must be billed with the "TN" modifier. 1. A correction/ replacement claim is required for processing.
AD361	No Tribal license/LOA For Transport	Effective 10/1/2014, all non-emergency medical transportation providers that transport AHCCCS members (pick up and/or drop off) on reservation will be required to obtain a Tribal business license from the Tribe.

		● A copy of the Tribal business license must be submitted to AHCCCS Provider Registration for documentation. When auditing claims AHCCCS will ensure that this documentation is on file. ● Failure to obtain and submit your Tribal business license will result in claims recoupment Prior authorization will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration.
AD364	No records submitted with claim	**This Is a manual claim denial edit. For outpatient behavioral health claims, the signed consent to treat, treatment plan, progress notes and medical documentation was not submitted with the claim.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. . 2. The AHCCCS 12-digit CRN/ICN number is used as the attachment/linking control number.
AD366	Attending Provider ID Test; Provider Type Cannot be Attending Provider.	**This is a manual claim denial, based on the review of the claim by the adjudication team, the attending provider was not active on the service date.** 1. The provider must verify the provider's effective date of enrollment using the AHCCCS Online Provider portal. 2. If the date of service is prior to the effective date, no action can be taken at the claims level. 3. If the provider's effective date has been corrected and is now active for the date of service, the provider can resubmit the claim or contact provider services for assistance. **4.** If the provider disagrees with the effective date, the provider must contact provider enrollment to resolve the discrepancy.
AD373	Provider license – This HCPCS not allowed	**This denial is used when a provider is licensed as a counseling facility and the claim is for a service which requires a license as an outpatient treatment center. This claim cannot be rebilled. The provider is encouraged to take the following steps:** 1. Change provider type with AHCCCS enrollment from 77 to CF 2. Review requirements for a counseling facility and requirements for an outpatient treatment center facility on the ADHS web site. 3. Review services available/provided at the facility and limit them to the services within the scope of the counseling facility license.
AD962	Referring/Ordering Provider NPI is Missing.	**This edit is a manual claim denial, based on the review of the claim by the adjudication team.** 1. The referring / ordering provider must be registered with AHCCCS FFS or the claim will deny due to the provider's NPI number not on file. 2. The provider must verify the referring / provider information, this can be done via the AHCCCS Online Provider portal. 3. If the date of service is prior to the provider's enrollment, no action can be taken. 4. If the provider's information has been updated, the provider can resubmit the claim for consideration.

AD963	Missing progress notes/ reports	The patient progress notes, which record the treatment administered, are absent. 1. The provider must submit a copy of the "progress notes/report. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD965	Missing mental health assessment.	**This is a manual edit set at the claims level.** 1. The provider must submit a copy of the behavioral/mental health assessment. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD966	Missing consent form.	**This is a manual edit set at the claims level.** 1.The provider must submit a copy of the signed consent to treat form. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD967	Missing/invalid parent/guardian signature	**This is a manual edit set at the claims level.** 1.The provider must submit a complete / valid parent/guardian signature. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
AD968	Per Diem cannot be with other codes billed on the same day.	This denial is received when a Per Diem code and other service(s) are submitted for the same date of service. The *other service codes* are not separately payable as determined to be included in the per diem services. 1. Verify if the code set is appropriate to be billed together. 2. The provider must review and if appropriate submit a correction/replacement claim with documentation that supports the services billed.
EV100	ECS Initiated Void	• Adjust, Void or Resubmitted claim. The AHCCCS processing system will identify an Adjust, Void or Resubmitted claim with the reason code EV100. This is an action initiated by the provider when an adjustment, correction or void of a claim is submitted. • The referenced claim number will be canceled and any payments if issued under that specific claim number will be recouped/ taken back. • To locate the replacement claim number via the online provider portal, providers can do a claim search with the member ID, date of service and provider ID number. A summary or list of claims that match the search criteria will appear with the status of each claim.

		• Important Note: Once the 12-digit AHCCCS CRN/ICN number is in a Void status, that claim number cannot be used again for any action / reason.
MD002	Deny Sterilization Consent Form Not Attached to Claim.	**This is a medical review denial based on AHCCCS policy for approval of a voluntary sterilization for both females and males under the AIHP FFS program.** 1. AHCCCS requires a completed Federal Consent Form to be submitted with all claims for voluntary sterilization procedures. AHCCCS FFS Provider Billing Manual, Chapter 11 Practitioner Services 2. This form is available in AMPM Exhibit 420-1. Attachment A Consent to Sterilization 3. Sterilization services are not covered for Federal Emergency Services (FES) members, and claims for sterilization services for FES members will be denied. 4. The Consent to Sterilization form can be attached to the claim via EDI Solutions portal. 5. A replacement claim is not required if there are no changes to the coding details.
MD004	Resubmit with History and Physical	**This is a medical review denial requesting a copy of the member's History and Physical Report.** **Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not contact provider services to review the records on file. 2. The H&P can be attached to the claim via the EDI Solutions portal. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 3. The AHCCCS 12-digit CRN/ICN will be used as the linking/attachment number 4. A replacement claim is not required if there are no changes to the coding details.
MD005	Resubmit with Operative Report	**This is a medical review denial requesting a copy of the Operative Report for the date of service.** **Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not contact provider services to review the records on file. 2. The Operative Report can be attached to the claim via the EDI Solutions portal. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 3. The AHCCCS 12-digit CRN/ICN will be used as the linking/attachment number. 4. A replacement claim is not required if there are no changes to the coding details.

MD008	Resubmit with progress notes.	**This is a medical review denial which states the mentioned documentation is required for review. The submitter should not resubmit the claim if there are no changes in the coding details. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Submit the requested documentation using via the EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 3. The AHCCCS 12-digit CRN/ICN will be used as the linking/attachment number.
MD009	Resubmit the Medication Administration Records (MARS)	**This is a medical review denial requesting the Medication Administration Records which states the mentioned documentation is required for review. The submitter should not resubmit the claim if there are no changes in the coding details. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Submit the requested documentation using EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 3. The AHCCCS 12-digit CRN/ICN will be used as the linking/attachment number.
MD023	Resubmit with History & Physical, Operative Report, Discharge Records, Emergency Records	**This is a medical review denial requesting the H&P, Operative Report, Discharge Records and Emergency Room records. The submitter should not resubmit the claim if there are no changes in the coding details. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Submit the requested documentation using the EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number 3. The AHCCCS 12-digit claim number will be used as the linking/attachment number.
MD032	Sterilization - member is Not 21 Years Old.	**This is a medical review denial based on current AMPM Policy 420 – AMPM 420 Medical Policy for Maternal and Child Health Section E Sterilization - The member must be at least 21 years of age at the time consent is signed.**
MD034	Emergency Criteria Not Met.	**This is a manual claim denial entered by the medical review team.** 1. This denial identifies that the services based on the review of the medical documentation did not meet the federal definition of an "emergency" service under the FESP program and no further action can be taken. 2. "Emergency medical or behavioral health condition" for a FESP member means a medical condition (including labor and delivery) or a behavioral health condition manifesting itself by acute symptoms of sufficient severity, including extreme pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1. Placing the member's health in serious jeopardy; 2. Serious impairment to bodily functions; 3. Serious dysfunction of any bodily organ or part; or 4. Serious physical harm to self or another person (for behavioral health conditions).

		3. Only services that fully meet the federal definition of an emergency medical condition will be covered. Services may be medically necessary but may not meet this definition for FESP.
MD036	Charges not substantiated	**This is a manual review denial entered by the medical review team. The submitter should not resubmit the claim if there are no changes in the coding details.** Before submitting the claim, thoroughly review the documentation to ensure that it is complete and accurate. Check for any missing or incomplete information that may lead to a denial. 1. Submit the requested documentation using the EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 3. The AHCCCS 12-digit claim number will be used as the linking/attachment number.
MD038	Charges / services do not match documentation	**This is a manual review denial entered by the medical review team.** 1. Providers should review the charges billed and accompanying documentation. The claim may warrant review by your medical coding team. 2. Correct any discrepancies before submitting the claim. Thoroughly review the documentation to ensure that it is complete and accurate. **3.** Check for any missing or incomplete information that may lead to a denial.
MD039	Medical records do not match the date of service billed.	**This is a manual denial entered by the medical review team. The documentation does not match the dates/services on the claim.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number 4. The AHCCCS 12-digit CRN/ICN number is used as the attachment/linking control number.
MD040	Requested documentation not received.	**This is a manual denial entered by the medical review team.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number

		4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD041	No medical documentation submitted.	**This is a manual edit set by the medical review team.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3.Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD044	Emergency Room Must Be Billed as Inpatient	**This is a manual edit set by the medical review team.** 1. If a member is treated in the emergency room, observation area, or other outpatient department and is directly admitted to the same hospital, the emergency room, observation, or other outpatient charges must be billed on the inpatient claim and these services will be reimbursed as part of the DRG.
MD049	Resubmit Itemized Statement In Excel Format.	**This is a manual edit set by the medical review team.** The itemized statement is **the hospital's line-by-line item breakdown of the procedures and services** provided during the course of care within an inpatient or outpatient basis. The IZ must be in a legible format, to include each service date, revenue code in sequential order, CPT/HCPCS, Description, National Drug Codes (NDC), Quantity/Units and charge amounts. Each line of information must be on one page. **Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. The itemized statement can be uploaded via the EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD050	CPT Coding Incorrect	**This is a manual edit set by the medical review team. The provider must review the coding on the claim and the documentation to determine if a correction claim is required for processing.** The biller/submitter Providers should review the charges billed and accompanying documentation. The claim may warrant review by your medical coding team.

MD053	Explain Unlisted Procedure	**This is a manual edit set by the medical review team. The provider must review the coding on the claim and provide documents that detail the service performed. This may include providing a copy of the operative report for review. The submitter should not resubmit the claim if there are no changes in the coding details.** 1. Submit the requested documentation using the EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number 3. The AHCCCS 12-digit claim number will be used as the linking/attachment number.
MD058	Bundled Into Other Procedure	**This is a manual edit set by the medical review team.** Separately billed services have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
MD074	Billing Provider Not A Match on Records	**This is a manual edit set by the medical review team.** The rendering/service provider identified in the medical records does not match the provider information billed on the claim. No further action can be taken until the provider verifies their records and details entered on the claim.
MD082	Pages Missing From ER Record	**This is a manual edit set by the medical review team. The provider must review the medical documents previously submitted coding on the claim and provide documents that detail the service performed.** **Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Do not resubmit the claim if there are no changes to the coding details. 2. Submit the requested documentation using EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number 4. The AHCCCS 12-digit claim number will be used as the linking/attachment number.
MD090	Anesthesia Incorrectly Billed in Minutes.	**This is a manual edit set by the medical review team.** The number of minutes billed must not exceed the period of time expressed by the begin and end time entered on the claim. AHCCCS uses the limits and guidelines as established by ASA for base and time units. Every 15 minutes or any portion thereof is equal to one unit of time. The AHCCCS system will calculate units based on minutes billed for most anesthesia procedures. The AHCCCS system adds the base units for the ASA code to the number of base units (calculated from minutes billed) and multiplies the total by the established FFS rate to obtain the allowed amount. 1. A correction claim is required for processing of the claim.

MD091	Documentation Illegible	**This is a manual edit set by the medical review team.** 1. The documentation received was illegible and a claim payment decision could not be made. Prior to resubmitting the documentation, make sure the documentation is complete and legible. 2. Do not resubmit the claim if there are no changes to the coding details. 3. The documentation can be uploaded via the EDI Solutions portal. 4.Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 5. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD092	**Inappropriate Billing**	**This is a manual edit set by the medical review team. The service billed is not a match for the documentation submitted for review. The provider must review the billing details to determine if a correction claim is required.**
MD101	Resubmit With Itemized Statement and Emergency Room Records	A request for medical review documentation is a request for medical records to be submitted to ensure that payment for a claim is appropriate. Denial edits that are appended to the claim that begin with the prefix "MD" are entered by the medical review team only. This request may be prompted by "insufficient notes in the provider's HIE system or documents previously submitted did not include the necessary information. The edit denial description will specify what documents are required for review. If there are no changes to the billing information on the claim, providers do not need to submit a replacement claim. 1. The documentation can be uploaded via the EDI Solutions portal. 2. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD299	Resubmit with the Emergency Room Physician Records	**This is a manual edit set by the medical review team when the emergency room physician records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number. 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.

MD300	Resubmit Operative, Pathology and Anesthesia Records	**This is a manual edit set by the medical review team when the Operative Report, Pathology report and Anesthesia records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the CRN/ICN as the attachment number. 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD301	Resubmit Recovery Room Records	**This is a manual edit set by the medical review team when the Recovery Records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD302	Resubmit Laboratory Records	**This is a manual edit set by the medical review team when the Laboratory Records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD303	Resubmit laboratory and X-ray Records	**This is a manual edit set by the medical review team when the Laboratory and X-ray records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 4. The AHCCCS 12-digit CRN/ICN number is used as the attachment/linking control number.

MD304	Resubmit the Cardiac Cath Records	**This is a manual edit set by the medical review team when the Cardiac Cath records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD305	Resubmit Orders, Progress Notes and Medication Administration Records	**This is a manual edit set by the medical review team when the Physician Orders, Progress Notes and medication Administration Records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions Portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 4. The AHCCCS 12-digit CRN/ICN number is used as the attachment/linking control number.
MD306	Resubmit Dialysis Records	**This is a manual editing set by the medical review team when the Dialysis Records are required for review.** **Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD307	Resubmit Nuclear Medicine Records	**This is a manual edit set by the medical review team when the Nuclear Medicine Records are required for review. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1. Providers should not resubmit the claim if there are no changes to the coding details. 2. The documentation can be uploaded via the EDI Solutions portal. 3. Set Purpose Code 11 (Solicited) must be selected when using the claim number as the attachment number. 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number.

MD309	Documents insufficient To Determine Emergency	**This is a manual edit set by the medical review team. This error is when the medical documentation submitted is insufficient to support reimbursement for the services billed.** 1. The provider must review the submitted documents to determine if there are any other medical records that would support the services billed. **2. The claim cannot be returned to medical review with the exact documents attached.**
MD310	Documentation Incomplete	**This is a manual edit set by the medical review team. The documentation provided is incomplete and a claim payment decision cannot be made.** 1. Prior to resubmitting the documentation, make sure the docs are complete and legible and support the service provided. 2. Do not resubmit the claim if there are no changes to the coding details. 3. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via the EDI Solutions portal. 4. The AHCCCS 12-digit claim number is used as the attachment/linking control number .
MD312	Prior Authorization is Pended	**This is a manual edit set by the medical review team.** 1.The provider must review the prior authorization and take any appropriate actions as identified by the notes entered by the prior authorization review team. 2. No further action can be taken on the claim until the PA issue is resolved.
MD313	Hospital Prior Authorization is Pended	**This is a manual edit set by the medical review team.** 1.The provider must review the prior authorization and take any appropriate actions as identified by the notes entered by the prior authorization review team. 2. No further action can be taken on the claim until the PA issue is resolved.
MD314	Missing required treatment plan.	**This is a manual edit set by the medical review team. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1.The provider must submit the copy of the treatment plan. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.

MD315	Missing mental health assessment.	**This is a manual editing set by the documentation review team. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1.The provider must submit a copy of the mental health assessment. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD316	Missing Consent Form	**This is a manual edit set by the medical review team. Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1.The provider must submit a copy of the signed consent to treat form. 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be attached via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD317	Not conforming to AHCCCS Medical Policy 310-B Title XIX/XXI Behavioral health Service Benefit; general requirements	AHCCCS covers Title XIX/XXI behavioral health services (behavioral health and/or substance use) within certain limits for members when medically necessary as specified in 42 CFR 440.130(d). Topics included in this policy include but are not limited to the following: Service and Treatment Planning, ICD Diagnostic Codes, Emergency Behavioral Health Services, Clinical Oversight and Supervision, Behavioral Health Services to Family Members For additional information, providers should review 310-B in its entirety and the AHCCCS Covered Behavioral Health Services Guide (CBHSG).
MD318	Invalid Billing H0004 (HQ) modifier; Place of Service POS (12) Not Allowed	**Group therapy, H0004 HQ modifier cannot be billed with place of service 12 (home).** 1. This is a billing error; and requires the submitter to review and correct the claim details prior to resubmission of the claim.
MD319	**Mismatch providers / rendering and billing**	**The individual who performed the service is different from the individual billing the service.**

MD322	**Progress notes are missing member responses to services.**	**Complying with Medical Record Documentation Requests: The provider should only submit the requested documentation, not the entire medical records as previously submitted with the claim.** 1.The provider must submit a copy of the missing documents 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD323	**Progress notes do not include diagnosis.**	**If a document is missing details, the provider must only submit the missing or required documentation.** 1.The provider must submit a copy of the missing documents 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD324	**Treatment Plan Does Not Contain Measurable Goal**	**Treatment goals shall be developed in accordance with the following:** a. Specific to the member's behavioral health condition(s), b. Measurable and Achievable, c. Cannot be met in a less restrictive environment, d. Based on the member's unique needs and tailored to the member and the family's/HCDM and designated representative's choices where possible, and e. Support the member's improved or sustained functioning and integration into the community. For Out Patient services refer to AMPM 320-O Behavioral Health Assessments and Treatment Services Planning 2. All services shall have identified goals that are measurable, including frequency, duration, and method for indicating member's definition of goal achievement.
MD325	**Treatment plan not signed by member.**	**This is a clinical review denial.** 1.The provider must submit a copy of the missing documents 2. The provider should not resubmit the claim if there are no changes in coding or charges. The documentation can be uploaded via EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
MD326	**Assessment does not support need for services**	Missing member presenting problem and or diagnostic information per AMPM policies 940 Medical Records and Communication of Clinical Information and 320-0 Behaviroral Health Assessements and Treatment Service Planning.

MD327	**Problem not on treatment plan/not medically justified**	The treatment plan is missing the member's presenting problem or member's vision/goal for recovery or diagnosis code per AMPM 320-0 Behavioral Health Assessments and Treatment Service Planning.
MD331	**Consent for older than 1 year from date of services.**	**The Consent Form is invalid and expires after one year from date of service.** Refer to AMPM policies 320-Q General and Informed Consent and 940 Medical Records and Communication of Clinical Information.
MD332	**Documents do not support services/codes billed**	CPT/HCPCS Code billed on the claim is not supported by documentation submitted. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD335	**Progress notes do not support the duration requested.**	The documentation is inconsistent and does not support the time billed. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD340	**Progress notes not reflecting services provided**	The progress note does not detail the specific services that were delivered. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD352	**Progress notes do not align with treatment plan.**	Progress notes are missing diagnosis or presenting problem from treatment plan per AMPM 940 Medical Records and Communication of Clinical Information.
MD405	**Invalid member ID information AMPM940 (III)(A)(1)(B).** Medical Records and Communication of Clinical Information.	This denial edit refers to Policy 310-B (Title XIX/XXI Behavioral Health Services Benefit; section #3, titled Medical Records Requirement, subsection A, b. Member identification information on the first page of the medical record including: i. Member name, ii. Member AHCCCS Identification (ID), or iii. Member DOB.
MD413	**Provider signature on treatment plan not dated.**	Missing the date, the provider signed the document. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the members' needs. Adhere to the time frames of completion for notes.
MD417	**Treatment plan for IOP/Services, services billed are not Intensive Outpatient program**	The treatment plan identifies IOP services recommended, but services billed are not IOP. Prior to the submission of the claim, ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the members' needs. Adhere to the time frames of completion for notes.

MD418	**Claim mismatch units/code documented**	The number of units billed do not match the number of billable units documented. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD423	**Recipient name, date of birth does not match documents.**	Standard denial when the member information does not match the supporting documentation for review. Prior to the submission of the claim, ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the members' needs. Adhere to the time frames of completion for notes.
MD431	**Uncredentialed / licensed provider**	Invalid Signature - missing provider credentials. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD433	**Correct time of start and completion of services required.**	Services must reflect the exact date the services were performed. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD438	**Treatment plan missing duration/frequency**	Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD440	**Treatment plan does not include diagnosis or level of care (LOC)**	Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD454	**Member/guardian signature is missing/invalid.**	Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD463	**Missing/invalid provider signature.**	The signature of the provider on the claim form is either missing or illegible. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD464	**Invalid provider/BHP signature on individual service plan (ISP)**	Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD466	**Missing/invalid treatment plan for date of service**	The required documentation is missing and must be provided for review. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the

		provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
MD475	**Missing/invalid progress notes (PN) for date of service**	Required documentation is missing, a progress note for this date of service is not provided. Prior to the submission of the claim ensure the key elements of behavioral health documentation are present. Each documentation entry should be signed and dated by the provider. Documentation should clearly justify the need for treatment and demonstrate how the services provided address the member's needs. Adhere to the time frames of completion for notes.
PH001	**Pend utilization Notes Required**	**Prior Authorization Status Code Review -** With each PA request the provider must include medical documentation that supports the request. If documents were uploaded to the PA request no further action is required until the PA review is completed. If documents were not initially submitted with the PA request - refer to the attachment tool guide below. ● **Prior Authorization Submission must be done via the** AHCCCS Online Provider Portal . ● **Documentation Attachment Process:** How to Attach Documentation to the PA Case ● **Prior Authorization Service Code Check:** Prior authorization will continue to be a condition of payment. Providers can use this tool to verify if a prior authorization is needed - FFS Prior Authorization Guide List Please note that Prior Authorization requirements are subject to change. ● **PA Review Comments:** If further information is required by the PA team, they will enter comments under the specific PA case informing the provider what additional information is needed for a decision. Providers should periodically check the status of the PA.
PH004	Pend / Notification of Admission Required	**Prior Authorization Status Code Review -** With each PA request the provider must include medical documentation that supports the request. In this case, the PA team has requested the admission report. Refer to the attachment guide below to upload the necessary documentation to the PA for review. ● **Documentation Attachment Process:** How to Attach Documentation to the PA Case
PH005	Pend/ICD9, CPT, HCPCS, Date of Service, Price Required	**Prior Authorization Status Code Review -** With each PA request the provider must include documentation that supports the request. In this case, the PA team has requested either one or all the elements that may be omitted/missing. The provider must review the PA case to determine what specific information is required and then upload the information. Refer to the attachment guide below to upload the necessary documentation to the PA for review. ● **Documentation Attachment Process:** How to Attach Documentation to the PA Case
SD005	Adjustment /Void Has Unmatched Key Fields	**The claim edit denial SD005 "Unmatched Key Field", indicates the replacement claim action failed and the original claim has not been replaced.**
SD006	Original claim is already voided.	**The original AHCCCS claim number can only be used once in the replacement/correction claim process. Once the claim status changes to Void, the claim number cannot be used for future claim resubmissions.** A corrected or replacement claim is a replacement of a previously submitted claim (e.g., changes or corrections to charges, clinical or procedure codes, dates of service, member information, etc.). The new claim will be considered as a replacement of a previously processed claim.

SD201	Explanation of Benefits not received.	**This is a system generated edit to inform the provider that the explanation of benefits is required for processing of the claim.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD206	Sterilization Consent form not received.	**This is an informational denial edit that directs the provider to submit a copy of the Federal Sterilization Consent Form.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD208	Trip Report Not Received.	**This is an informational denial edit that directs the provider to submit a copy of the AHCCCS Daily Trip Report.** 1. If there are no changes to the claim details, date of service, codes, miles, and the only document required is the AHCCCS NEMT Daily Trip report, the document can be uploaded via the EDI Solutions portal. 2. The AHCCCS 12-digit claim reference number can be used as the "attachment/linking" control number. 3. The AHCCCS DTR is required with each NEMT claim submission.
SD209	Operative report not received	**This is an informational denial edit that directs the provider to submit a copy of the operative report for medical review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD210	Emergency room record not received.	**System generated requests for documentation will begin with the prefix "SD". This system generated request is used to inform / instruct the provider what documentation is needed and to submit the requested documentation for claim review.** The provider should not resubmit the claim if there are no changes in coding or charges. 2. The requested documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD211	Itemized statement not received.	**This is an informational denial edit that directs the provider to submit a copy of the itemized statement for medical review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit CRN/ICN number is used as the attachment/linking control number.

SD212	Admission Face Sheet Not Received	**This is an informational denial edit that directs the provider to submit a copy of the admission face sheet for medical review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD213	Admission History/Physician Not received	**This is an informational denial edit that directs the provider to submit a copy of the admission history and physician details for medical review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD214	Discharge/ interim Summary not received	**This is an informational denial edit that directs the provider to submit a copy of the discharge / Interim summary medical review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD215	Labor and Delivery report not received	**This is an informational denial edit that directs the provider to submit a copy of the labor and delivery report for medical review.** 1. The provider should not resubmit the claim if there are no changes in coding or charges. 2. The documentation can be uploaded via the EDI Solutions Portal. 3. The AHCCCS 12-digit claim number is used as the attachment/linking control number.
SD306	Provider at Detail Line Mismatch	**Billing Two Different Service Provider NPIs On a Single Claim is Not Allowed** AHCCCS does not recognize multiple rendering providers on one claim. If the line level rendering provider **(Form locater 24J)** is different from the claim level rendering provider (Form locator 31), separate claims must be submitted for payment. Claims submitted with multiple rendering providers will be accepted by AHCCCS, ***but denied*** *within the AHCCCS claims adjudication system.* ***It will be the responsibility of the biller to submit a correction claim for both providers if applicable for consideration.*** **Refer to the FFS Provider Manual Chapter3 Provider Records and Registration.pdf**