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Arizona Health Care Cost Containment System

# TOPICS:
# NEMT CLAIM SUBMISSION UPLOADING THE DAILY TRIP REPORT - TIBCO

DFSM Provider Training Team
September 24, 2019

# AHCCCS ONLINE

# CLAIM SUBMISSION TRAINING

# NEMT PROVIDERS

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# Reminder: AHCCCS COVERAGE

- AHCCCS covers medically necessary non-emergency medical transportation to and from an AHCCCS covered medical or behavioral health service for most recipients.
- Transportation must only be provided to transport the recipient to and from the nearest AHCCCS covered medical or behavioral health service.
- Tribal Business License - Effective 10/1/2014 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 department.

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## **Toolbar-** there are 6 Tabs that must be completed in order to submit a claim for covered NEMT services.

1. SUBMITTER
2. PROVIDERS
3. PATIENT  SUBSCRIBER

4. ATTACHMENT
5. CLAIM INFORMATION
6. SERVICE LINES

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# GETTING STARTED

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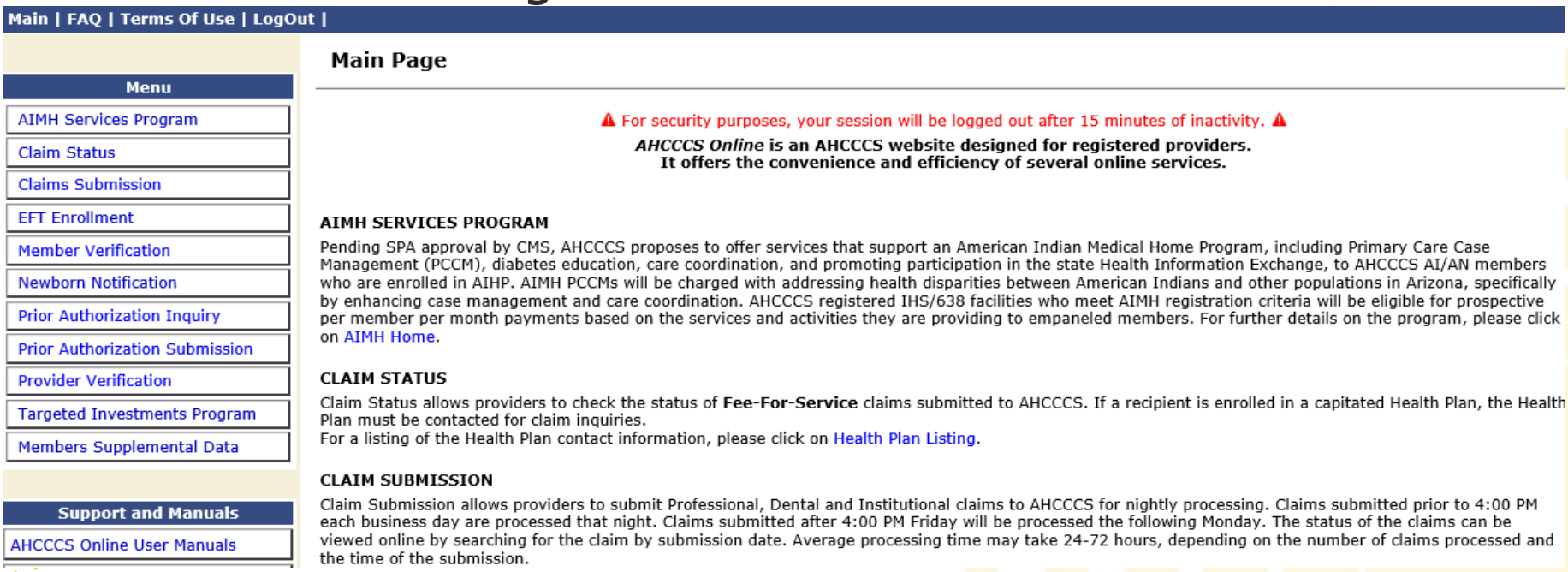
# https://azweb.statemedicaid.us

1. Sign In:  Must have a valid username and password.
2. On the Main Page - Menu– select Claims Submission

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# Claims Submission Page

## TYPE OF CLAIM – Select PROFESSIONAL and click GO

### Claim Submission

Claims submitted to AHCCCS prior to 4:00 PM, Monday through Friday, will be processed within 24 to 48 hours. Once the claim has been sent for processing, it can no longer be modified via the web. After the processing deadline, corrections will need to be submitted as a **Replacement** or **Void**. The claim will not be accepted if any required data elements are missing. The claim will also be rejected if the recipient is not eligible for coverage at the time the service is rendered. Claims will be processed under the following Identification Number (Non-Person Entity):

**Payer/Receiver Electronic Transmitter Identification Number:** 866004791

**NOTE:** You cannot view the processing status of claims submitted by other users.

**Enter New Claim**

Type of Claim: Professional Go...

**View Claim Processing Status**

Submission Date(s): - Go...

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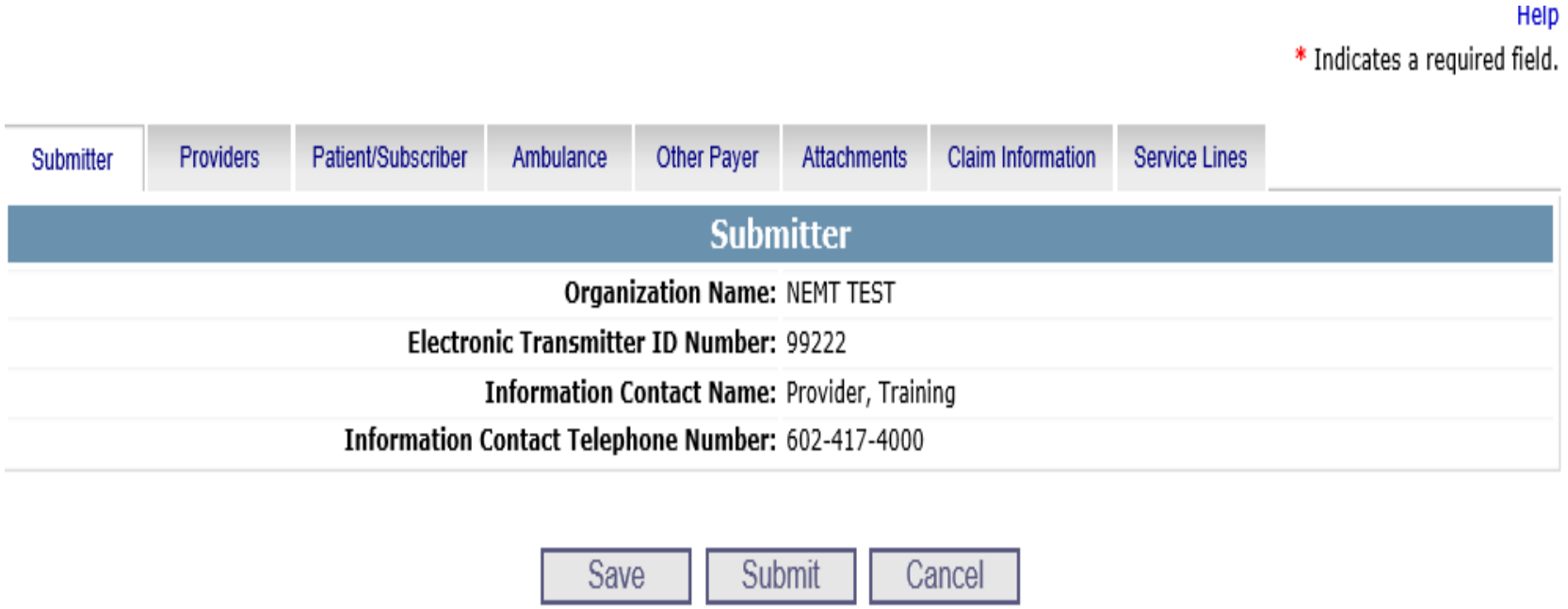
# Professional Claim Submission

1. Confirm the Submitter information is correct.
2. Next - Select the tab **PROVIDERS**.

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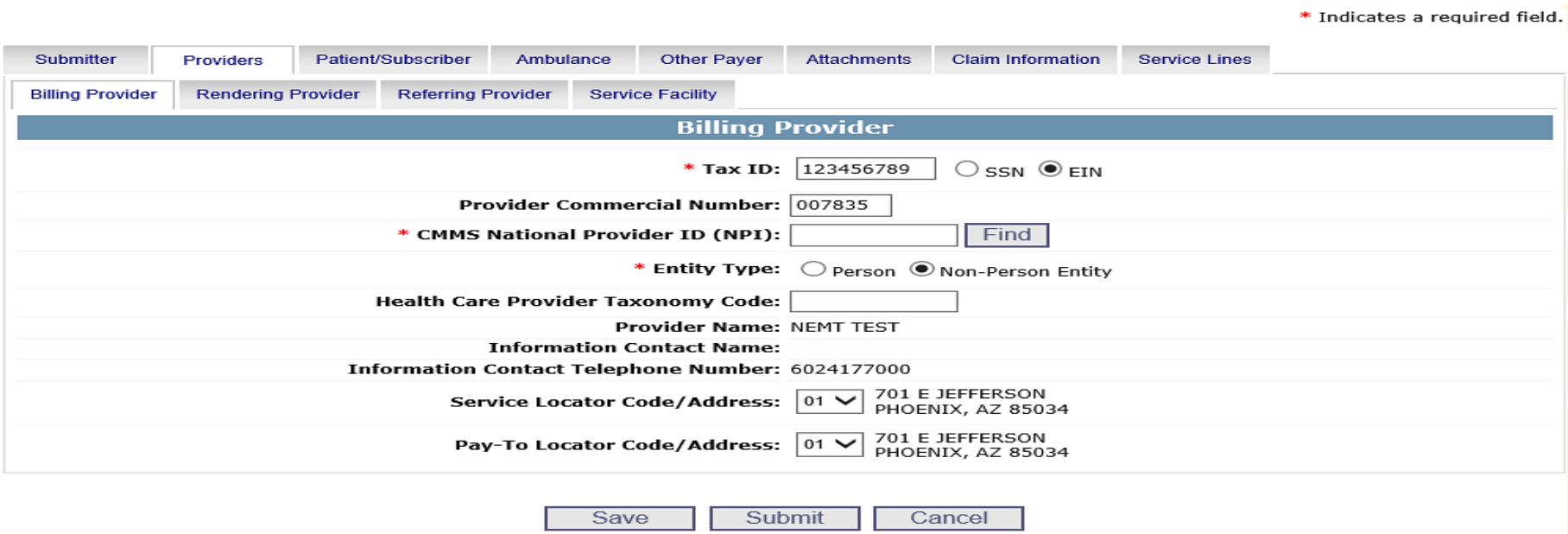
# Professional Claim Submission

# Billing Provider Tab

1. Complete the **Billing Provider Information**, this will include the **TAX ID, National Provider ID and Non-Person Entity fields**.
2. If you do not have a NPI number, enter your 6 digit AHCCCS provider number in the Provider Commercial Number field.

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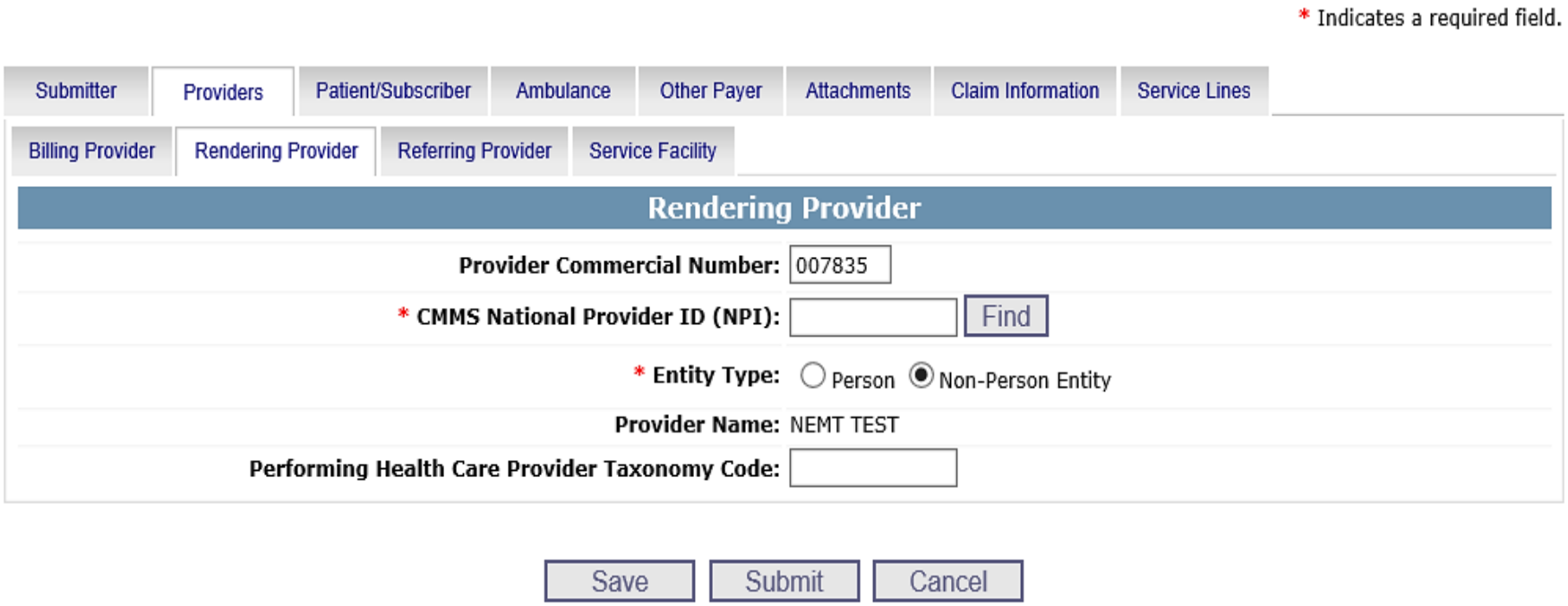
# Rendering Provider Tab

1. On the Rendering Provider tab – complete the CMMS National Provider ID field (NPI) **and** **Non-Person Entity field**.
2. If you do not have a NPI number, enter your 6 digit AHCCCS provider number in the **Provider Commercial Number** field, leaving the NPI number field blank.

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# Patient/Subscriber Tab

1. Enter the AHCCCS Member ID and date of birth **(MM/DD/YYYY),** and click the **FIND** button to verify the member information.
2. On the Payer Responsibility field – click the down arrow key to select payer responsibility. If AHCCCS is the primary payer, select P-Primary.


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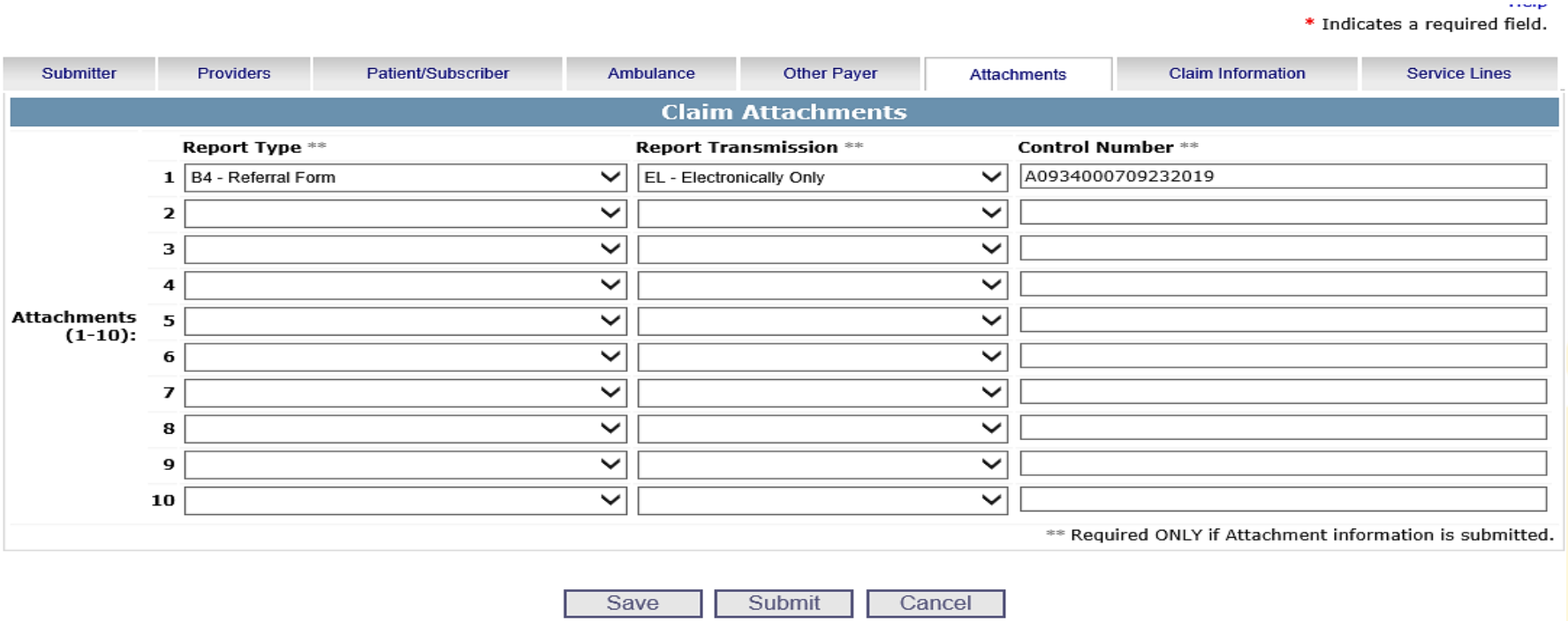
# ATTACHMENTS TAB

**The Attachment tab is the only way to notify the AHCCCS processing system that you are submitting an Electronic attachment** (Daily Trip Report) **with the claim.**

1. **The Report Type (B4) and Report Transmission (EL) codes should be used only.**
2. The **CONTROL NUMBER** field will change based on the Member ID and Date of Service.
3. The Control number entered on the Attachment tab **MUST MATCH** the control number entered In the Transaction Insight Portal (TIBCO).



* Indicates a required field.

Submitter | Providers | Patient/Subscriber | Ambulance | Other Payer | Attachments | Claim Information | Service Lines

**Claim Attachments**

| Attachments (1-10): | Report Type ** | Report Transmission ** | Control Number ** |
|---|---|---|---|
| 1 | B4 - Referral Form | EL - Electronically Only | A0934000709232019 |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

** Required ONLY if Attachment information is submitted.

Save | Submit | Cancel

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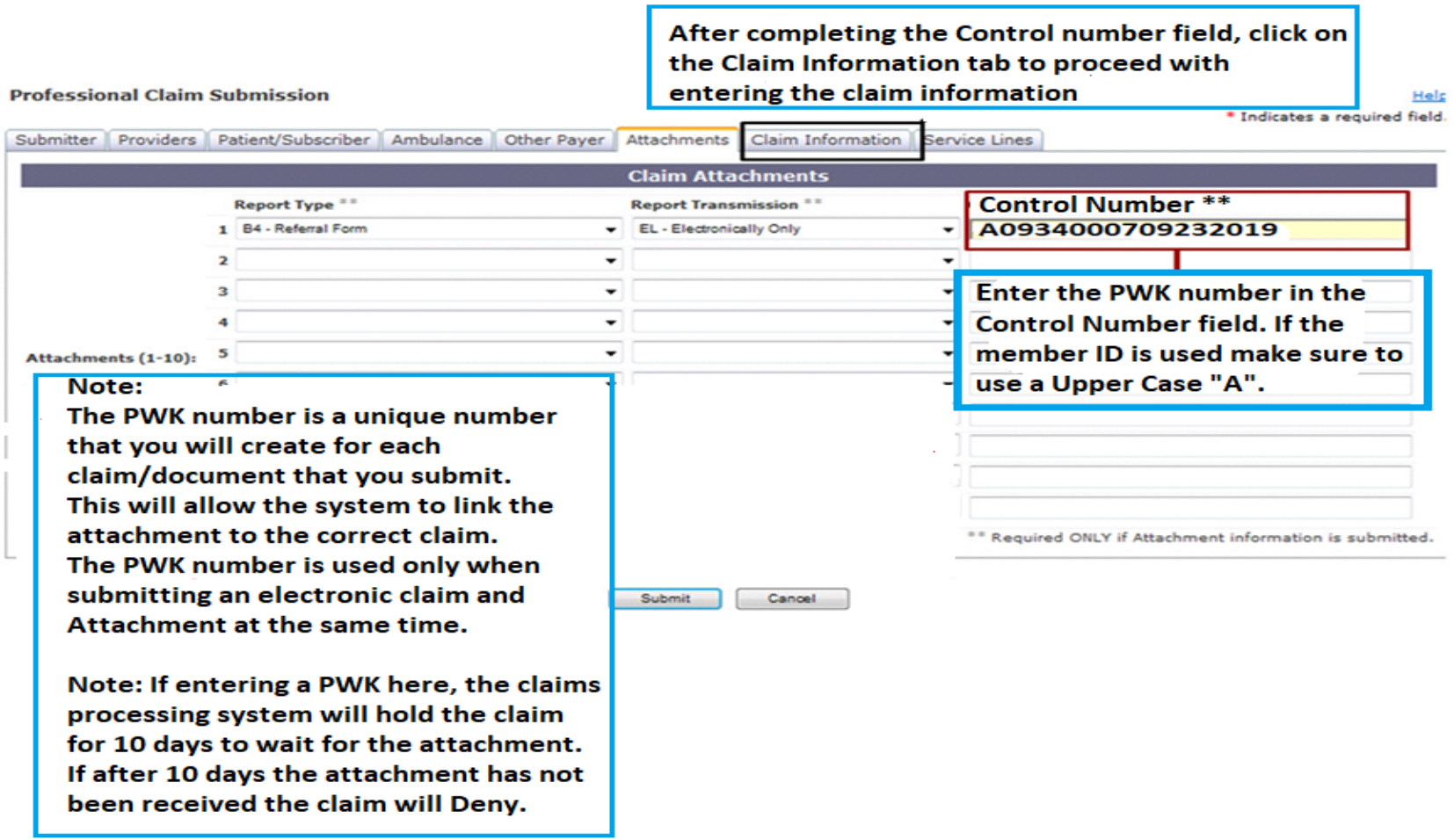
# COMPLETING THE ATTACHMENT TAB

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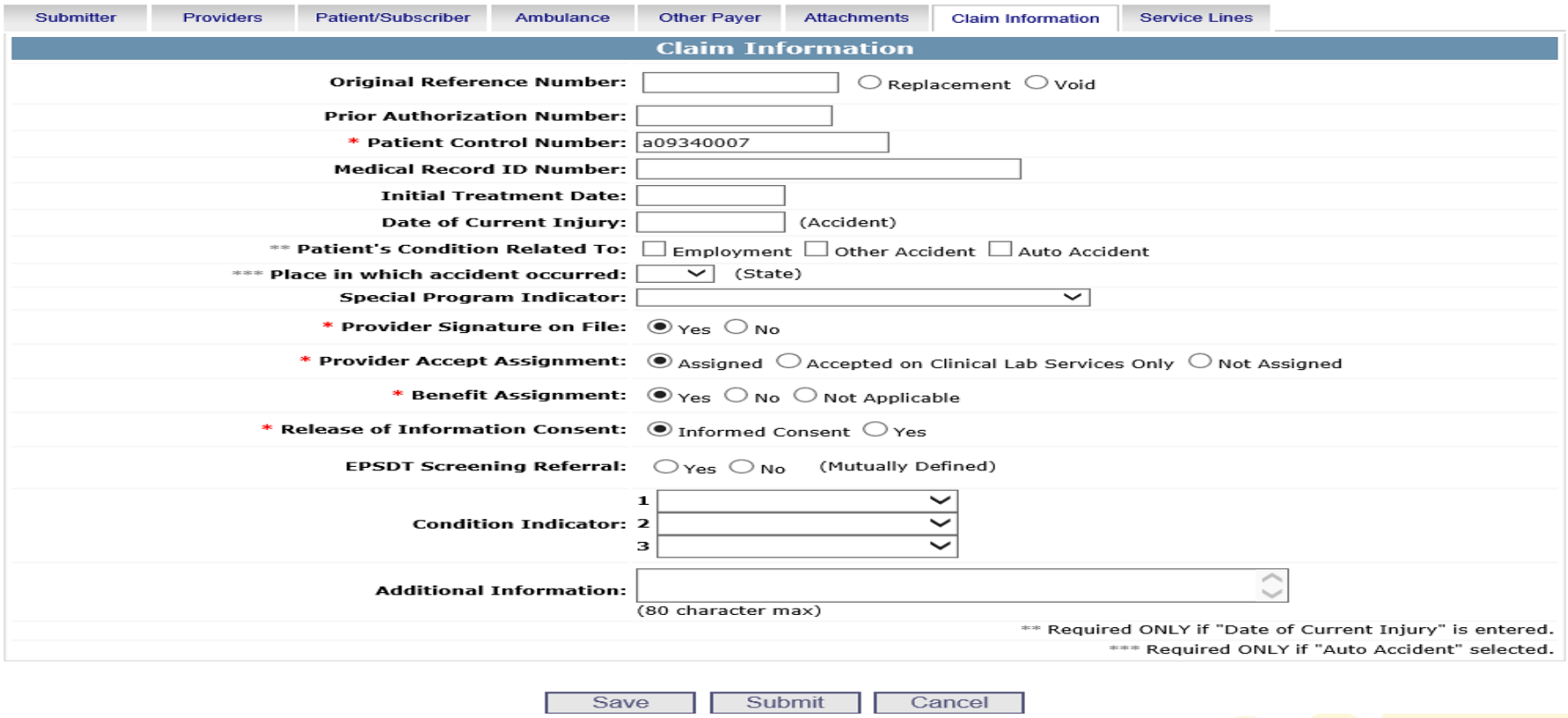
# CLAIM INFORMATION TAB

*** Indicates a required field - Provider Signature on File, Provider Accept Assignment, Benefit Assignment and Release of Information Consent.**

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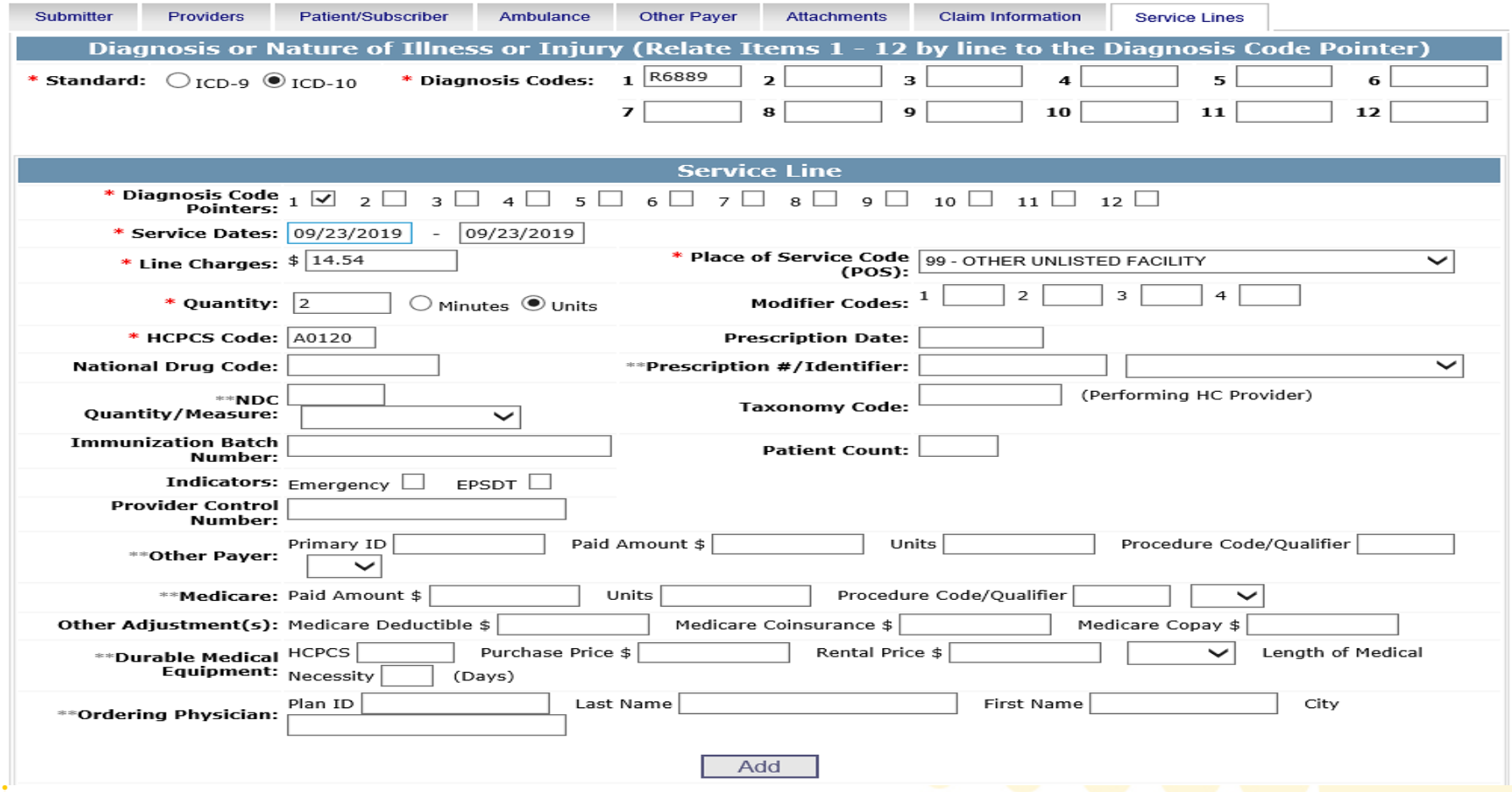
# SERVICE LINES TAB

Line #1 – Enter the Base code for the transport (ex. A0120). This example shows a round trip transport. Complete the fields and then click the ADD button to bring up another page to enter the miles.

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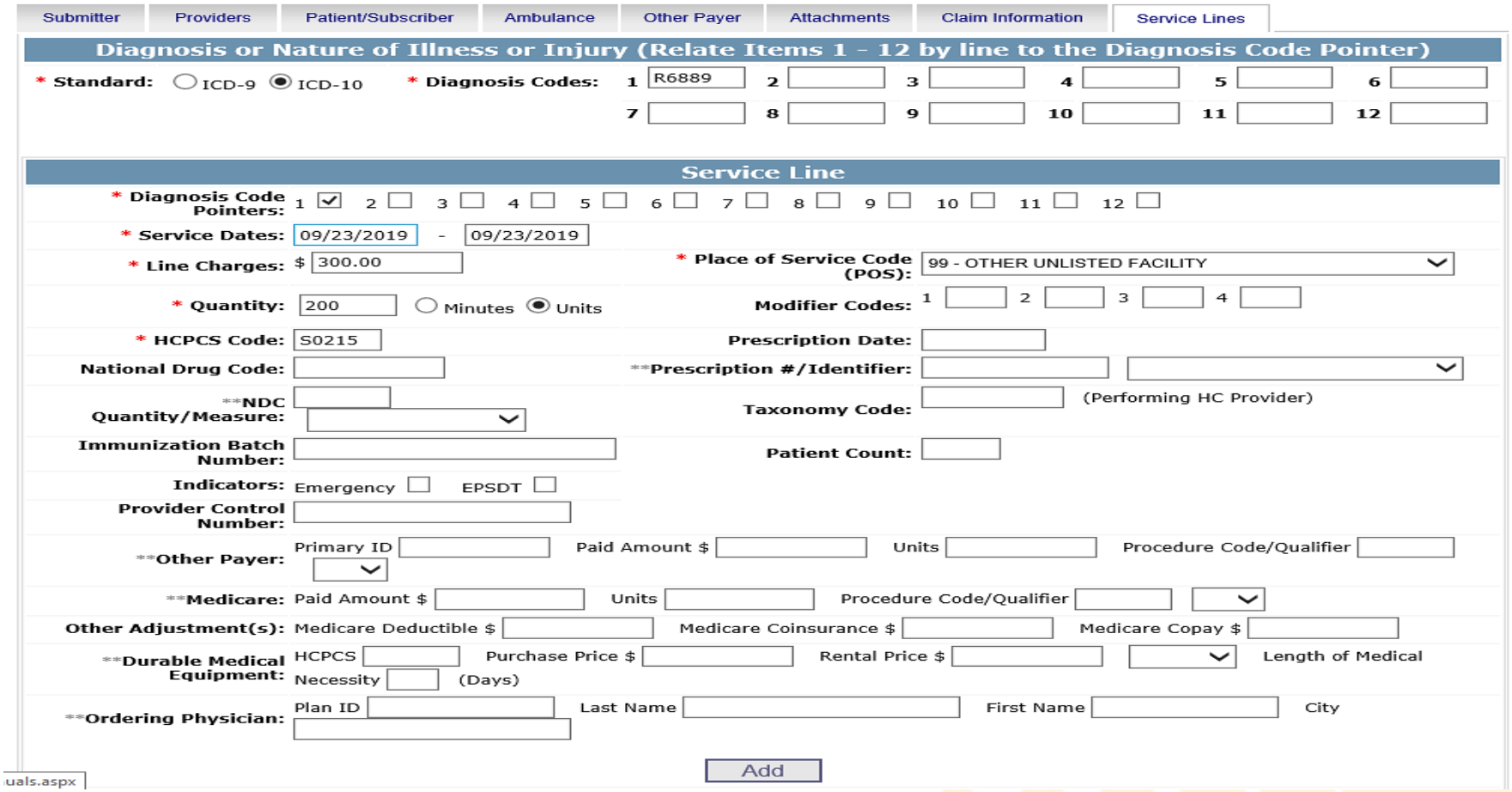
# SERVICE LINES TAB

Line #2 – Enter the Miles code for the transport (ex. S0215). This example shows a round trip transport. Complete the fields and then click the ADD button to bring up another page.

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# On this screen you will be able to verify the billing information entered and also to correct any errors before submitting the claim.

The **Pencil** icon is the edit button.

1. To make a correction, click on the pencil next to the line that you want to correct.
2. Once you are done making the correction, click the ADD button to accept the correction, then you are ready to click the **SUBMIT** button.
3. You will receive the message **"Transmission Successful".**

| Line No. | Begin Date | End Date | POS | HCPCS | Mod 1 | Mod 2 | Mod 3 | Mod 4 | NDC Code | NDC Units | Diag 1 | Diag 2 | Diag 3 | Diag 4 | Diag 5 | Diag 6 | Diag 7 | Diag 8 | Diag 9 | Diag 10 | Diag 11 | Diag 12 | Min./ Units | Type | Line Charges | Medicare Paid U Amount |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 9/23/2019 | 9/23/2019 | 99 | A0120 | | | | | | 0 | ✓ | | | | | | | | | | | | 2 | UN | 14.54 | |
| 2 | 9/23/2019 | 9/23/2019 | 99 | S0215 | | | | | | 0 | ✓ | | | | | | | | | | | | 200 | UN | 300.00 | |
| | | | | | | | | | | | | | | | | | | | | | | | | Totals: | $314.54 | $0.00 |

Save Submit Cancel

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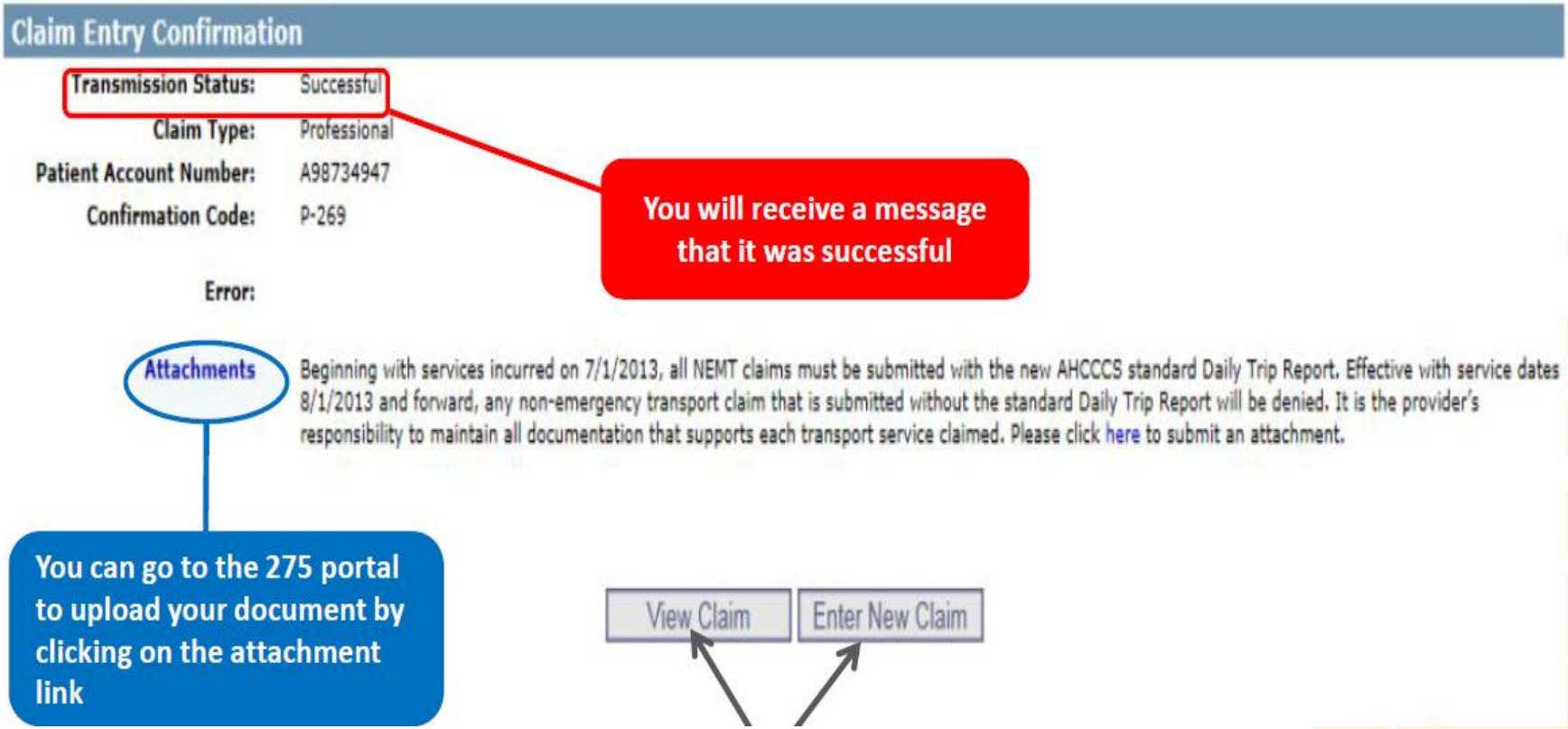
# Claim Entry Confirmation Screen

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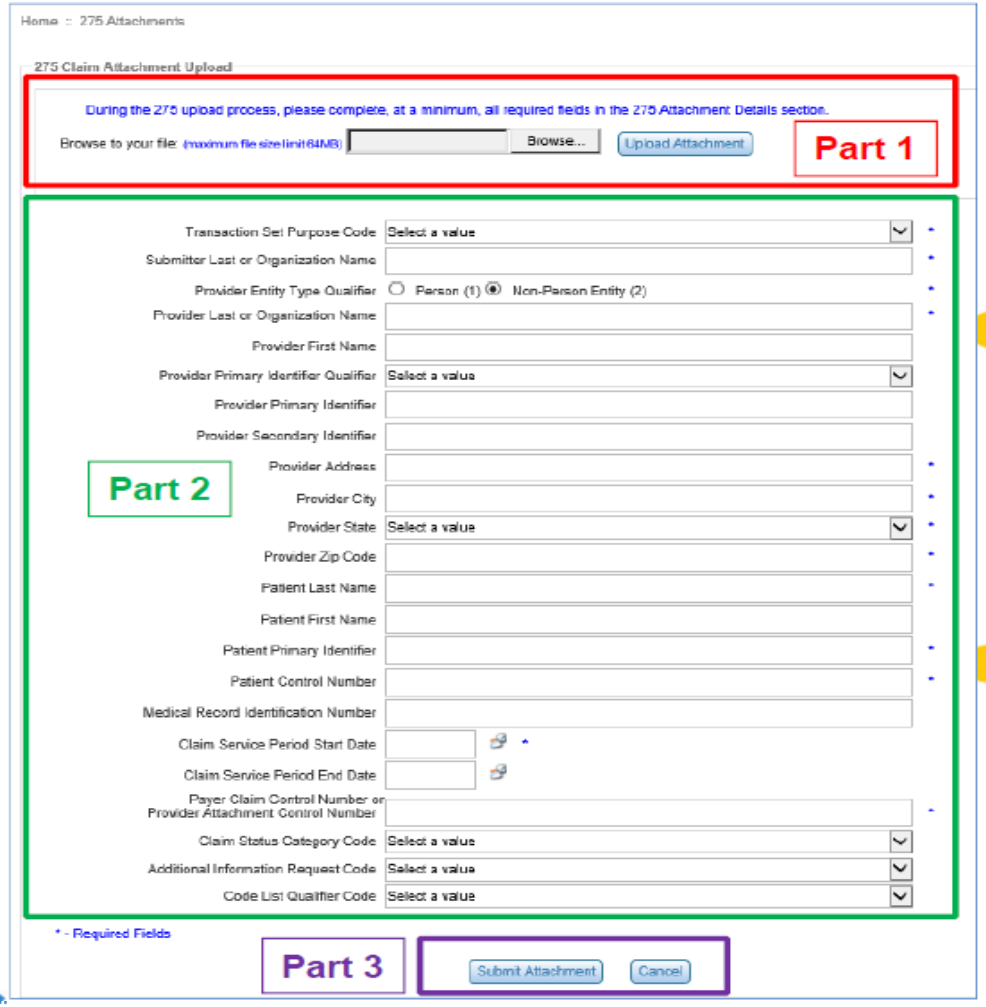
# TRANSACTION INSIGHT PORTAL

## TIBCO – UPLOADING THE DAILY TRIP REPORT

# TRANSACTION INSIGHT PORTAL (TIBCO)

## 275 ATTACHMENTS PAGE




**The 275 Attachments page have three parts:**

**Part 1: Upload Attachment**
**Part 2: Details**
**Part 3: Save Attachment**

*** Required Fields**
**NOTE:**
**Provider Primary or Secondary Identifier/Qualifier are also required fields.**

**Response Type is - 02 – Add (unsolicited).**
**The PWK number must be entered in the Provider Attachment Control Number field.**

| | |
|---|---|
| Transaction Set Purpose Code | 02- ADD |
| Submitter Last or Organization Name | IHS Shiprock |
| Provider Entity Type Qualifier | ○ Person (1) ◉ Non-Person Entity (2) |
| Provider Last or Organization Name | IHS Shiprock |
| Provider First Name | |
| Provider Primary Identifier Qualifier | XX-NPI |
| Provider Primary Identifier | Enter the Provider NPI |
| Provider Secondary Identifier | |
| Provider Address | 801 EAST JEFFERSON |
| Provider City | PHOENIX |
| Provider State | AZ - Arizona |
| Provider Zip Code | 85034 |
| Patient Last Name | DOE |
| Patient First Name | JANE |
| Patient Primary Identifier | A12345678 |
| Patient Control Number | Q-12345 |
| Medical Record Identification Number | |
| Claim Service Period Start Date | 09/01/2019 |
| Claim Service Period End Date | |
| Payer Claim Control Number or Provider Attachment Control Number | A1234567809012019 |
| Claim Status Category Code | Select a value |
| Additional Information Request Code | Select a value |
| Code List Qualifier Code | Select a value |

* - Required Fields

Submit Attachment Cancel

These 3 fields can stay at "Select a value" no action required.

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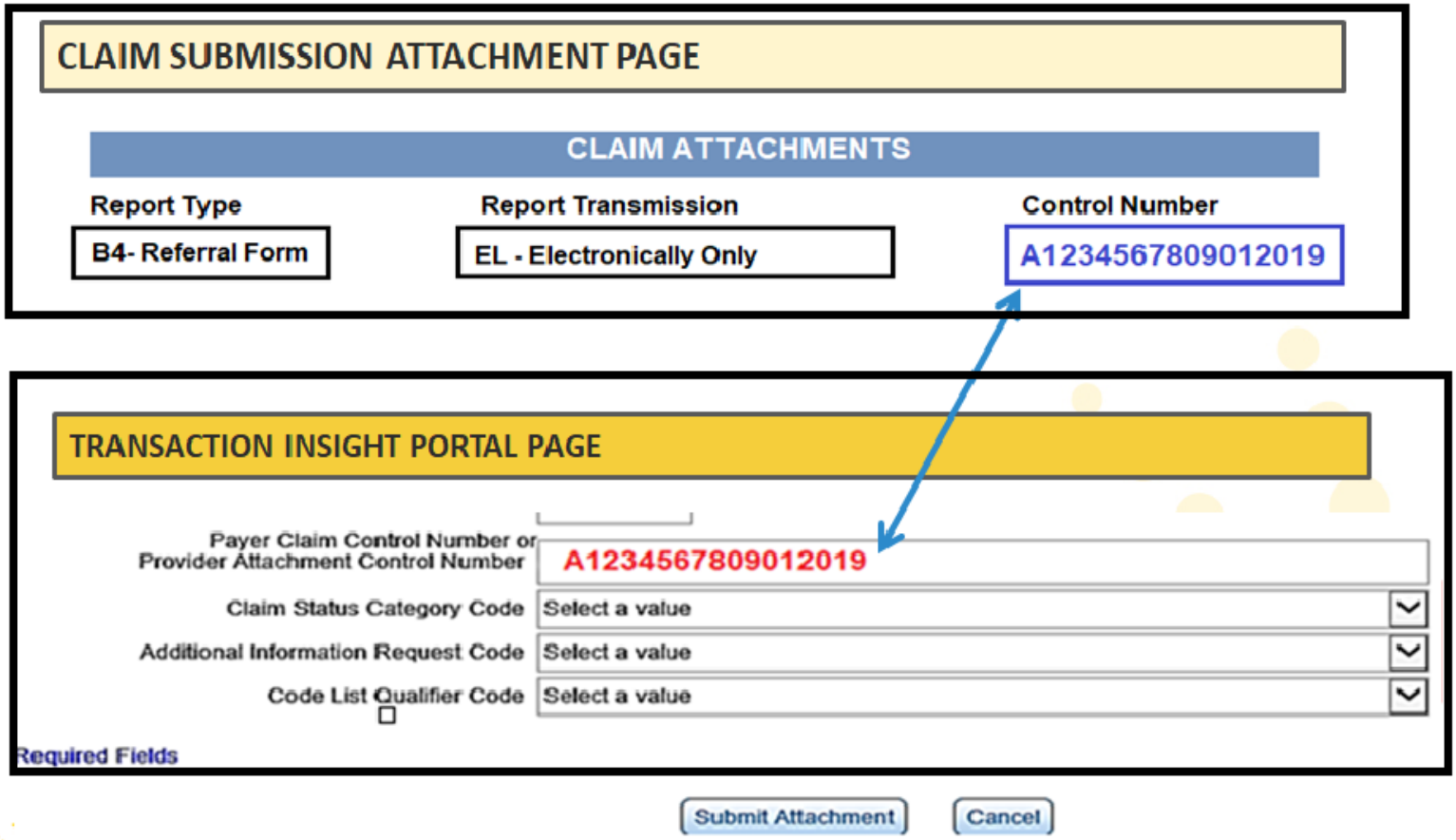
# Claim Screen and TI Attachment Screen Match

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## Response Type - 11-Response (solicited) → (AHCCCS requested the documentation)
## The AHCCCS 12 digit CRN must be entered in the Provider Attachment Control Number.

| | | |
|---|---|---|
| Transaction Set Purpose Code | 11 - RESPONSE | * |
| Submitter Last or Organization Name | IHS Shiprock | * |
| Provider Entity Type Qualifier | ○ Person (1) ◉ Non-Person Entity (2) | * |
| Provider Last or Organization Name | IHS Shiprock | * |
| Provider First Name | | |
| Provider Primary Identifier Qualifier | XX-NPI | |
| Provider Primary Identifier | Enter Provider NPI | |
| Provider Secondary Identifier | | |
| Provider Address | 801 EAST JEFFERSON | * |
| Provider City | PHOENIX | * |
| Provider State | AZ - Arizona | * |
| Provider Zip Code | 85034 | * |
| Patient Last Name | DOE | * |
| Patient First Name | JANE | * |
| Patient Primary Identifier | A12345678 | * |
| Patient Control Number | Q-12345 | * |
| Medical Record Identification Number | | |
| Claim Service Period Start Date | 09/01/2019 | * |
| Claim Service Period End Date | | |
| Payer Claim Control Number or Provider Attachment Control Number | Enter the 12 digit AHCCCS Claim Reference Number | * |
| Claim Status Category Code | R4- Documentation Request | |
| Additional Information Request Code | 11503-0 | |
| Code List Qualifier Code | LOI-LOINC Codes | |

* - Required Fields

Submit Attachment  Cancel

When using the 11-Response make sure to select "R4 Documentation Request" prompt. The Request code and Qualifier code fields leave as shown.

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# Important Tips:

1. The PWK number must begin with a upper case "A".
2. Do not use a lower case "a", this is not a match.
3. Make sure the PWK number that is entered on the claim attachment tab is entered in the same format in TIBCO.

| Correct Format | Incorrect Format |
|---|---|
| CRN 192016589012 | 0192016589021 2# |
| PWK A1234567809052019 | a12345678090519 |

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# Video Trainings:
# Claim Submission
# TIBCO Submission

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# Thank You!

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