Third Party Liability (TPL)

September 2021

AHCCCS
Arizona Health Care Cost Containment System

About This Course

Please note that these materials are designed for Fee-for-Service programs, including the American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authorities (TRBHAs), and Tribal Arizona Long Term Care Services (ALTCS).

This training presentation will cover how to submit Third Party Liability claims, including Medicare, to AHCCCS.

If you have any questions about this presentation please email the providertrainingffs@azahcccs.gov

General Information

General Information

The services described in this training are global in nature and are listed here to offer general guidance.

Additional information on these topics can be found in the Fee-for-Service Provider Billing Manual at:

- https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap09Medicare.pdf

And in the IHS-Tribal Provider Billing Manual at:

- https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chap07Medicare.pdf



General Information on TPL

Definitions

“Coordination of Benefits” means the activities involved in determining Medicaid benefits (COB) when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

“Third-party” means a person, entity or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

“Third-party liability” means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan.

Definitions

“First Party Liability” means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

“Post Payment Recovery” happens subsequent to payment of a service by a Contractor, and the efforts by that Contractor to retrieve payment from a liable third party.

“Cost Avoidance” means to deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C. R9-22 Article 10.

Definitions

“Explanation of Benefits (EOB)” is a statement from a health insurance plan (the First- and Third-Party payers) describing what costs were covered for your health care. It is generated when a claim is submitted to the health insurance plan.

“Remittance Advice (RA)” provides information about claims adjudicated by the AHCCCS Division of Fee For Service Management (DFSM), including claims paid or voided, claims which were denied, and in process and adjusted claims.

NOTE: Each of these documents (the EOB and RA) show payment details of a provider’s claim for services.

Payer of Last Resort

AHCCCS is considered the "Payer of Last Resort" (per A.A.C. R9-22-1003), unless specifically prohibited by federal or state law. AHCCCS shall be used as a source of payment for covered services ***only after all other sources of payment for covered services have been exhausted per A.R.S. 36-2946.***

- NOTE: This means that AHCCCS has liability for payment of benefits ***after*** other first and third-party payer benefits have paid on the claim.

Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

IMPORTANT: The claims submitted to AHCCCS **must** exactly match the original claims submitted to the primary payer source.

Payer of Last Resort

- **IMPORTANT:** If a member's record indicates the existence of first or third-party coverage, but no insurance payment is indicated on the claim (EOB for example) **from that first or third-party coverage source**, **then the claim submitted to AHCCCS Medicaid will deny.**
- When a member has Medicare, first or third-party coverage, and EOB will be required by AHCCCS in order for AHCCCS to process the claim.
  - **This is required even IF the provider knows in advance that the service is not covered by the other payer source and that no payment will be made.** The provider must still submit to the other payer source first to obtain documentation of the valid denial (such as an EOB).

General Information

Cost Avoidance

A.A.C. R-22-1003 Cost Avoidance:

Section A advises that the Administration's reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability.

Section C advises that the requirement to "cost avoid" applies to all AHCCCS-covered services under Article 2 of the A.A.C. chapter. The only exception provided by Rule is when the claim is for:

1. Labor and delivery and postpartum care; or
2. The liability is from an absent parent, and the claim is for prenatal care or EPSDT services.

When is AHCCCS NOT the Payer of Last Resort?

Exceptions

There are certain situations where AHCCCS is not the payer of last resort.

In these situations AHCCCS either must either:

1) Pay the full amount of the claim and *then* seek out Post-Payment Recovery, *or*
2) Depending upon the member's other coverages, AHCCCS may be the primary payer.

The upcoming slides detail when AHCCCS is **not** the payer of last resort.

When is AHCCCS NOT the Payer of Last Resort?

Post Payment Recovery

Post Payment Recovery happens subsequent to payment of a service by a Contractor, and the efforts by that Contractor to retrieve payment from a liable third party. This is required to prevent a delay in a member receiving the service.

Under state and federal law and R9-22-1003 (E), AHCCCS must pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement from the First- or Third-Party payer (Post-Payment Recovery) when the claim is for:

1. Preventive pediatric services, including EPSDT services and administration of vaccines under the Vaccines For Children (VFC) Program; or
2. The liability is from an absent parent whose obligation to pay support is being enforced by Division of Child Support Enforcement;

When is AHCCCS NOT the Payer of Last Resort?

When is AHCCCS the Primary Payer?

Per R9-22-1002, AHCCCS is not the payer of last resort (AHCCCS will be the primary payer) when the following entities are the third-party:

1. The payer is an Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

General Information

Other Items of Note

As previously described, AHCCCS shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is submitted, unless one of the notated exceptions apply, when a claim is submitted without the required other coverage payment EOB/remit/information.

If the probable existence of a First or Third-party's liability cannot be established or if Post Payment Recovery is required, then the claim will be adjudicated and AHCCCS will follow the Post-Payment Recovery process also known as Pay and Chase.

Third Party Liability

What is Third Party Liability?

Third party liability means that the member has another medical insurance plan, and it is the primary payer for their medical services.

NOTE: The term Third-Party Payer is *different* than Third Party Liability (TPL).

- *Both* First-Party and Third-Party Payers *are a part of* Third Party Liability.

First-Party Payers

First-Party Payer

Coordination of benefits with a First-Party Payer includes, but is not limited to the following:

- Private health insurance;
- Employment-related disability and health insurance;
- Long-term care insurance;
- Other federal programs not excluded by statute from recovery;
- Court ordered or non-court ordered medical support from an absent parent;
- State workers compensation;
- Automobile insurance, including underinsured and uninsured motorists insurance;
- Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust;
- First-party probate estate recovery; and/or
- Adoption-related payment.

Third-Party Payers

Third-Party Payer

Coordination of benefits with a Third-Party Payer includes, but is not limited to the following:

- Motor vehicle injury cases,
- Other casualty cases,
- Tortfeasors,
- Restitution recoveries, and/or
- Worker's compensation cases.

Reminder: The term Third-Party Payer is *different* than Third Party Liability (TPL). *Both* First-Party and Third-Party Payers are a part of Third Party Liability.

Third Party Liability

How Does the Process Work?

For members that have a primary insurance, AHCCCS will be the last payer to consider reimbursement of the claim. (Except for the exceptions listed under federal or state law.)

- A copy of the primary payer's Explanation of Benefits (EOB) will be required for consideration of the claim, ***even when the service provided is a non-covered service for the primary payer.***
- Even if a provider has the reasonable expectation that a service will *not* be reimbursed under the member's primary payer (such as their health plan), a claim must still be submitted to that primary payer to obtain a formal determination (such as a denial/EOB).
- This denial/EOB must then be submitted to AHCCCS with the claim.

Responsibility to Appeal

Appealing the Primary Payer is the Provider's Responsibility

If the first- or third-party payer (such as a health plan) denies a claim for a covered service, then the provider must follow that health plan's appeal process.

The provider **must** exhaust all remedies before the claim can be submitted to AHCCCS, and before AHCCCS can consider the covered service.

Once all other payer sources have been utilized, then the provider **must** submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission. If this is not done, then the claim submitted to AHCCCS may deny.

Tribal Self Insured Plans

Tribal Self-Insured Plan

If the member has primary coverage with a **Tribal Self Insured plan** then AHCCCS Medicaid assumes primary responsibility over the Tribal Self-insured plan.

- Tribal Self-Insurance. A health plan that is funded solely by a Tribe or Tribal organization and for which the Tribe or Tribal organization assumes the burden of payment for health services covered under the plan either directly or through an administrator.



Verifying Member Eligibility & Coverage Changes

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Reporting Coverage Changes

When a member's TPL or Medicare coverage changes, how is this reported?

Requests to update a member's TPL or changes in their Medicare coverage should be reported by the member.

Members can report their changes via HEAplus at:

- Web: https://www.healthearizonaplus.gov/Login/Default

  Or

- Phone: 855-432-7587

Verifying Member Enrollment

Provider Responsibility to Verify Member Enrollment

It is a provider's responsibility to verify a member's enrollment!

Health care providers may use any one of several verification processes to obtain eligibility and enrollment information for a Medicaid member, including any information regarding their Medicare or Third Party Payer Liability (if available).

- https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFSChapter2Eligibility.pdf

Fee-for-Service Member Enrollment and Eligibility

Verification Processes Available to Providers Include:

1. AHCCCS Online Provider Portal
2. Interactive Voice Response
3. Medical Electronic Verification System (MEVS)
4. AHCCCS Batch 270/271 Eligibility Verification Request and Response

Member Verification - Available Options

1. AHCCCS Online Provider Web Portal

- This allows AHCCCS providers to verify eligibility and enrollment status.
- AHCCCS providers can view Third Party Liability , Copayments (if applicable), Medicare Coverage, Behavioral Health Services, Share of Cost, Special Program enrollment and Additional Benefits information.

To create an online account and begin using the application, providers must go to https://azweb.statemedicaid.us.

Member Verification - Available Options

2. The Interactive Voice Response System (IVR)

- This allows an unlimited number of phone verifications by entering information on a touch-tone telephone.
  - Providers may call IVR at:
    - Phoenix: (602) 417-7200
    - All others: 1-800-331-5090

Member Verification - Available Options

3. The Medical Electronic Verification System (MEVS)

- This uses a variety of applications to provide member information to providers.
- For information on MEVS, please contact EMDEON at: https://www.changehealthcare.com/contact-us

Member Verification - Available Options

4. AHCCCS Batch 270/271 Eligibility Verification Request and Responses

- Providers can also verify information through a batch process (270/271), in which the provider sends a file of individuals to AHCCCS. AHCCCS returns this file with its responses the following day.
- Information on that process can be obtained by calling the AHCCCS Help Desk at (602) 417-4451.

Eligibility and Enrollment Processes

1 AHCCCS Online Portal

2 Interactive Voice Response (IVR)

3 Medical Electronic Verification System (MEVS)

4 AHCCCS Batch 270/271 Eligibility Verification Request and Responses:



Reimbursement Amounts and TPL

TPL and Payment Amounts

Reimbursement

The AHCCCS Administration's reimbursement responsibility is limited to no more ***than the difference between the Capped Fee-For-Service schedule and the amount of the first- or third-party liability***.

An AHCCCS registered provider agrees to accept the Capped Fee-For-Service rate as payment in full.

- *Note:* For IHS/638 Providers, the All-Inclusive Rate (AIR) is considered the Capped Fee-For-Service rate, for claims for offered services that meet AIR reimbursement criteria.

TPL and Payment Amounts

How Does Reimbursement Work When Fee Schedules Have Different Allowed Amounts?

Insurance payers may have a different fee schedule or allowed amount assigned to each CPT/HCPCS code. Some payers allowed amounts may be higher or lower than others.

If the first- or third-party coverage **paid more** than the Capped Fee-For-Service rate, then no further reimbursement is made by AHCCCS.

- **IMPORTANT:** AHCCCS *will not* issue a payment when the primary insurance payer's payment exceeds the AHCCCS allowable amount.

If the primary insurance allowed amount is ***less than*** the AHCCCS allowed amount, it is possible that a payment will be considered (based on review).

TPL and Payment Amounts

How Does Reimbursement Work When Fee Schedules Have Different Allowed Amounts?

Sometimes members have 3 or more coverage plans.

Should more than one coverage plan make payment and the total amount paid by *all the coverage plans* is more than the AHCCCS Capped Fee-For-Service fee schedule amount, then there will be no AHCCCS payment.

- **IMPORTANT:** The provider cannot balance bill the member for any amount. Arizona Revised Statute §36-2903.01(K) prohibits providers from billing AHCCCS members, including QMB Only, for AHCCCS-covered services.

Differences Between TPL and Medicare

With **TPL**, AHCCCS pays the difference between the AHCCCS Capped Fee-for-Service fee schedule and the total amount paid by *all the coverage plans*.

- If the total amount already paid by the member's TPL(s) is more than the AHCCCS Capped Fee-For-Service fee schedule amount, then there will be no AHCCCS payment.

With **Medicare**, what AHCCCS pays is based on the type of Medicare coverage the member has (QI1-Part B, SLMB, QMB Dual, or Non-QMB Dual).

TPL Examples

Example 1 (Surgical)

A provider bills **$4,500.00** for a surgical procedure:

- The first-party plan allowed **$1,388.23**, and paid **$1,110.58**. It also shows a 20% coinsurance amount of **$277.65**;
- The AHCCCS Capped Fee-For-Service schedule allows **$753.21** for the surgery.
- In the above example, **no AHCCCS payment will be made**, since the provider has already been paid ***more*** than the Capped Fee-For-Service rate.
- In this case, the provider must accept the $1,110.58 as payment in full and cannot balance bill the member for any amount.

TPL Examples

Example 2 (HMO)

When the first-party payer is an HMO-type health plan, the same coordination of benefits process apply. For example, a contracted HMO provider bills **$150.00** for an office visit.

- The HMO plan benefit has a member co-pay of **$30.00** and the plan pays the contracted provider **$50.00**.
- The AHCCCS Capped FFS schedule allows **$41.39** for the office visit.
- **No AHCCCS payment will be made**, since the provider has already been paid ***more*** than the AHCCCS Capped FFS rate. The provider must accept the $50.00 as payment in full.

Please note that AHCCCS ***does not*** reimburse co-pays, deductibles or coinsurance amounts. (However, rules are different for QMB Only, QMB Dual and Non-QMB Dual.)

TPL Examples - Medicare QMB Dual

Example 3 (Service Not Covered by Medicare)

A provider renders a service that is statutorily *not* covered by Medicare.

However, the member is a *dual eligible member* (QMB Dual) with both Medicare and AHCCCS Medicaid, and the service rendered *is* covered by Medicaid.

The provider still must submit a claim to Medicare for the service rendered, even though they have the reasonable expectation that it will denied.

- This is a necessary step to obtain a formal determination and to obtain the denial/EOB.

When the claim is submitted to Medicare, it is submitted with the Modifier GY.

- **Modifier GY** – to be used when physicians, practitioners, or suppliers want to indicate that the items or services are statutorily non-covered or are not a Medicare benefit.

TPL Examples - Medicare QMB Dual

Example 3 (Service Not Covered by Medicare) Continued…

Once the provider obtains the denial from Medicare, they submit the denial and the claim to AHCCCS Medicaid for the service.

- Medicare pays $0.00 for the statutorily non-covered service.
- AHCCCS pays the AHCCCS Capped FFS rate for the Medicaid covered service.
- The claim must be submitted to AHCCCS *exactly* as it was submitted to Medicare.

TPL Examples - Medicare QMB Dual

Example 4 (IHS or 638 Clinic)

An IHS or 638 free-standing clinic submits a claim to Medicare for a clinic-definable service (PCP visit), for a dual eligible member (QMB Dual).

- Medicare pays $50.00 for the office visit, and this is applied to the member's deductible.
- The AHCCCS Capped FFS schedule allows $519.00 (the 2021 AIR) for the office visit.
- However, AHCCCS does not pay $469.00 on the claim (the difference between the Capped FFS schedule and what Medicare paid), since for QMB Dual members AHCCCS' payment liability is limited to Medicare Cost Sharing. In this case, that is the deductible. In this example, AHCCCS would pay $50.00.

TPL Examples - Private Insurance

Example 5 (IHS or 638 Clinic)

An IHS or 638 free-standing clinic submits a claim to a private insurance for a clinic-definable service (PCP visit).

- The TPL pays $50.00 for the office visit, and this is applied to the member's deductible.
- The AHCCCS Capped FFS schedule allows $519.00 (the 2021 AIR) for the office visit.
- AHCCCS pays $469.00 on the claim, since that is the difference between the payment made by the first party payer (TPL) and AHCCCS' FFS rate.




Medicare Cost Savings Plans

General Information

Specified Low-Income Medicare Beneficiary (SLMB) Program

Specified Low-Income Medicare Beneficiary (SLMB) Program

(Health Plan ID# 008040)

For members enrolled as SLMB, please note that this is a Medicare Savings Program that pays *only* the member's Medicare Part B premium.

AHCCCS does not reimburse providers for the Medicare cost-sharing amounts (copay/coinsurance/deductible).

AHCCCS SLMB-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. **No claim payments are done by AHCCCS Administration**.

Qualified Income (QI1)-Part B Buy In

Qualified Income (QI1) Program-Part B Buy In (Health Plan ID# 008050)

For members enrolled as QI1, please note that this is a Medicare Savings Program that pays *only* the member's Medicare Part B premium.

AHCCCS does not reimburse providers for the Medicare cost-sharing amounts (copay/coinsurance/deductible).

AHCCCS QI1-PART B BUY-IN is strictly a Medicare Savings Program that pays Medicare Part B premium. **No claim payments are done by AHCCCS Administration**.

Qualified Medicare Beneficiary (QMB) Only

Qualified Medicare Beneficiary (Health Plan ID# 008715)

Members who are QMB Only qualify for Medicare, but **not** Medicaid.

AHCCCS can reimburse the provider for the Medicare deductible, coinsurance, and copay.

If Medicare denies the service and upholds the denial upon the provider's appeal, then AHCCCS makes no payment.

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.

QMB Dual

Qualified Medicare Beneficiary Dual

A QMB Dual member is an individual who qualifies under the federal QMB program ***and*** Medicaid (AHCCCS). Per A.A.C. R9-29-302:

1. AHCCCS will pay the following costs for FFS members when the services are received from an AHCCCS registered provider and the service is covered:

a) By Medicare only, then AHCCCS pays only the Medicare deductible/coinsurance/copay;
b) By Medicaid only, then AHCCCS pays the FFS rate; or
c) c) By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible/ coinsurance/copay.

2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.

QMB Dual

Qualified Medicare Beneficiary Dual (#008715)

A.A.C. R9-29-302.E. advises:

“A QMB Dual eligible member who receives services under 9, A.A.C. 22, Article 2 or 9, A.A.C. 28, Article 2 from a registered provider is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges.”

Non-QMB Dual

Non-Qualified Medicare Beneficiary Dual

Non-QMB Dual – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as “Dual Eligible”).

Per A.A.C. R9-29-303:

1. AHCCCS will pay the following costs for FFS members when services are received from an AHCCCS registered provider and the service is covered:

a) By Medicare only, then AHCCCS shall not pay the Medicare deductible or coinsurance or copay;

b) By Medicaid only, then AHCCCS pays the FFS rate; or c) By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible, coinsurance or copay.

Non-QMB Dual

Non-Qualified Medicare Beneficiary Dual

Non-QMB Dual – this individual does not qualify for the federal program but is eligible for both Medicare and Medicaid (also known as “Dual Eligible”).

Per A.A.C. R9-29-303:

2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance/copay.




Medicare as the TPL

Medicare Secondary Payer Claims

Medicare as the Primary Payer

AHCCCS is the secondary payer to Medicare.

This means that for members with Medicare, that Medicare is the primary coverage for that member.

Providers ***must submit claims* to Medicare *first***, prior to billing AHCCCS.

IMPORTANT: The claims must be submitted to Medicare, ***even when the provider expects that Medicare will deny the claims***.

- This can be done by using a modifier to indicate that it is a non-covered Medicare service when billing Medicare. ***(GZ or GY Modifiers)***

Medicare Secondary Payer Claims

Medicare as the Primary Payer

The below modifiers are submitted with the claim to Medicare. Modifiers used to indicate a non-covered Medicare service (when billing to obtain the EOB) are:

- **Modifier GZ** -- to be used when physicians, practitioners, or suppliers want to indicate that they *expect that Medicare will deny an item or service as not reasonable and necessary*, **and** they **do not have** an ABN signed by the beneficiary.
- **Modifier GY** – to be used when physicians, practitioners, or suppliers want to indicate that the items or services are statutorily non-covered or are not a Medicare benefit.

IMPORTANT: If these modifiers are submitted to Medicare, ***they must also be submitted to AHCCCS in the same manner or the claim may fail***.

*****The modifiers must also be included on the AHCCCS claim.*****

The claim submitted to AHCCCS must exactly match the claim submitted to Medicare.

Medicare Secondary Payer Claims

Medicare as the Primary Payer

When a provider submits a claim to Medicare, the following occurs:

- ***For Approved Medicare Claims:*** Medicare will **automatically** transfer claims that were approved for payment to AHCCCS for additional consideration.
- ***For Denied Medicare Claims:*** Medicare **does not crossover claims** that were denied. If a claim is denied by Medicare, then the provider must resolve the Medicare denial (including following Medicare's claim reconsideration process) before AHCCCS can consider a claim as the secondary payer. Once this has been done, then the provider may submit the claim to AHCCCS, along with a copy of the final determination from Medicare. (i.e. EOB)
  The provider must be the one to submit the EOB and claim to AHCCCS. These do not crossover automatically.
- ***For Adjusted Medicare Claims:*** Medicare **does not crossover claims** that have been adjusted.

Medicare Secondary Payer Claims

Medicare as the Primary Payer

When a provider submits a claim to Medicare, the following occurs:

- ***For Approved Medicare Claims that Paid at 100%:*** Medicare **does not crossover claims** that were approved ***and paid for the full requested amount*** to AHCCCS for additional consideration.
- ***For FQHC Claims:*** Medicare **does not crossover claims** FQHC services to AHCCCS for additional consideration.

Additional Information on Medicare Denials

Medicare Denials

When Medicare denies a covered service based on medical necessity, or if the service was not delivered in the appropriate setting, the service **will not be paid by AHCCCS**.

If Medicare denies a covered service, the provider must follow the Medicare appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of Medicare's final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

Medicare Claims and the Remittance Advice

Medicare Crossover Claims

All crossover claims are identified on the provider's Medicare Remittance Advice (RA).

The AHCCCS Remittance Advice will also have an indicator that will show that the claim was an automatic crossover from Medicare to Medicaid.

IHS & 638 Providers and Dual Eligible Members

All-Inclusive Rate Example

An IHS clinic has a dual eligible member, and submits a claim to Medicare, and Medicare pays $83.08. A common question from providers is: ***Can we bill the rest of the AIR to AHCCCS? ($519)***

- When an IHS provider submits a claim to AHCCCS following payment by Medicare, they shall submit the full amount ($519) of the AIR to AHCCCS (not the difference of, in this example, $435.92).
- AHCCCS does not pay the difference between the Medicare allowable and the AIR. However, (depending on the member's eligibility) if Medicare applied $83.08 to the deductible, then AHCCCS would pay $83.08.
- Please note this is just one example.

RECAP: Medicare as the Primary Payer (For Denied Medicare Claims)

It is important for providers to understand the following:

1. If a member has Medicare, they must submit the claim to Medicare first.
2. If the claim is denied, the provider **must exhaust all appeals options with Medicare.** A provider cannot receive a denial, then submit a claim to AHCCCS without first doing this. AHCCCS will deny the claim in these situations.
3. If the Medicare claim has been denied, ***and the provider has exhausted all appeals options with Medicare***, a provider must know the claim will not crossover to AHCCCS automatically. This means that if a provider would like additional consideration, a provider must submit the following to AHCCCS:
   - The Claim
   - The EOB
   - Copy of the Final Appeal Decision by Medicare



Resolving Claim Denials

Working Third Party Claim Denials

Claim Denials

Providers must resolve claim denials with the primary payer first before AHCCCS can consider secondary payment.

Claims will often deny due to:

- Missing or inaccurate information (required fields that are left blank);
- Common billing errors (such as an incorrect member ID or provider ID);
- Incomplete information (date of service, coding, modifiers); and/or
- Illegible forms.
- Please note, this is not an all-inclusive list.

Working Third Party Claim Denials

Claim Appeals Following a Denial

If the first- or third-party payer (such as a health plan) upholds the denial reason for a covered service, then the provider must follow that health plan's appeal process.

A copy of the member's first- or third-party payer's appeal decision **must** be submitted to AHCCCS with the claim. If this is not done, then the claim submitted to AHCCCS may deny.

Common TPL/Medical Denials

Denial Code	Description
H216.1	Recipient not eligible for entire date of service.
H189.1	Member has Medicare coverage
H179.3	Recipient enrolled in plan (SLMB)
L067.1	Recipient has Part B – data missing
H139.1	Other coverage field is missing
H192.1	Recipient has other insurance, TPL data is missing

Claim Number Assignment

How to Read a Claim Number (CRN)

AHCCCS claims numbers are assigned 12 digits.

Example CRN: **20 197 8** xxxxxx (201978000000)

The first 2 digits represent the year the claim was received.

The 3rd – 5th digits represent the day of the year (197 = 07/15/2020) (Julian date).

The **6th** digit indicates how the claim was submitted to AHCCCS.

Example:

6 = EDI submission (clearing house or provider submission)

8= Medicare crossover claim.

Claim Submission Requirements

AHCCCS
Arizona Health Care Cost Containment System

Claim Submission Requirements

Clean Claim Definition

As defined by ARS §36-2904 (G)(1) a “clean claim” is:

- A claim that may be processed without obtaining additional information from the provider of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Timely Filing of Claims

Timely Filing

In medical billing, “timely filing” is the timeframe within which a **claim** must be submitted to the payer (AHCCCS Medicaid or other health insurance company), in order to be paid.

- If a claim is submitted outside of the timely filing deadline, then the claim will deny.

Timely Filing limits are ***different*** for Fee-for-Service providers and IHS/638 Tribal providers.

FFS Providers: Timely Filing of Claims

FFS Providers

The initial claim must be received by AHCCCS within:

- 6 months of the date of service (even if payment from Medicare or Other Insurance Liability has not yet been received); or
- 6 months from the retro-eligibility posting date; or
- 6 months from the date of discharge for an Inpatient hospital claim.

NOTE: The provider has up to **12 months** from the date of service to correctly resubmit the claim with the Medicare/Other Insurance payment Remit/EOB/EOMB, or to correct any errors on the claim. This must occur within 12 months of the date of service, which is the clean claim time frame.

IHS/638 Providers: Timely Filing of Claims

IHS 638 Providers (for Title XIX Members)

The initial claim must be received by AHCCCS within:

- 12 months of the date of service (even if payment from Medicare or Other Insurance Liability has not yet been received); or
- 12 months from the retro-eligibility posting date; or
- 12 months from the date of discharge for an Inpatient hospital claim.

IHS/638 Providers: Timely Filing of Claims

IHS 638 Providers (for Title XXI, KidsCare Members)

The initial claim must be received by AHCCCS within:

- 6 months from the date of service (even if payment from Medicare or Other Insurance Liability has not yet been received); or
- 6 months from the retro-eligibility posting date; or
- 6 months from the date of discharge for an Inpatient hospital claim.

IHS/638 Providers: Timely Filing of Claims

IHS 638 Providers (for both Title XIX and Title XXI, KidsCare Members)

- The IHS/638 provider has up to 12 months from the date of service to correctly resubmit a claim for services provided to a Title XIX/XXI member with the Medicare/Other Insurance payment Remit/EOB.
- They have 12 months from the date of service to submit a corrected claim with no errors.
- This all must occur within 12-months of the date of service, which is the clean claim time frame.

Claim Submission Requirements

Remittance Advice and Explanation of Benefits

Providers must submit a separate RA/EOB with each claim form.

If a provider submits multiple claims for a member, but includes only one copy of the RA or EOB, the payment document will be attached to the claim with highest coinsurance and deductible amount. The other claims in the package will be denied for lack of a Medicare RA or Other Coverage RA/EOB.

- **Note:** The remark/reason code key page(s) is required, along with the RA/EOB. Failure to submit this information will lead to the claim being considered incomplete (it is not a clean claim), and will result in the denial of the claim.

Entering TPL Information on a CMS 1500 Claim Form

CMS 1500 Claim Form

For claims associated with a TPL, the provider must enter in how much the first or third party payer actually paid for in Field 29, Amount Paid.

For TPL, the TPL PAID amount is entered in as follows:

- CMS 1500 Claim Form: Enter the total amount paid by the TPL (for all combined service lines) in Field 29.

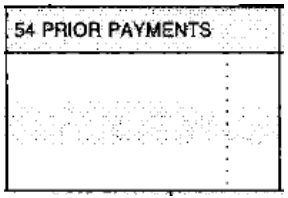
Entering TPL Information on a UB-04 Claim Form

UB 04 Claim Form

For claims associated with a TPL, the provider must enter in how much the first or third party payer actually paid for the total claim, in Field 54, Prior Payments.

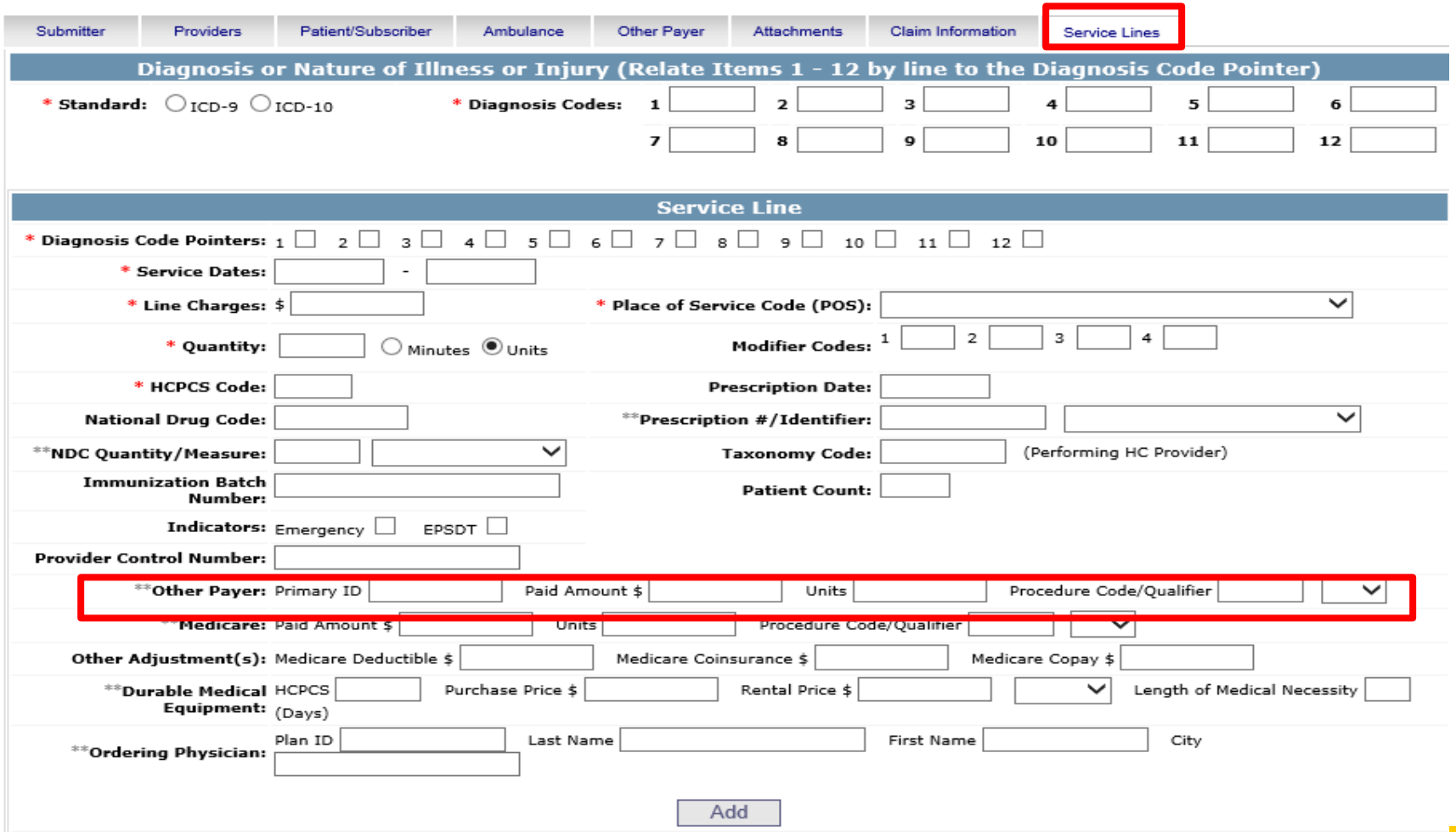
For TPL, the TPL PAID amount is entered in as follows:

- UB-04 Claim Form (I or O): Entered for the whole claim on a UB inpatient or outpatient (Form I or Form O)



1500 AHCCCS Online Provider Portal Fields

AHCCCS
Arizona Health Care Cost Containment System


Submitter
Providers
Patient/Subscriber
Ambulance
Other Payer
Attachments
Claim Information
Service Lines
Diagnosis or Nature of Illness or Injury (Relate Items 1 - 12 by line to the Diagnosis Code Pointer)
* Standard: ICD-9 ICD-10
* Diagnosis Codes: 1 2 3 4 5 6 7 8 9 10 11 12
Service Line
* Diagnosis Code Pointers: 1 2 3 4 5 6 7 8 9 10 11 12
* Service Dates: -
* Line Charges: $
* Place of Service Code (POS):
* Quantity: Minutes Units
Modifier Codes: 1 2 3 4
* HCPCS Code:
Prescription Date:
National Drug Code:
**Prescription #/Identifier:
**NDC Quantity/Measure:
Taxonomy Code: (Performing HC Provider)
Immunization Batch Number:
Patient Count:
Indicators: Emergency EPSDT
Provider Control Number:
**Other Payer: Primary ID Paid Amount $ Units Procedure Code/Qualifier
**Medicare: Paid Amount $ Units Procedure Code/Qualifier
Other Adjustment(s): Medicare Deductible $ Medicare Coinsurance $ Medicare Copay $
**Durable Medical Equipment: HCPCS Purchase Price $ Rental Price $ Length of Medical Necessity (Days)
**Ordering Physician: Plan ID Last Name First Name City
Add

CMS 1500 Example: Office Visit Services

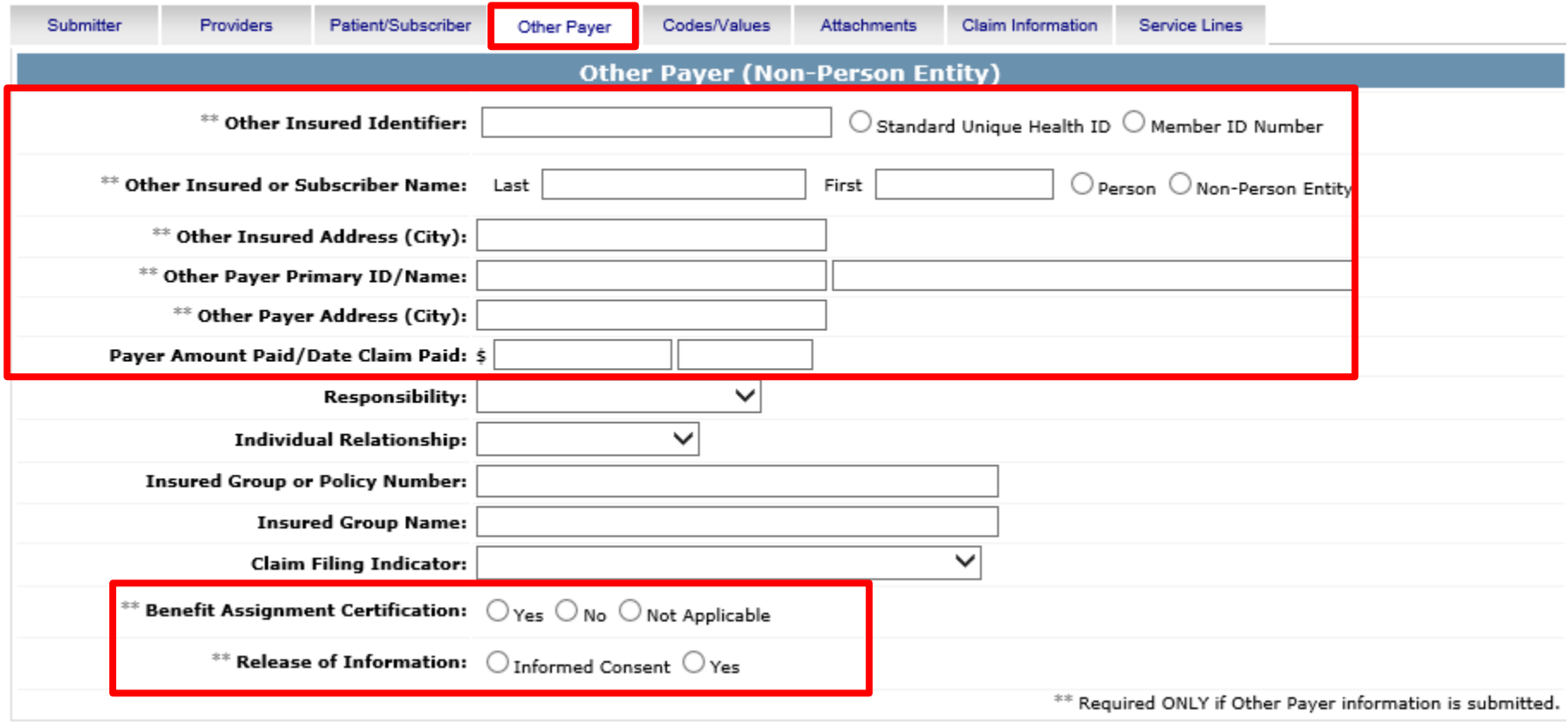
TPL paid amount is entered for *each line* on the claim.

Service	billed	TPL paid amount	AHCCC rate	AHCCCS claim pays	
L1. 99215	$175.00	$0.00	$101.71	$101.71	($101.71-$0.00=$101.71)
L2. 88150	$48.00	$15.00	$12.47	$0.00	(TPL paid more then AHCCCS rate)
L3. 36415	$7.00	$7.00	$2.60	$0.00	(TPL paid more then AHCCCS rate)

Provider cannot balance bill recipient for any amount since the AHCCCS rate was paid.

Note: If a service is not covered by AHCCCS then no payment will be made by AHCCCS.

UB TPL Online Amount Fields


Submitter
Providers
Patient/Subscriber
Other Payer
Codes/Values
Attachments
Claim Information
Service Lines
Other Payer (Non-Person Entity)
** Other Insured Identifier:
Standard Unique Health ID
Member ID Number
** Other Insured or Subscriber Name:
Last
First
Person
Non-Person Entity
** Other Insured Address (City):
** Other Payer Primary ID/Name:
** Other Payer Address (City):
Payer Amount Paid/Date Claim Paid: $
Responsibility:
Individual Relationship:
Insured Group or Policy Number:
Insured Group Name:
Claim Filing Indicator:
** Benefit Assignment Certification:
Yes
No
Not Applicable
** Release of Information:
Informed Consent
Yes
** Required ONLY if Other Payer information is submitted.

UB Example

1st example

Recipient's employer health plan pays primary on this ER facility claim, bill was submitted with the primary EOB.

Total billed amount: $4560.00

TPL billed	TPL allowed	Deductible	TPL pays at 80%	TPL pays	AHCCCS rate	AHCCCS pays
$4560.00	$4560.00	-$1000.00	$3560.00	$2848.00	$2850.00	$2.00

In this example, the AHCCCS rate is higher than the TPL paid amount by $2.00. Since the total amount paid to the hospital is the AHCCCS rate, the hospital cannot balance bill the recipient for any amount.

2nd example

TPL billed	TPL allowed	Deductible	TPL pays at 80%	TPL pays	AHCCCS rate	AHCCCS pays
$4560.00	$4560.00	-$0.00	$4560.00	$3648.00	$2850.00	$0.00

In this example, the AHCCCS rate is *less than* the TPL paid amount. AHCCCS would make NO payment on this claim. Since the provider received total payment more than the AHCCCS rate, the hospital cannot balance bill the recipient for any amount.


DFSM Provider Education and Training Unit

DFSM Provider Training

The DFSM Provider Education and Training Unit can assist providers with the following:

- How to submit and status claims or prior authorization requests through the AHCCCS Online Provider Portal (FFS programs, including AIHP, TRBHAs and Tribal ALTCS).
- Submission of documentation using the Transaction Insight Portal (i.e. the AHCCCS Daily Trip report, requested medical records, etc.).

Additionally, the DFSM Provider Training unit offers trainings with informational updates to program changes, system updates, and changes to the AHCCCS policy, AHCCCS guides and manuals.

Education and Training Questions?

The DFSM Provider Education and Training Unit does not instruct providers on how to code or bill for a particular service.

For additional information on rates and coding please follow the below guidelines:

- Rates - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- Coding - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
  - NOTE: The Coding team cannot instruct providers on how to code or bill for a particular service. Those questions should be directed to the provider's professional coder/biller.
- ACC Plan Claims - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.

The DFSM Provider Training Team can be reached at ProviderTrainingFFS@azahcccs.gov

Technical Questions?

For technical assistance with the AHCCCS Online Provider Portal, please call:

- AHCCCS ISD Customer Support Desk at 602-417-4451 or ISDCustomerSupport@azahcccs.gov

Claims Questions?

For claims questions that cannot be resolved on the portal, please outreach the Claims Customer Service team at:

- Phone: (602) 417-7670 – Select Option 4
- From: Monday – Friday from 7:30am – 4:00pm (Phoenix Time).

The Claims Customer Service team can assist with the following items:

- Details regarding a claim status that cannot be answered on the AHCCCS Online Provider Portal;
- Providing denial codes and general information regarding denied claims; and
- Providing general information about approved and pended claims.

NOTE: Providers should not call the Claims Customer Service team if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims.

Policy Information

AHCCCS FFS Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

AHCCCS IHS/Tribal Provider Billing Manual:

- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/ProviderManuals/IHStribalbillingManual.html

AHCCCS Medical Policy Manual

- https://www.azahcccs.gov/shared/MedicalPolicyManual/

Thank You.