



# Behavioral Health Residential Facility (PT B8) Claim Submission Training

DFSM Provider Training  
July 2023

# About This Training

These materials are designed for the AHCCCS Fee-For-Service (FFS) programs, including American Indian Health Program (AIHP), DD-Tribal Health Program (DD THP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

This training presentation will cover How to submit a Behavioral Health Residential Facility (BHRF) claim using the AHCCCS Online Provider Portal. The claim form type is the CMS 1500 (Professional)/837P format.

If you have any questions about this training presentation, email:

[ProviderTrainingffs@azahcccs.gov](mailto:ProviderTrainingffs@azahcccs.gov)



# AHCCCS Online Provider Portal

# AHCCCS Online Provider Portal

Submitting claims electronically is the fastest and most efficient way to submit claims to a payer. The AHCCCS Online Provider Portal is a free application offered to registered FFS providers to submit claims directly to the Fee-for-Service (FFS) program.

- Registered providers must have a valid ***Username and Password.***
- Providers must keep your login information safe and secure.
- It is prohibited to share your account information.



# AHCCCS Online Provider Portal Functions

Provider Portal Functions Include:

- Member eligibility verification (Medicare/Third Party Liability (TPL),
- Claim status and submission,
- Prior authorization status and submission,
- Electronic Fund Transfer (EFT),
- Provider Verifications and more.

# Helpful Information

Submitting a clean claim is critical to avoid denial errors and delays receiving reimbursement. A clean claim is a claim that has no errors and can be processed without additional information from the provider. The AHCCCS Claims Processing system will deny claims with errors that are identified during the editing process and will provide notification when additional information is required for review.

The [AHCCCS Online Provider Portal](#) provides claim updates in real time. This is a great tool to utilize to stay on top of claims submissions, prior authorizations requests and more; even if the claim was submitted via EDI or a clearing house.

The [Transaction Insight Portal](#) (275) is another free application that providers can use to attach necessary documentation to the claim submission. ***If you only need to submit additional documents for review, it is not necessary to resubmit the claim.***

# AHCCCS Online Provider Portal Quick Guide



Under **New Account**, select **Register** for an AHCCCS Online account and complete the request form.

<https://azweb.statemedicaid.us/Account/Register.aspx>

The screenshot shows the "Sign In" section of the AHCCCS website. It features a "Sign In" heading, a "Username:" label next to a text input field, a "Password:" label next to a text input field, and a "Sign In" button below the fields.

URL **Sign In to the AHCCCS Online Portal.**

<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/>



# Getting Started

## CMS 1500 Claim (*Professional*) Form Submission



# Required Billing Information

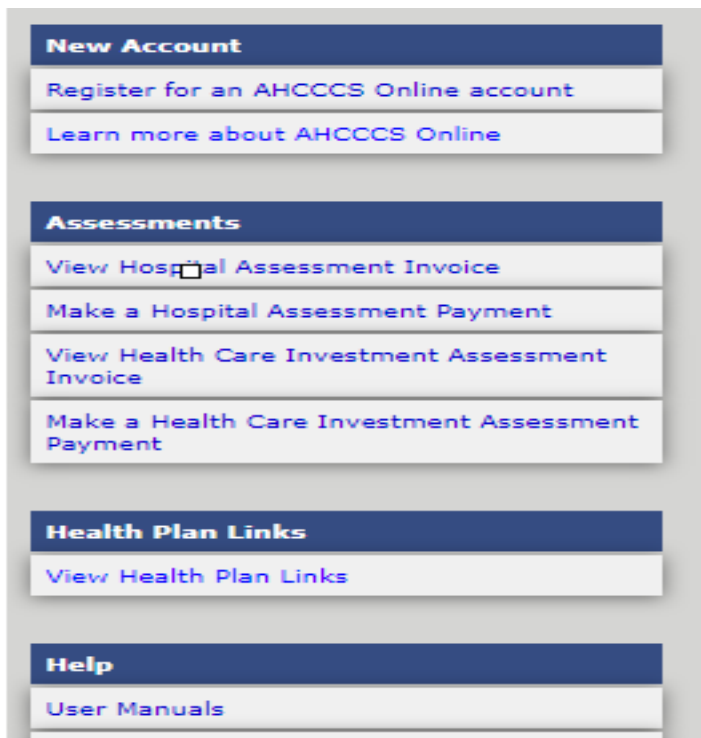
- Verify the member's eligibility and enrollment,
- The prior authorization must be in an approved status before the claim can be submitted for processing,
- Have all the billing information available at the time of submission:
  - Member ID,
  - Date of birth,
  - Date span (cannot exceed 7 days per service line),
  - Billing code (H0018),
  - ICD-10 Behavioral health diagnosis code,
  - Total units must match the dates of service billed on the claim,
  - Charge amount (multiple the per diem rate times the number of days billed),
  - National Provider Identification(NPI).

## BHRF Per Diem Code (H0018)

- The BHRF per diem code (H0018) is the only code approved for BHRF providers to bill for covered services. The services must be identified in the member's treatment plan and require a prior authorization ***before the member is admitted***.
- H0018 does not include “room and board”.

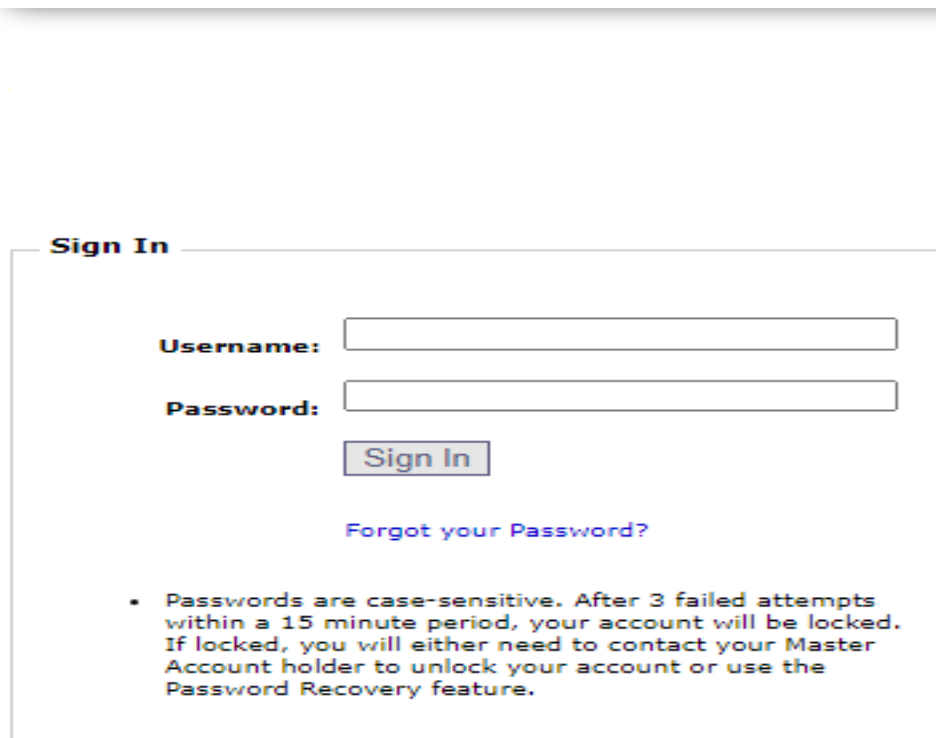
# Sign In to the AHCCCS Online Portal.

<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=/>



The screenshot shows a vertical navigation menu with four main sections, each with a dark blue header and a light gray background:

- New Account**
  - [Register for an AHCCCS Online account](#)
  - [Learn more about AHCCCS Online](#)
- Assessments**
  - [View Hospital Assessment Invoice](#)
  - [Make a Hospital Assessment Payment](#)
  - [View Health Care Investment Assessment Invoice](#)
  - [Make a Health Care Investment Assessment Payment](#)
- Health Plan Links**
  - [View Health Plan Links](#)
- Help**
  - [User Manuals](#)



The screenshot shows the Sign In page with the following elements:

- Sign In** header
- Username:**
- Password:**
- 
- [Forgot your Password?](#)
- A warning message:
  - Passwords are case-sensitive. After 3 failed attempts within a 15 minute period, your account will be locked. If locked, you will either need to contact your Master Account holder to unlock your account or use the Password Recovery feature.

# Let's Submit The Claim

Click Claim Submission



Menu
<a href="#">AIMH Services Program</a>
<a href="#">Claim Status</a>
<a href="#">Claim Submission</a>

Claim Submission

Enter New Claim

Type of Claim:

***Congratulations you are in. Click Go.***

# General Notes:

- **Service Line Tab** - You can enter multiple diagnosis codes (Dx). Omit the decimal point (for example F10.34 would be entered as F1034).
- **Diagnosis code pointer** - you will need to check a box for every diagnosis code that is entered ( for example, if 2 dx codes are entered, you must check Dx. pointers 1 and 2.
- **Payer Responsibility** - If the member does not have any other insurance, select (P) for Primary. If the member has a primary payer other than AHCCCS, select (S) for secondary payer, etc.

# Completing the Billing Provider Tab

Submitter	<b>Providers</b>	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Billing Provider</b>	Rendering Provider	Referring Provider	Service Facility				

The Tax ID, EIN, CMMS NPI, Non-Person Entity, Service and Pay-to-Locator fields are the only fields that must be completed on the Billing Provider tab.



After completing these fields, do not select save or submit, simply go to the top of the tool bar and select the Rendering Provider Tab.

## Billing Provider

* Tax ID:	<input type="text" value="enter"/>	<input type="radio"/> SSN	<input checked="" type="radio"/> EIN
** Provider Commercial Number:	<input type="text"/>		
* CMMS National Provider ID (NPI):	<input type="text"/>	<input type="button" value="Find"/>	Click the down arrow and select the NPI, next click Find.
* Entity Type:	<input type="radio"/> Person	<input checked="" type="radio"/> Non-Person Entity	Select Non-Person
Health Care Provider Taxonomy Code:	<input type="text"/>		
Provider Name:	<input type="text"/>		
Information Contact Name:	<input type="text"/>		
Information Contact Telephone Number:	<input type="text"/>		
Service Locator Code/Address:	<input type="text"/>		Click the down arrows to select the Service and Pay-to-Locator addresses.
* Pay-To Locator Code/Address:	<input type="text"/>		

# Completing the Rendering Provider Tab

Submitter	Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
Billing Provider	<b>Rendering Provider</b>	Referring Provider	Service Facility				

### Rendering Provider

Provider Commercial Number:

\* CMMS National Provider ID (NPI):   **Next, click Find.**

\* Entity Type:  Person  Non-Person Entity

Provider Name:

**\*\* Service Locator Code/Address:**

Performing Health Care Provider Taxonomy Code:

\*\* Required ONLY when Billing and Rendering providers are different, or Billing provider's service address is missing.

# Completing The Patient Subscriber Tab

<b>Patient/Subscriber</b>	Ambulance	Other Payer	Attachments	Claim Information	Service Lines
<b>Insured or Subscriber</b>					
<b>* Member ID Number/Date of Birth:</b>		<input type="text" value="Enter ID"/>	<input type="text" value="MM/DD/YYYY"/>	<input type="button" value="Find"/>	<a href="#">Click Find</a>
<b>Person Name:</b>					
<b>Gender:</b>					
<b>Residential Address:</b>					
<b>* Payer Responsibility:</b>		<input type="text"/>			<a href="#">Click down arrow and select appropriate payer responsibility.</a>



# Other Claim Tabs

BHRF providers will not complete the **Ambulance** and **Other Payer** tabs.

The **Attachment tab** is completed if you are attaching documentation with the claim for consideration. For example, if the member has a primary payer other than AHCCCS and you are attaching a copy of the explanation of benefits (EOB) with the claim submission.

# Attachments Tab

- **Report Type** – Click the drop down and select **B4 “Referral Form”**.
- **Report Transmission** – Click the drop down and select **“EL – Electronically Only”**
- **Control Number** – In this column you will create the unique PWK number. The recommended format is the member’s **AHCCCS ID** and the **Date of Service with no spacing or special characters, (A1234567807012023)**.
- The **“A”** in the AHCCCS ID must be **“capitalized”** on the attachment tab and in the Transaction Insight Portal.

# Claim Information Tab

Providers	Patient/Subscriber	Ambulance	Other Payer	Attachments	<b>Claim Information</b>	Service Lines
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## Claim Information

**Original Reference Number:**   Replacement  Void

**Prior Authorization Number:**

**\* Patient Control Number:**  Facility account number assigned to the member's account.

**Medical Record ID Number:**

**Initial Treatment Date:**

**Date of Current Injury:**  (Accident)

**\*\* Patient's Condition Related To:**  Employment  Other Accident  Auto Accident

**\*\*\* Place in which accident occurred:**  (State)

**Special Program Indicator:**

**\* Provider Signature on File:**  Yes  No

**\* Provider Accept Assignment:**  Assigned  Accepted on Clinical Lab Services Only  Not Assigned

**\* Benefit Assignment:**  Yes  No  Not Applicable

**\* Release of Information Consent:**  Informed Consent  Yes

Release of Information Consent - Select "Informed Consent" if a signed consent by the patient to release medical data is on file.

# Service Lines Tab

- HCPCS Code - H0018
- PA must be approved before submission of the claim.
- Total Days billed cannot exceed seven (7) days per service line.
- Service dates cannot overlap multiple months.
- Examples of correct and incorrect billing date spans
  - **Correct billing:** 7/1/2023 - 7/7/2023 (7 days).
  - **Incorrect billing:** 7/1/2023 - 7/22/2023 (22 days).
  - **Incorrect billing:** 6/20/2023 - 7/10/2023 (overlap multiple months).

# Required Fields Service Lines Tab

- ICD-10 (button),
- Behavioral health diagnosis code,
- Diagnosis code pointer,
- Service date span,
- Line charges (rate multiplied by the number of days billed),
- Quantity (number of days billed cannot exceed 7 days per service line,
- Units (button),
- HCPCS (H0018),
- Place of service code (99).

**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 F99 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: 07/01/2023 - 07/07/2023

\* Line Charges: \$ 1800.00 Rate (x) Days

\* Place of Service Code (POS): 99 - OTHER UNLISTED FACILITY

\* Quantity: 7  Minutes  Units

\* HCPCS Code: H0018

Modifier Codes: 1  2  3  4

Prescription Date:

At the bottom of the page, click ADD to accept the information entered.

Add

\*\* All or none of the information is required for the line or group.

# Missing Claim Fields

Message from webpage



**ATTENTION!** Please correct the following item(s):

**--- BILLING PROVIDER ---**

- Missing Tax ID.
- Missing Tax ID Type (SSN or EIN).
- Missing Provider Commercial Number or NPI.
- Missing Entity Type (Person or Non-Person).
- Missing Provider Name.
- Missing Pay-To Locator Code/Address.

**--- RENDERING PROVIDER ---**

- Missing Provider Commercial Number or NPI.
- Missing Entity Type (Person or Non-Person).
- Missing Provider Name.

**--- PATIENT/SUBSCRIBER ---**

- Missing Member ID Number.
- Missing Member Date of Birth.
- Missing Payer Responsibility.

**--- CLAIM INFORMATION ---**

- Missing Patient Control Number.
- Missing Provider Signature on File.
- Missing Provider Accept Assignment.
- Missing Benefit Assignment.
- Missing Release of Information Consent.

If a required field is missing information, the Online system will identify the fields that have an error. Make the necessary correction(s) and proceed with the claim submission.

OK

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 Amount
1	6/20/2023	6/27/2023	99	H0018						0	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	UN	1,800.00	
																								<b>Totals: \$1,800.00</b>		<b>\$0.00</b>

Each time you enter a service line, the portal will present a summary of the claim information. If the details are correct, simply click the **SUBMIT** button. If you need to make a correction, Click the Pencil icon to the left of the service line, make the correction, than select "Update" then "Submit".



# Claim Submission Confirmation Page

## Claim Entry Confirmation

<b>Transmission Status:</b>	Successful
<b>Claim Type:</b>	Professional
<b>Patient Account Number:</b>	A09340007
<b>Confirmation Code:</b>	P-297

### Attachments

You can go to the 275 portal to upload your document by clicking on the attachment link

Beginning with services incurred on 7/1/2013, all NEMT claims must be submitted with the new AHCCCS standard Daily Trip Report. Effective with service dates 8/1/2013 and forward, any non-emergency transport claim that is submitted without the standard Daily Trip Report will be denied. It is the provider's responsibility to maintain all documentation that supports each transport service claimed. Please click [here](#) to submit an attachment.

View Claim

Enter New Claim

# Claim Submission Confirmation Page

- **Claim View Tab**
  - select this tab to view the full page details of the current claim submission.
- **Enter New claim Tab**
  - select this tab to enter a new claim.



# Division of Fee-for-Service Management (DFSM) Provider Education and Training Unit

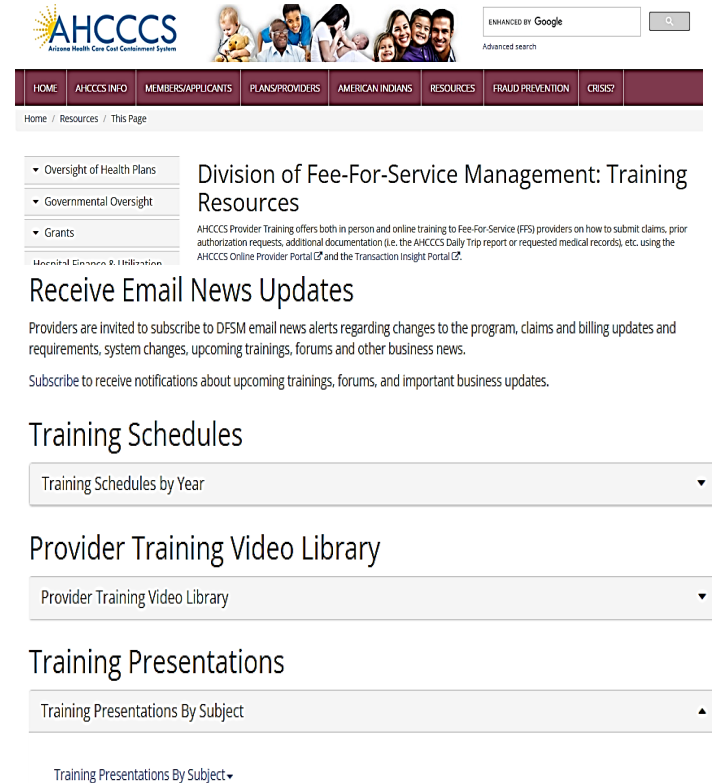
# Provider Education And Training

- The DFSM Provider Training team offers live training webinars and videos on many topics including how to submit and status claims and prior authorization requests, using the AHCCCS Online Provider Portal for the FFS programs including AIHP, TRBHA and Tribal ALTCS.
- The training team also provides training on the Transaction Insight Portal application that is used to submit supporting claims documentation i.e., the AHCCCS Daily Trip report, explanations of benefits, medical records and more.
- We also offer updates to program changes, system updates, and changes to the AHCCCS policies, guides, and manuals.



# Provider Education And Training Schedule

- The provider training schedules are posted quarterly. Providers can also view any of the learning materials that are available on the training webpage.
- To attend a live webinar, registration is required. Go to the Training Resources web page, select **Training Schedules, current year and quarter**. Select the training of your choice and complete the registration form and submit.
- All trainings are held via Zoom.
- In addition to offering live webinars, the Provider Education team is available to assist providers with one-on-one training needs.
- [Division of Fee-For-Service Management Training Resources](#)



The screenshot shows the AHCCCS website interface. At the top, there is a navigation bar with links for HOME, AHCCCS INFO, MEMBERS/APPLICANTS, PLANS/PROVIDERS, AMERICAN INDIANS, RESOURCES, FRAUD PREVENTION, and CRISIS. Below the navigation bar, the page title is "Division of Fee-For-Service Management: Training Resources". The main content area includes a section for "Receive Email News Updates" with a subscription form and a "Training Schedules" section with a dropdown menu for "Training Schedules by Year". There is also a "Provider Training Video Library" section with a dropdown menu for "Provider Training Video Library" and a "Training Presentations" section with a dropdown menu for "Training Presentations By Subject".

# Education And Training Questions

- **Rates** - Questions on AHCCCS FFS rates should be directed to the rates team at [FFSRates@azahcccs.gov](mailto:FFSRates@azahcccs.gov)
- **Coding** - Questions on AHCCCS Coding should be directed to the coding team at [CodingPolicyQuestions@azahcccs.gov](mailto:CodingPolicyQuestions@azahcccs.gov)
- **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.
- **Note:** The Provider Training and the Medical Coding teams cannot advise or instruct providers on how to code or bill for a service. Providers should direct coding questions to your professional coder or biller.

For training requests or questions about this presentation email:

[providertrainingffs@azahcccs.gov](mailto:providertrainingffs@azahcccs.gov)

# Need Help!

If you need assistance with the following:

Questions about warrants, paper EOBs, or EFTs please contact the Division of Business & Finance (DBF) at [ahcccswarrantinquiries@azahcccs.gov](mailto:ahcccswarrantinquiries@azahcccs.gov) or call **(602) 417-5500**. Hours: **10:00 AM – 4:00 PM Arizona Time**.

To check the status of your EFT, please email the Division of Business & Finance (DBF) at [ahcccsfinanceeft@azahcccs.gov](mailto:ahcccsfinanceeft@azahcccs.gov)

Questions related to electronic transactions or to request an ERA transaction setup email [servicedesk@azahcccs.gov](mailto:servicedesk@azahcccs.gov) or contact **(602) 417-4451**. Hours: **7:00 AM – 5:00 PM Arizona Time**.

Providers should use the AHCCCS Online website as the first step in checking the status of the prior authorizations and claims. Our Provider Services representatives are skilled to provide help to many *basic* prior authorization and claims questions. To reach **Provider Services call (602) 417-7670**.

Provider Services Call Center Operation Hours: **Monday-Friday from 7:30 A.M. - 5:00 P.M.**

*Providers should not call the Provider Services 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. Providers should refer to the AHCCCS Website Plans/Providers for more information.*

Questions?



Thank You.