





Correcting Claim Submission Errors
Voids and Replacements

DFSM Provider Training
July 2023

AHCCCS
Arizona Health Care Cost Containment System

About this Course

These materials are designed for the AHCCCS Fee-For-Service 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 when it is appropriate to submit a replacement claim versus initiating a void of the claim via the AHCCCS Online Provider Portal. The claim form types that are included in this presentation are the CMS 1500 (Professional), Institutional (UB-04) and the American Dental Association (ADA) claim forms.

If you have any questions about this training presentation, email the Provider Training Unit: **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 Quick Guide

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

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

URL Sign In to the AHCCCS Online Portal.

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




What is a Fee-for-Service Replacement Claim

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What is a Replacement Claim?

- A replacement claim is a claim that has been previously adjudicated but may have paid incorrectly, or a line item denied or contained other data errors.
- Replacing a FFS claim requires the 12-digit AHCCCS Claim Reference Number (CRN) which is a unique number assigned to each individual claim.
- When a replacement claim is submitted, the original paid amount will be taken back and replaced with the correct information and payment amount.

What is a Replacement Claim?

Common claim errors may include the following:(this is not an all-inclusive list).

Common Claim Replacement Errors	
AHCCCS Member ID	Modifier(s)
Incorrect Date of Service	Billed Charges
CPT / HCPCS	Remove a service line that was billed in error.
Billed Units	Third Party Liability payment.

Submitting a Replacement Claim

- The replacement claim, ***must include*** the 12-digit AHCCCS Claim Reference Number (CRN) that is assigned to the claim.
- The CRN enables the AHCCCS system to identify the specific claim that you want to replace or correct.
- The AHCCCS claims system is programmed to link the replacement claim to the claim reference number that you enter in the ***"original reference number"*** field when you are completing the Service Lines tab.

Submitting a Replacement Claim

Resubmission Error: If a claim is re-submitted without the CRN, the claim will be treated as a first-time submission and may not pass the 6-month initial claim filing deadline or the 12-month clean claim period. If the initial CRN is not provided, the claim also may be denied as a duplicate of an existing claim and no further action taken.

How to Submit a Replacement Claim

- Make any necessary changes and/or add lines to the replacement claim.
- ***Resubmit all lines from the original claim even if the lines contained no changes or do not require correction.***
- If any previously paid lines are omitted, the AHCCCS system will assume that those lines should not be considered for reimbursement and payment will be recouped.
- All fields cannot be changed on a replacement claim. There may be instances when the claim will have to be Voided and a New claim submitted. This will be discussed later in this presentation “How to Void a Claim”.

Correcting a Paid or Denied Claim

When to submit a replacement claim (not all inclusive list)

- To adjust a paid or denied claim.
- To recoup previously paid lines.
- To recoup individual lines, rather than the entire claim.
- Providers must submit the replacement or correction claim to AHCCCS for processing within the 12 month clean claim time frame.

Important Note: Any claim received past the 12 month period no action will be taken by the program.

Helpful Resources and Tools

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 you are using another method to submit your claims.

The Transaction Insight Portal is another free application that provider can use to upload required documents to the claim submission. If you need to submit additional documents for review, providers do not need to resubmit the claim.

Replacement Claim Reminders

- ✓ Indicate the Claim Reference Number (CRN) for the replacement.
- ✓ Resubmit the claim in its entirety, including all lines of the original claim.
- ✓ Failure to include all lines in a multi-line claim will result in a recoupment on paid lines not accounted for on the replacement claim.
- ✓ Correct any errors that were identified on the original claim submission.
- ✓ If the replacement claim is to remove a service line that should not have been billed and the service is not being replaced then omit that line of service on the replacement claim. The system will recoup the monies paid on that specific line of service.




AHCCCS Claim Status Codes

AHCCCS Claim Status Codes

Claim Status Code	Description
A = Approved	All lines of services approved for payment.
M = Mixed Pay Status	Multiple service lines billed; all lines did not approve for payment.
D = Denied	The entire claim denied.
U = Un-adjudicated	The claim may be holding for review or additional information may be required, i.e. (medical records).
V = Void	The claim has been recouped, or there has been a provider initiated action, or it was an audit recovery. Important Note: A CRN number that is in a Void status cannot be used again to submit another replacement claim.




Timely Filing Guidelines
For Fee-for-Service Providers

Timely Filing Requirements for Fee for Service (FFS) Providers

The initial claim must be received by AHCCCS within six (6) months from one of the following timeframes listed below:

Six (6) months from the date of service.

or

Six (6) months from the date that retro- eligibility is posted.

or

Six (6) months from the date of discharge of the patient for an inpatient claim.

If the applicable timeframe is met, then the provider will have up to 12 months from the date of service to submit a replacement claim.



Timely Filing Guidelines
For IHS/638 Tribal Providers

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Timely Filing Requirements for IHS/638 Tribal Providers

The initial claim must be received by AHCCCS within twelve (12) months from one of the following timeframes listed below:

Twelve (12) months from the date of service.

or

Twelve (12) months from the date that retro eligibility is posted.

or

Twelve (12) months from the date of discharge of the patient for an inpatient claim.

If the applicable timeframe is met, then the provider will have up to 12 months from the date of service to submit a replacement claim.


Timely Filing Guidelines For Title XXI KidsCare

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Timely Filing Requirements for Title XXI Kids Care

Fee-for-Service and IHS/638 Tribal Providers who are submitting claims for Kidscare members, the initial claim must be received by AHCCCS within six (6) months from one of the timeframes listed below:

Six (6) months from the date of service.

or

Six (6) months from the date that retro-eligibility is posted.

or

Six (6) months from the date of discharge of the patient for an inpatient claim.

If the applicable timeframe is met, then the provider will have up to 12 months from the date of service to submit a replacement claim.



Untimely Submission of Replacement Claims

Untimely Submission of Replacement Claims

Important Note: This rule applies to all Fee-for-Service and IHS/638 Tribal Providers that are submitting FFS and Kidscare claims.

- If an initial claim is submitted within the timely filing time frame, but a replacement claim is submitted ***outside of the timely filing time frame of 12 months***, this will result in **non-payment** of the claim.




When is it Appropriate to Replace a Denied Claim

When is it Appropriate to Replace a Denied Claim?

There may be many reasons to submit a replacement claim. Claims may deny for multiple reasons, such as: (not an all inclusive list)

- Service excluded,
- Incorrect coding (CPT/HCPCS/modifiers) etc.,
- Units exceed maximum allowance,
- Missing claim information.

Helpful Tips: The Remittance Advice and the AHCCCS Online Provider Portal provides "***real time status***" details of FFS claims to include paid, void, denied and claims in process. Providers can review the denial reason codes to determine what corrective action is required.

Replacement Claim Exception Fields

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Claim Fields That Cannot Be Corrected On A Replacement Claim

Every field can be corrected on the ***replacement claim except*** the following:

X Service Provider field (6 digit or NPI number)

X Billing Provider field (6 digit or NPI number)

X Tax Identification Number (TIN)

Important Note: If these fields must be changed, the provider must first "Void" the original claim and then submit the replacement as a "New" claim. In this scenario, do not reference the original claim number. Timely filing will still apply to the "New" submission.

Claim Example:
Fields That Cannot Be Changed On a Replacement Claim

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Claim Example: Incorrect Service Provider NPI

In this example the date of service is **1/2/2023.**

- The claim is received by AHCCCS on **1/10/2023** (within the 6 month timely filing period).
- The claim is denied on **1/11/2023** "service provider not active on date of service".

The provider reviews the claim details and determines the incorrect NPI for the service provider was entered on the initial submission and submits a "New" claim on 7/15/2023.

Per AHCCCS claim correction guidelines, the service provider field is one that cannot be corrected via a replacement claim submission.

Claim Example: Incorrect Service Provider NPI (cont.)

Provider Action Steps:

- The provider must Void the original claim.
- The correction claim (correct NPI) must be submitted as a “NEW” claim.

Note: In this example, the provider cannot reference the original claim number on the “Replacement/Correction” claim.

- The replacement claim was received on 7/15/2023 and denied “claim received past the timely filing period”.
- When submitting a claim to correct the provider information, it is critical that the claim is received within the 6 month timely filing period. If the “New” claim is received beyond the 6 month filing period, the claim will deny.




When to Void a FFS Claim

When to Void a Claim

The Void process is only used to recoup an entire claim. When a claim is voided , all paid lines (monies) are recouped and refunded back to AHCCCS.

- This process should only be used when there is no other alternative.
- Only the provider who submitted the original claim can void the claim.
- The claim becomes completely voided in the system which means any payments associated with the CRN will be recouped.
- If you want to void individual lines only, you must use the replacement process and omit the lines of services that you want recouped.
- If a provider received overpayment, the provider must notify AHCCCS and must initiate recoupment via the replacement or void process.

Reporting Claim Overpayments

- If the entire payment amount must be refunded to AHCCCS, for example due to the provider receiving the payment in full from another payer or third party, a time limit does not apply to refunding the overpayment back to AHCCCS.
- Important Note: If you select the Void option this will result in the recoupment of the entire claim and any payments issued.




How to Submit a Replacement Claim Using the AHCCCS Online Provider Portal

CMS 1500 Professional Claim Form

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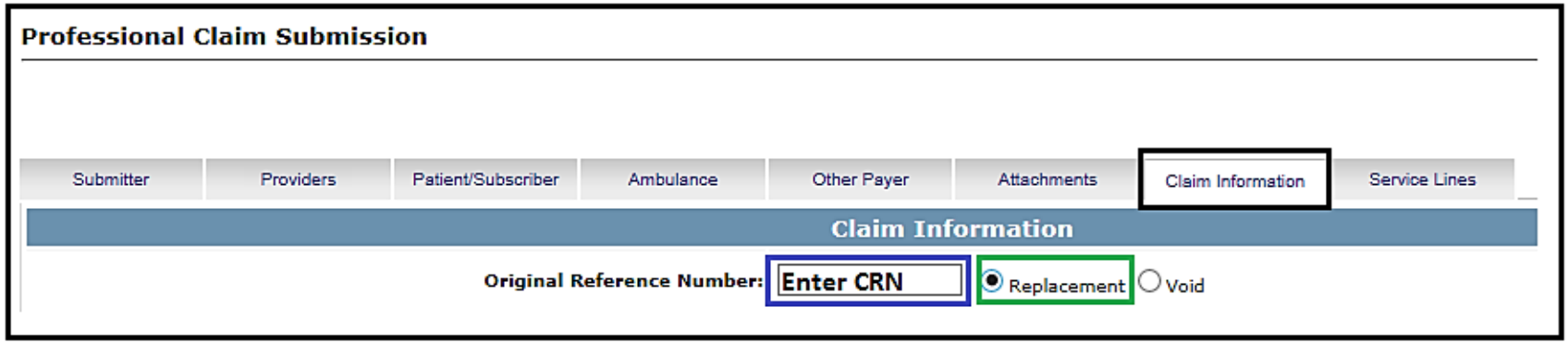
Replacement of a CMS 1500 / Professional Claim

To replace a CMS 1500 claim, providers must indicate the Claim Reference Number (CRN).

- If the claim number is not included on the replacement claim, the replacement claim will be considered a "new" claim and the replacement claim will not link to the original denial.
- Failure to indicate the CRN may also result in an "untimely filing" claim denial and the original claim number will not be adjusted.

Replacement - CMS 1500 / Professional Claim



1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Ambulance(if applicable) Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the claim reference number and select the Replacement button.
3. Next proceed to the Service Lines tab. On this page make sure to enter all service lines as previously billed on the original claim with the exception, if you are correcting the service line, enter the information as it should have been entered on the original claim.




How to Void a Claim Using the AHCCCS Online Provider Portal

CMS 1500 Professional Claim Form

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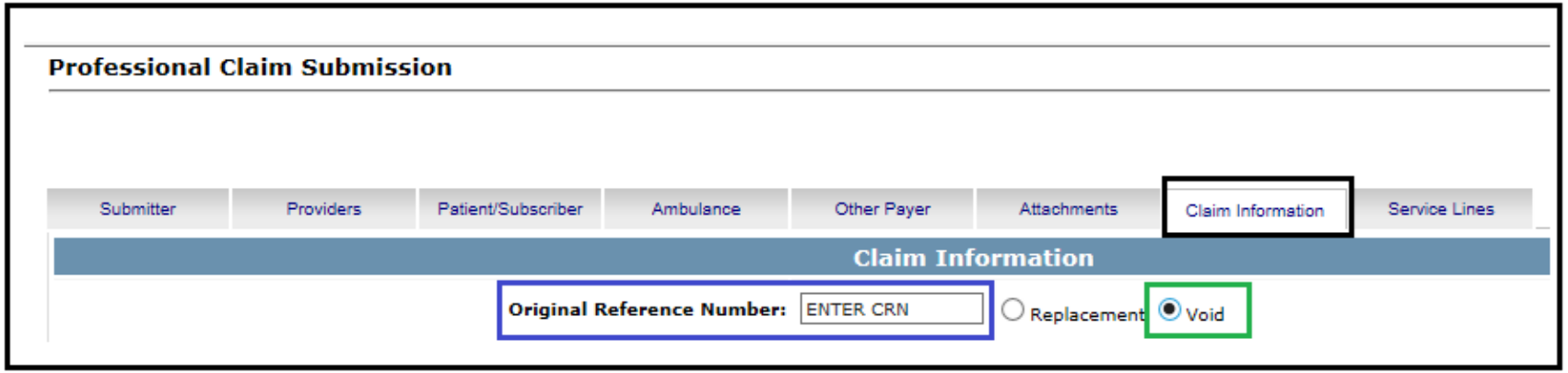
Voiding a CMS 1500 / Professional Claim

If you identify an overpayment, such as when the claim was submitted in error or a primary payer paid the claim in full, providers can submit a refund request to AHCCCS using the Void option.

- All service lines should be entered identical to the original claim submission including the billing, rendering and referring provide information.
- Include the Claim Reference Number (CRN) and select the Void option.

Void CMS 1500 / Professional Claim



1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Ambulance(if applicable) Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the claim reference number and select the Void button.
3. Next proceed to the Service Lines tab. On this page make sure to enter all service lines as previously billed on the original claim.




How to Submit a Dental Replacement Claim Using the AHCCCS Online Provider Portal

ADA 2012 Dental Claim Form

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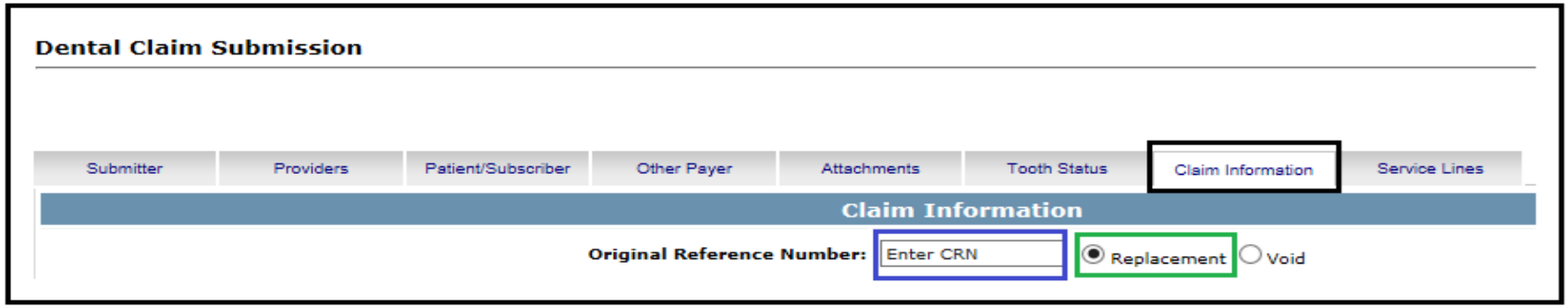
Replacement of an ADA 2012 / Dental Claim

- To replace an ADA dental claim, providers must indicate the *Claim Reference Number (CRN).*
- If the claim number is not included on the replacement claim, the replacement claim will be considered a "new" claim and the replacement claim will not link to the original denial.
- Failure to indicate the CRN may also result in an "untimely filing" claim denial and the original claim number will not be adjusted.

Replacement ADA (Dental) Claim Form



1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Ambulance(if applicable) Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the claim reference number and select the Replacement button.
3. Next proceed to the Service Lines tab. On this page make sure to enter all service lines as previously billed on the original claim with the exception, if you are correcting the service line, enter the information as it should have been entered on the original claim.


How to Void a Dental Claim Using the AHCCCS Online Provider Portal

ADA 2012 Dental Claim Form

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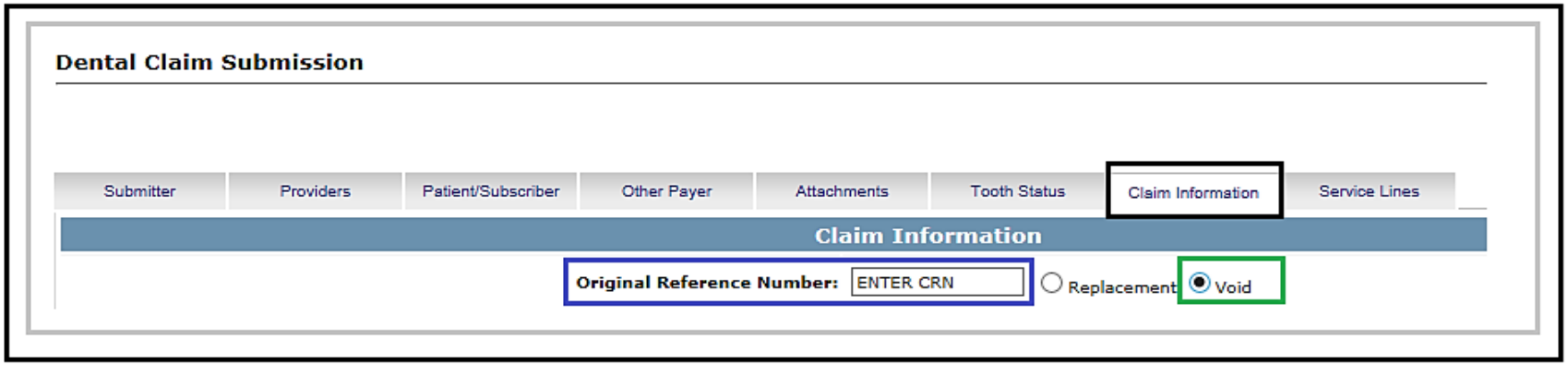
Void ADA 2012 (Dental) Claim Form



1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Ambulance(if applicable) Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the claim reference number and select the Void button.
3. Next proceed to the Service Lines tab. On this page make sure to enter all service lines as previously billed on the original claim.

How to Submit a Replacement or Void Using the AHCCCS Online Provider Portal

Institutional (UB-04) Claim Form

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Institutional UB-04 Bill Type Codes

To replace a UB-04 claim, providers must indicate the appropriate Bill Type code.

- If the appropriate Bill Type code is not included, it will cause the claim to be considered a "new" claim" and the replacement claim will not link to the original denial.
- If the claim reference number is not included on the replacement claim, the replacement claim will be considered a "new" claim" and the replacement claim will not link to the original denial.
- Failure to indicate the correct Bill Type code may also result in an "untimely" claim filing denial and the original claim number will not be adjusted.

Bill Type Code Assignment

- Bill Type codes are a four-digit numeric code that are submitted on the UB-04 claim form. For direct claim entry via the AHCCCS online provider portal, disregard the leading zero and enter the numeric characters (i.e. 131, 111).
- The first two digits excluding the zero indicate the type of facility. The final digit of the bill type code indicates the type of bill and or action initiated by the provider.

Bill Type Code (3rd digit)	Action
7 = Replacement of Prior Claim	AHCCCS will adjust the original claim. The corrections submitted represent a complete replacement of the previously processed claim.
8 = Void or Cancel of Prior Claim	AHCCCS will void the original claim based on the provider's request.

Examples of Common Replacement and Void UB-04 Bill Type Codes

Inpatient Hospital Claim

- 111 – Hospital Inpatient – Admit through Discharge
- **117 – Hospital Inpatient – Replacement Claim**
- **118 – Hospital Inpatient – Void Claim**

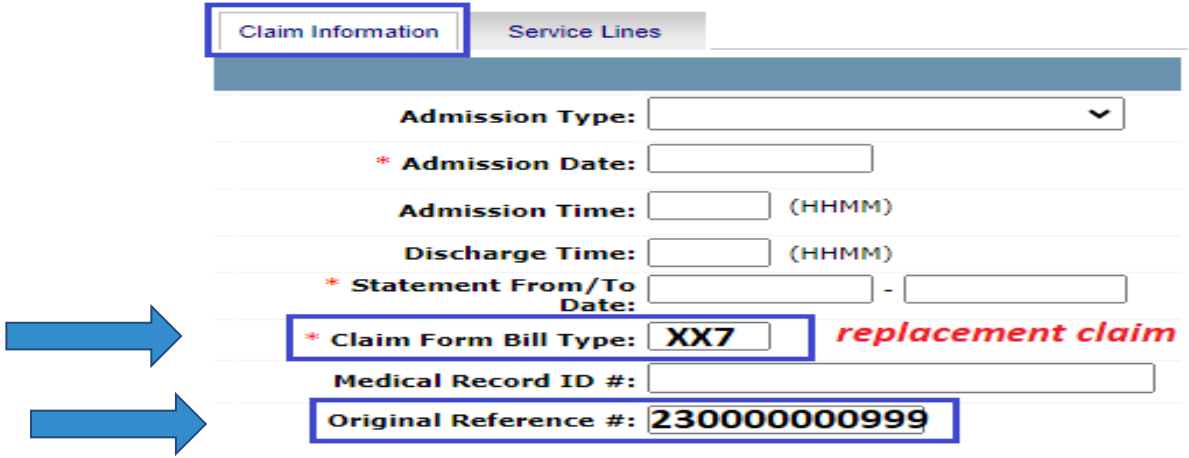
Hospital Outpatient (Including Emergency Department)

- **131** – Hospital Outpatient (including ED) – Admit through Discharge
- **137 – Hospital Outpatient (including ED) – Replacement Claim**
- **138 – Hospital Outpatient (including ED) – Void Claim**

Skilled Nursing Facility

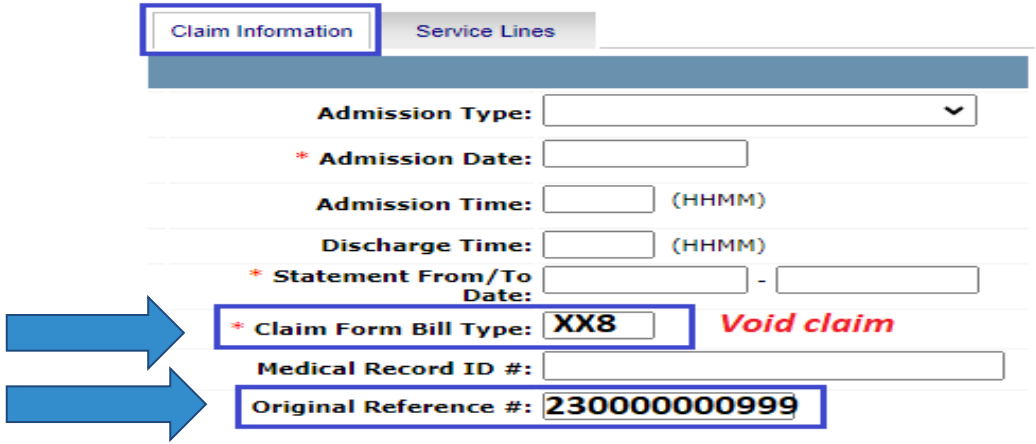
- **211** Skilled Nursing Facility Inpatient - Admit through Discharge
- **217 Skilled Nursing Facility Inpatient - Replacement Claim**
- **218 Skilled Nursing Facility Inpatient - Void Claim**

Replacement of an UB-04 / Institutional Claim



1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the Bill Type Code to indicate that you are submitting a Replacement claim and include the Original Reference Number.
3. Next proceed to the Service Lines tab. On this page make sure to enter all service lines as previously billed on the original claim.

Voiding of an UB-04 / Institutional Claim



1. Complete the following tabs Submitter, Providers, Patient/Subscriber, Other Payer (if applicable), Attachments (if applicable) tabs. Once this is completed move on to the Claim Information tab.
2. On the Claim information tab enter the Bill Type Code to indicate that you are submitting a Void claim and include the Original Reference Number.
3. Next proceed to the Service Lines tab. On this page make sure to enter all service lines as previously billed on the original claim.



Unmatched Key Field Error (SD005)

Claim Denial - Unmatched Key Fields (SD005)

The denial edit SD005 “Unmatched Key Field”, indicates the replacement claim action failed and the original claim has not been replaced.

Action Step: SD005:

- This edit may set if changes are identified by the processing system.
- Review the replacement claim to determine if all fields were entered correctly, if no discrepancies are noted on the replacement claim, contact the provider services unit for assistance.
- If the replacement needs subsequent corrections, the replacement claim number becomes the “original” claim and should be used if additional corrections are required.

Questions?


DFSM Provider Education and Training Unit

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DFSM Provider Education and Training

The AHCCCS Provider Training Unit can assist providers in the following:

- AHCCCS Online Provider Portal Training:
  - How to submit and status claims and prior authorization using the AHCCCS Online Provider Portal;
- How to use the Transaction Insight Portal (for the submission of accompanying documentation);
- Provide clarification on AHCCCS policies and system updates;
- Changes to the program; and
- Other details.

For training requests please contact the DFSM Provider Training Team at **ProviderTrainingFFS@azahcccs.gov**

DFSM Provider Education and Training

Note: The provider training and medical coding teams cannot instruct providers on how to code or bill for a particular service. For example, questions regarding the use of modifiers, billing combination of codes, place of service etc, should be directed to your organization's coder/biller for guidance.

Note: Questions regarding the processing of claims by the AHCCCS Complete Care (ACC) Health Plans should be directed to the appropriate ACC Health Plan.

Who to contact?

- Questions on AHCCCS Fee-for-Service rates email **FFSRates@azahcccs.gov**
- Questions on AHCCCS Coding email **CodingPolicyQuestions@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 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

Questions related to electronic transactions or to request an ERA transaction setup email 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.

Thank You.