Understanding the AHCCCS Remittance Advice

Please note: These materials are designed for Fee-for-Service programs, including American Indian Health Program (AIHP), Tribal Regional Behavioral Health Authority (TRBHA) and Tribal Arizona Long Term Care Services (ALTCS).

What is the Remittance Advice?

The AHCCCS Fee-for-Service 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, claims that are in process, and adjusted claims.

The Remittance Advice is generated weekly.

- The paper Remittance Advice is mailed to the billing provider.
  - If the billing provider has submitted claims for multiple service providers, the Remittance Advice will contain a section for each service provider.

What is the 835 Transaction Remittance Advice?

The 835 Transaction is an Electronic HIPAA-Compliant form of the Remittance Advice.

It provides the same information about claims that the paper Remittance Advice does.

- Note: Information on how to sign up for the Electronic Remittance Advice setup is provided later on in this presentation.

Remittance Advice Overview

The Remittance Advice (RA), including the 835 Transaction, communicates the reason(s) why billed services are paid or denied to the claim submitter.

Both the current paper Remittance Advice (RA) used by AHCCCS and the electronic 835 RA Transaction have many adjudication code values and messages that serve this purpose.

The AHCCCS Remittance Advice will show the payer's claim reference numbers (CRN), EFT/ check number, service codes, description of services, denial reason codes, and remark explanations.

AHCCCS Division of Business Finance

At the end of each financial cycle the Division of Business Finance will issue a remittance advice.

The advice, or notice of payment, will be sent to each provider that had a claim adjudicate during the current week's financial cycle.

The remittance advice is separated into individual reports based on the status of the claim. Each report provides details for claims that are **Approved, Denied, Hold, Void, Un-adjudicated** including **Secondary Payer** claims (Medicare/Other Insurance).

Electronic Data Transactions Information

837I	Institutional Claims and Encounters. The standard format used by institutional providers to transmit health care claims.
837P	Professional Claims and Encounters. The standard format used by health care professionals and suppliers to transmit health care claims
837D	Dental Claims and Encounters. The standard format used by dental providers to transmit dental claims.
835	Electronic Remittance Advice (ERA) also know as (835) – provides detailed payment information for professional, institutional.
834	Enrollment and Disenrollment – transmit enrollment information from the sponsor of the insurance coverage (AHCCCS) to a health care payer (an AHCCCS Health Plan) on a daily and monthly basis.
820	Capitation Payment Transaction- is a weekly file that provides each AHCCCS health plan with an electronic remittance advice for its capitation payments.

Electronic Data Transactions Information

276 / 277	Claim Status Request / Response – request claim status on Fee for Service (FFS) claims that were submitted direct to AHCCCS Administration. Excludes Pharmacy Benefit Manager (PBM) claim status.
270 / 271	Eligibility Request and Response – verification of Eligibility, Coverage, or Benefit Inquiry.
278	Referral Authorization (Request) and (Response)- used to check the status of a prior authorization request.

Request for Electronic Remittance Advice (ERA) or 835 Transaction Setup

AHCCCS Information Services Division EDI Customer Support is the first point of contact for questions related to electronic transactions or to request an ERA transaction setup. The preferred method of contact is email.

- Note: If providing PHI data, please make sure your email is secured.
- All inquiries will result in the assignment of a Service Request or Incident for AHCCCS reporting purposes. Contact information:
- Email: Servicedesk@azahcccs.gov
- Telephone Number: (602) 417-4451
- Hours: 7:00 AM – 5:00 PM Arizona Time, Monday through Friday

Request for Electronic Remittance Advice (ERA) or 835 Transaction Setup

AHCCCS considers the provider *our trading partner* and a request for electronic remittance advice (ERA) or 835 transaction setup must come from an authorized individual from within the provider's organization; **it cannot be initiated by the provider's clearinghouse, software vendor, or billing service.**

The authorized individual must be someone from within the provider's own organization that has the authority to accept the electronic Trading Partner Agreement (TPA) executed from the Community Manager (CM) web portal.

Only the provider can accept the TPA as it is a *contractual agreement* between the provider and AHCCCS.

Note: The provider's CM account activation cannot be done by the provider's clearinghouse, software vendor, or billing service.

Setting up an ERA/835 Account

When setting up an account, the provider must provide:

- Customer Name
- Provider Name
- Customer Email Address
- AHCCCS 6 digit Provider ID and/or NPI
- Who will retrieve the ERA/835? Is it a practice or a clearinghouse on behalf of the health care provider?
- If a clearinghouse is to be used, include the name of the clearinghouse.

Benefits of Receiving an Electronic Remittance Advice

- Fast and accurate way to posting payment details, adjustments and denials.
- More detailed payment information for each claim and service line
- View and print information for a single claim
- View and print the summary page
- Ability to share files and reports
- Ability to export data
- Reduce Lag Time

What Information is on the 835 Remittance Advice (RA)?

The RA details how the claim was processed by the payer, and will include; Payer Paid Amounts, Denied Claims, Claims that are in a Void status, claim Adjustments and claims in process.

- The RA will help you to identify any additional action that may be required to resolve the claim.
- The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full.

Remittance Advice Vocabulary

Claim Reference Number

A Claim Reference Number (CRN) is assigned to all claims when they are initially submitted to AHCCCS.

The first five digits indicate the Julian Date of receipt as follows:

- Examples - CRN 200286789000 , CRN 200288789000

Digits 1 - 2 – reflect the year the claim was received by AHCCCS (2020)

Digits 3 - 5 – indicates the date the claim was received by AHCCCS, (028) IS January 28th.

Digits 6 – 10 – indicates how the claim was submitted by Paper, EDI or Medicare Crossover claim.

- The 6th field may show the number (6 = EDI) or (8= Medicare Crossover).

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Invoice Numbers and Financial Lines of Business

The Invoice Number links payments to the services that generated the payment. Invoice numbers that begin with "A" represent acute care services for example practitioner, "L" represents ALTCS services and 'B" behavioral health service.

Identifier	Program Description	Examples
A	Acute Fee for Services	A1234567890101
L	Long Term Care services – ALTCS	L1234567890101
K	Kids Care services	K1234567890101
M	FQMB – Federal Qualified Medicare Beneficiary	M1234567890101
N	JDOC - Juvenile Department of Correction	N1234567890101
J	MDOC – Maricopa Department of Correction	J1234567890101
C	BKFS – Behavioral KidsCare Fee Service	C1234567890101
B	Behavioral Fee For Services	B1234567890101

Invoice Numbers (i.e. A1234567890101)

The Invoice Number, Check Number and Payment Date appear on each page of the remittance notice.

Sample Remittance Advice – Paid Non-Facility Claims

```
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
NON-FACILITY REMITTANCE ADVICE - ACUTE
PAID CLAIMS - INVOICE DATE: 04/16/2004

1    HOLLIDAY, DOC                    INVOICE NUMBER:   A9800000000001
1    HOLLIDAY, DOC                    CHECK NUMBER:     48746
                                      PAYMENT DATE:     04/20/2004
```

Invoice Numbers (i.e. A1234567890101)

Invoice Numbers are linked to the Payment Reference number or Check Number (EFT).

- The 6th thru 11th digit of the invoice number (6#####) represents the AHCCCS 6 digit provider number.
- The last 2 digits of the invoice number (01) represents the "pay to location" for the provider.

SAMPLE REMITTANCE ADVICE – PAID NON-FACILITY CLAIMS

```
              ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
                NON-FACILITY REMITTANCE ADVICE - ACUTE
                PAID CLAIMS - INVOICE DATE: 04/16/2004

1   HOLLIDAY, DOC                               INVOICE NUMBER:   A9800000000001
1   HOLLIDAY, DOC                               CHECK NUMBER:     48746
                                                PAYMENT DATE:     04/20/2004
```

Informational Codes

Informational Codes appear on the Remittance Advice when there is some type of adjustment to the payment of a claim.

Informational Codes will only appear on claims/services that would apply to that specific informational code.

Informational Codes

- **Claim Adjustment Group Code (Group Code)**- Consists of two alpha characters that assign the responsibility of a Claim Adjustment on the EOB i.e.
  - CO-Contractual Obligations
  - OA – Other Adjustments
- **Claim Adjustment Reason Code (CARC)** – Provides a reason for a payment adjustment that describes why a claim or service line was paid differently than it was billed.
- **Remittance Advice Remark Code (RARC) -** Are used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing.

Remittance Advice Contents and Fields

Overall Format of the RA

Remittance Advice Contents

The Remittance Advice is divided into seven sections:

1. **Paid claims**
2. **Adjusted claims**
3. **Denied claims**
4. **Voided claims**
5. **Claims in process** - This section includes claims pending or reported on a previous Remittance and still in process.
6. **Processing Notes** - This page provides an alphabetical listing of denial reason codes and pricing explanation codes. Each is listed only once even if it applies to multiple claims.
7. **Grievance Process** - This page informs providers of their grievance rights.
    - For additional information on grievances please refer to Chapter 28, Claim Disputes.

Remittance Advice Contents

Examples of all seven sections of the paper Remittance Advice (RA) can be found in:

- The Fee-for-Service Provider Billing Manual, as Exhibits to Chapter 27, Understanding the Remittance Advice; and
- The IHS/Tribal Provider Billing Manual, as Exhibits to Chapter 18, Understanding the Remittance Advice.

Remittance Advice Reports

- Approved
- Denials
- Void
- Adjustments
- Secondary Payer Claims
- Medicare Crossover Claims

Remittance Advice Contents

The Remittance Advice also specifies the following information for providers:

- Number of claims in the file
- Payment amount
- Check/EFT number
- Payee and provider information
- Control numbers (provider)
- Interest payments or penalty adjustments
- Total provider payment
- Provider Identification Numbers

Remittance Advice Fields

Patient Name	The first and last name of the recipient.
CRN	Claim Reference Number.
Claim Status	Indicates the status of the claim when the claim completed processing.
Patient Control Number	Tracking number assigned by provider.
Score Date	The last recorded date of action taken on the claim
Date(s) of Service	Date the service was rendered.
Billed Amount	Total amount charged for the individual service.
Billed Units	The number of times the service was rendered.
Allowed Units	Represents the plan's allowed units of service for the procedure billed.
Reason CDS	Explains the reason a service line is denied, reduced or recouped.

Remittance Advice Fields

Allowed Amount	AHCCCS Fee for Service rate.
Previously Paid	The amount that previously paid prior to an adjustment.
Net Paid Amount	Amount reimbursed for the service.
Service Code	Identifies the service rendered (CPT/HCPCS)
Modifier	Add description to a service or procedure without changing the definition of the code.
Number of Claims	Total claims processed under a specific "Report" heading, ie Paid, Denied claims.
Total Billed Amount	Total charge amount for all claims listed on the remittance.
Total Remit Amount	Total charge amount paid out for all claims listed on the remittance.

Reviewing the Remittance Advice

Paid Claims - Review this section to determine which claims have been paid and if those claims were paid correctly. Any errors, such as claims that have not paid the correct number of units, should be resubmitted (if within timely filing guidelines), noting the original claim reference number (CRN).

Adjusted Claims – This section will report any claims submitted by the provider as adjustments due to payment or billing error.

If problems still exist with a claim, it may be submitted again if within the timely filing guidelines.

This section also will report any claims that were adjusted by AHCCCS as a result of an audit or review.

Reviewing the Remittance Advice

Denied Claims - Review each denial reason and determine the action necessary to correct the claim.

Voided Claims - This section will report any claims submitted by the provider as a voided transaction. There are many reasons a claim may be voided. These may be claims that have been paid by other insurance and now need to be voided so that AHCCCS can recoup its payment. This section also will report any claims that were voided by AHCCCS as a result of an audit or medical review recoupment.

Paid Claims Report

Billing Provider: 123456 01 State Hospital NPI 1234567890 INVOICE NUMBER: A123456712345601
Service Provider: 123456 State Hospital NPI 1234567890 CHECK NUMBER: 2019999999999
PAYMENT DATE: 10/17/2019

PAID CLAIMS - INVOICE DATE 10/17/2019

AHCCCS ID RECIPIENT	Name Patient Account Number	CRN DATE	SCORE	SERVICE CD/ MODIFIER	DATES OF SERVICES	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS	
				L5824 K3 LT	9/30/2019		2	900.00 ALLOWED MOUNT (*)
A12345678	AHCCCS, TOM	190000000099001				1,500.00		------------------------------
A12345678	XXXXXXXX9	10/01/2019				2.00		900.00 NET PAID AMOUNT

AHCCCS ID RECIPIENT	Name Patient Account Number	CRN DATE	SCORE	SERVICE CD/ MODIFIER	DATES OF SERVICES	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS	
					9/29/2019		2	900.00 ALLOWED MOUNT (*)
A12345678	AHCCCS, JOE	190000000101001		L7824		1,500.00		------------------------------
A12345678	XXXXXXXX8	10/01/2019		K3 LT		2.00		900.00 NET PAID AMOUNT

AHCCCS ID RECIPIENT	Name Patient Account Number	CRN DATE	SCORE	SERVICE CD/ MODIFIER	DATES OF SERVICES	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS	
					9/30/2019		2	900.00 ALLOWED MOUNT (*)
A12345678	AHCCCS, MARY	190000000011001		L3124		1,500.00		------------------------------
A12345678	XXXXXXXX7	09/30/2019		K3 LT		2.00		900.00 NET PAID AMOUNT

Number of Claims:	3
Total Billed Amount:	4,500.00
Total Remit Amount:	2,700.00

Adjusted Claims Report

CRN SCORE DATE	SERVICE CD/ MODIFIER	DATES OF SERVICE	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS		
	99233		300.00 3.00	3.00	222.00 148.00- -------- 74.00	ALLOWED AMOUNT(*) PREVIOUSLY PAID NET PAID AMOUNT
	90828		800.00 5.00	5.00	680.00 544.00- -------- 136.00	ALLOWED AMOUNT(*) PREVIOUSLY PAID NET PAID AMOUNT
	99233		290.00 3.00	3.00	146.00 190.00- -------- 44.00-	ALLOWED AMOUNT(*) PREVIOUSLY PAID NET PAID AMOUNT

- **New Allowed Amount is listed first**
- **Previously Paid Amount is "backed out" as negative**
- **Net Paid Amount shows the difference**
- **Net Paid Amount will be negative if the adjusted Allowed Amount is less than the original Allowed Amount**
- **Last page of Adjusted Claims section lists totals**

DENIED CLAIM

Billing Provider: 123456 01 State Hospital NPI 1234567890 INVOICE NUMBER: A123456712345601
Service Provider: 123456 State Hospital NPI 1234567890 CHECK NUMBER: 2019999999999
PAYMENT DATE: 10/17/2019

DENIED CLAIMS - INVOICE DATE 10/13/2019

Billing Provider: 123456 01 State Hospital NPI 1234567890 INVOICE NUMBER: A123456712345601
Service Provider: 123456 State Hospital NPI 1234567890 CHECK NUMBER: 2019999999999
PAYMENT DATE: 10/17/2019

□

AHCCCS ID	RECIPIENT NAME	PATIENT ACCOUNT NBR	CRN	SERVICES CD / MODIFIER	DATES OF SERVICE	BILLED AMOUNT	BILLED UNITS
A12345678	A12345678 AHCCCS, SUE	XXXXXXX9	190000000050001	99285	9/15/2019	1,600.00	1.00
Reason CDS: MD034							
A12345678	A12345678 AHCCCS, BUDDY	XXXXXX8	190000000040001	99283	6/25/2019	600.00	1.00
Comments: RECIPIENT ENROLLED IN HEALTH PLAN 010497 - STEWARD HEALTH CHOICE AZ							
Reason CDS: L050.0							

Number of Claims: 2
Total Billed Amount: 2,200.00

Common Claim Denials

- Member Not Eligible
- Coverage Termed
- Non-Covered Charges
- Provider Not Enrolled
- Incorrect Member ID
- Untimely Filing

- Coding Errors
- Not Medically Necessary
- Missing Claim Information
- Additional Medical Documentation Required
- Prior Authorization Required

- Duplicate Claim On File
- Previously Paid Claim
- Service not Covered for contract type.
- Primary payer EOB required.
- Services do not match Primary Payer's EOB.

Voids

REPORT ID:
PROGRAM ID:

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
NON-FACILITY REMITTANCE ADVICE

VOIDED CLAIMS - INVOICE DATE:

BILLING PROVIDER: NPI: INVOICE NUMBER:
SERVICE PROVIDER: NPI: CHECK NUMBER:
PAYMENT DATE:

TAX ID:
FORM TYPE: FORM 1500

AHCCCS ID RECIPIENT	NAME PATIENT ACCOUNT NUMBER	CRN SCORE DATE	SERVICE/CD MODIFIER	DATES OF SERVICE	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS		
A12345678 A12345678	Last Name, First Name Account Number	CRN Number MM/DD/YYYY	00400 AA	MM/DD/YYYY	2,000.00 1	1	0.00 200.00- 200.00-	ALLOWED AMOUNT (*) PREVIOUSLY PAID NET PAID AMOUNT

PRICE EXPL: *AHA
REASON CDS: MD 034
COMMENTS: DENIED ADJUSTMENT OF PREVIOUS PAYMENT

NUMBER OF CLAIMS: 1
TOTAL BILLED AMOUNT: 2000.00
TOTAL RECOUPED AMOUNT: 200.00

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Medicare Crossover Claims

Name Patient Account Number	CRN SCORE DATE	SERVICE CD/ MODIFIER	DATES OF SERVICES	BILLED AMOUNT BILLED UNITS	ALLOWED UNITS	
			9/30/2019			900.00 ALLOWED MOUNT (*)
AHCCCS, BUDDY	1900000000000	L5824		1,500.00	2.00	-------------------------
XXXXXXXX9	1 10/02/2019	K3 LT		2.00		900.00 NET PAID AMOUNT

SUB *MCC

MEDICARE CROSSOVER CLAIM

Remittance Advice Contents

In addition to the individual sections, the Remittance Advice also has the following pages to provide additional information:

Pages in the Remittance Advice			
Address Page	Processing Notes	Denied Facility Claims	Adjusted Facility Claims
Financial Summary	Paid Facility Inpatient Claims	Paid Facility Outpatient Claims	Voided Facility Claims
Paid Non-Facility Claims	Adjusted Non-Facility Claims	Facility Claims In-Process	
Denied Non-Facility Claims	Voided Non-Facility Claims	Non-Facility Claims In-Process	

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The Address Page

The *Address Page* of the Remittance Advice displays the billing provider's name, ID and pay-to mailing address, as well as the Invoice Date and Payment Date.

Information reported on the Address page includes:

- **REPORT ID**
- **PROGRM ID**
- **BILLING PROVIDER ID number plus locator codes and name**
- **TAX ID of the billing provider.**
- **INVOICE DATE**
- **PAYMENT DATE**
- **BILLING PROVIDER NAME**

Financial Summary Page

The *Financial Summary* page reports payment and invoice data. If all claims are in process or denied, the page will indicate “No Active Invoices.”

Information reported along the top of the Financial Summary page includes the following:

- REPORT ID
- PROGRAM ID
- BILLING PROVIDER ID number plus locator codes and name
- TAX ID of the billing provider.
- PAYMENT DATE is the check date.

Financial Summary Page

Additional information reported on the Financial Summary page includes:

- PAY FOR CATEGORY – This indicates the member's health plan. (i.e. Acute, AHCCCS Long Term Care Services, KidsCare, etc.)
  - Please note that the *total amount* for each membership category will be printed on separate lines (as applicable).
    - Example: If a RA reports information for Acute members and for Long Term Care members, these two categories will appear as separate lines. A KidsCare category would not appear on that RA.

PAY FOR CATEGORY	CHECK NUMBER	INVOICE DATE	INVOICE NUMBER	TYPE	GROSS AMOUNT	DISCOUNT	NET AMOUNT
ACUTE FEE-FOR-SERVICE	48746	04/16/2004	A0400000000001		1033.21	.00	1033.21
TOTALS					1033.21	.00	1033.21

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Financial Summary Page

Additional information reported on the Financial Summary page includes:

- CHECK NUMBER – This is the check number that payment was sent out on.
- INVOICE DATE - This is the date the invoice was created.
- INVOICE NUMBER
- TYPE - column will indicate “CR” if the provider has a credit.
- GROSS AMOUNT - is the total remitted for each Pay Category.
- DISCOUNT – any discounts taken.
- NET AMOUNT – is the total to be paid.

Processing Notes Page

Report ID: Arizona Health Care Cost Containment System

PROGRAM ID: REMITTANCE ADVICE – PROCESSING NOTES

BILLING PROVIDER: NPI: 1234567890

TAX ID: xxxxxxxxxx

**NOTE TYPES: M= PRICING METHOD, P = PRICING TYPE, R= REASON CODE T = TIER, X = MODIFIER

NOTE	TYPE	DESCRIPTION
L050.1	R	RECIPIENT ENROLLED IN PLAN FOR ENTIRE SERVICE DATE SPAN
L050.3	R	RECIPIENT ENROLLED IN PLAN THAT DOES NOT ALLOW PAYMENT
MD034	R	EMERGENCY CRITERIA NOT MET
L099.1	R	RECIPIENT NOT ELIG/ENRL FOR ENTIRE DOS; INVALID ELIGIBILITY

Provider Payment Summary Report

PROVIDER NAME : AHCCCS MEDICAID
NPI # : 1234567890
CHECK DATE : 10/01/2019
CHECK/EFT TRACE # : 0000000000

Total Number of Claims : 100

BILLED AMOUNT	:	5000.00
TOTAL REASON CODE ADJUSTMENT AMOUNT	:	1500.00
TOTAL ALLOWED AMOUNT	:	3500.00
TOTAL COINSURANCE AMOUNT	:	00.00
TOTAL DEDUCTIBLE AMOUNT	:	00.00
TOTAL PAID TO PROVIDER	:	3500.00
TOTAL INTEREST AMOUNT	:	0.00
TOTAL CHECK/EFT AMOUNT	:	3500.00

AHCCCS Online Provider Portal Claim Status Tab Review

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AHCCCS Online Provider Portal
Claim Status

Information about the Claim Status can also be found by using the AHCCCS Online Provider Portal. To view this, follow the below steps.

1. Once logged into AHCCCS Online, select the member and/or date range of the claims you would like to review.
2. Once this is done, select the claim you would like to review.
3. Click on "Claim Status"
4. Verify that you are on the correct claim by looking under the "Claim Header" and verifying the "Claim Number" matches the CRN of the claim you are looking for.
5. Under "Price Accounting Summary" you can look at each line item of the claim and see, line-by-line, if they are each approved, denied, pended, etc.
   - Please note, it is possible for a claim to have mixed status responses for the line items. (i.e. Line items 1-2 may have approved and line item 3 may have denied).

AHCCCS Online Provider Portal
Claim Status

When searching by member, only the member claims *submitted by that provider rep* will come up. When searching by date span, all claims submitted by the provider representative *who is currently logged in* will come up for that date range, and it will appear as shown below.

By going to the Claim Status Response screen, you can see claim status details.

Claim Type	Creation Date/Time	Submission Date/Time	Patient Account #	Service Prov. NPI	Billing Prov. NPI	Date From	Date Thru	Status	Processing Date/Time	CRN Adjudication
Institutional	06/01/16 01:50 PM	06/01/16 01:50 PM	99999999			06/01/16	06/01/16	Processed	06/01/16 02:59 PM	
Institutional	12/30/16 03:12 PM	12/30/16 03:12 PM	A98155234			12/30/16	12/30/16	Processed	12/31/16 09:00 AM	
Professional	04/29/16 09:54 AM	04/29/16 09:54 AM	A95983554			04/29/16	04/29/16	Processed	04/29/16 12:00 PM	
Professional	05/26/16 09:25 AM	05/26/16 09:25 AM	A99999999			05/26/16	05/26/16	Processed	05/26/16 12:00 PM	
Professional	06/06/16 10:52 AM	06/06/16 10:52 AM	A99999999			06/01/16	06/04/16	Processed	06/06/16 12:00 PM	
Professional	06/13/16 02:15 PM	06/13/16 02:15 PM	A99999999			06/01/16	06/01/16	Processed	06/13/16 02:59 PM	
Professional	06/16/16 01:15 PM	06/16/16 01:15 PM	99999999			06/01/16	06/01/16	Processed	06/16/16 02:59 PM	
Professional	06/27/16 01:26 PM	06/27/16 01:26 PM	A99999999			06/01/16	06/01/16	Processed	06/27/16 02:59 PM	
Professional	06/29/16 01:52 PM	06/29/16 01:52 PM	A9999999	1366765190	1366765190	06/01/16	06/01/16	Processed	06/29/16 03:00 PM	
Professional	06/30/16 11:17 AM	06/30/16 11:17 AM	A9999999	1265880090	1265880090	06/20/16	06/27/16	Processed	06/30/16 12:00 PM	
Professional	07/08/16 10:33 AM	07/08/16 10:33 AM	A99999999			06/01/16	06/05/16	Processed	07/08/16 12:00 PM	
Professional	07/11/16 01:40 PM	07/11/16 01:40 PM	A999999999			06/01/16	06/01/16	Processed	07/11/16 03:00 PM	
Professional	11/16/16 10:34 AM	11/16/16 10:34 AM	A98155234			11/16/16	11/16/16	Processed	11/16/16 12:00 PM	
Professional	11/21/16 02:36 PM	11/21/16 02:36 PM	A98155234			11/21/16	11/21/16	Processed	11/21/16 03:00 PM	
Professional	11/22/16 09:59 AM	11/22/16 09:59 AM	A98155234			11/22/16	11/22/16	Processed	11/22/16 12:00 PM	
Professional	11/25/16 02:08 PM	11/25/16 02:08 PM	A98155234			11/22/16	11/22/16	Processed	11/25/16 03:00 PM	
Record Count:	**16**									

AHCCCS Online Provider Portal Claim Status

Claim Status Response

Recipient Search | Claim Search | Help

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

NPI: 1234567890
Organization Name: Main Clinic
Type: MD-PHYSICIAN
Status: ACTIVE

Recipient

AHCCCS ID: A12345678
Gender: M
Name: Ahcccs, Buddy
DOB: MM/DD/YYYY

Claim Header

Claim Number: 190000000033
Claim Status: MIXED
Status Date: 10/01/2019
Medical Record #:
Patient Acct. #: XXXXXX1
Patient Status:
Rcvd. Recipient ID: A12345678
Bill Type:
Service Prov ID: 123456

Price Accounting Summary

Line #	Claim Status	Srv Beg Date	Srv End Date	Srv Code	Billed Amount	Payment Amount
01	APPROVED	09/01/2019	09/01/2019	99285	$1,010.00	$153.65
02	APPROVED	09/01/2019	09/01/2019	93042	$75.00	$7.72
03	DENIED	09/01/2019	09/01/2019	94760	$56.00	$0.00

AHCCCS Online Claim Status Response

Claim Reference Number (CRN)

The Claim Reference Number (shows as Claim Number in the AHCCCS Online Provider Portal) is a twelve character number used to uniquely identify a claim in the AHCCCS claims processing system.

It consists of:

1. A five character Julian date that is the claim receipt date;
2. A one character indicator of the medium by which the claim was received;
3. A one character type indicator for the source of claims received on tape; and
4. A five character sequence number.

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AHCCCS Online Provider Portal Claim Status

Claim Status Response

Recipient Search | Claim Search | Help

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

NPI: 1234567890 | Organization Name: Main Clinic
Type: MD-PHYSICIAN | Status: ACTIVE

Recipient

AHCCCS ID: A12345678 | Gender: M
Name: Ahcccs, Buddy | DOB: MM/DD/YYYY

Claim Header

Claim Number: 190000000033 | Medical Record #: | Rcvd. Recipient ID: A12345678
Claim Status: MIXED | Patient Acct. #: XXXXXX1 | Bill Type:
Status Date: 10/01/2019 | Patient Status: | Service Prov ID: 123456

Price Accounting Summary

Line #	Claim Status	Srv Beg Date	Srv End Date	Srv Code	Billed Amount	Payment Amount
01	APPROVED	09/01/2019	09/01/2019	99285	$1,010.00	$153.65
02	APPROVED	09/01/2019	09/01/2019	93042	$75.00	$7.72
03	DENIED	09/01/2019	09/01/2019	94760	$56.00	$0.00

AHCCCS Online Claim Status Response

Other Useful Items on the AHCCCS Online Provider Portal "Claim Status" Screen

- The **Status Date** is the effective date of the claim's adjudication.
- The **Patient Account Number** is the unique number submitted by the provider to identify a recipient's claim(s).
- The **Service Provider ID** is the identifier used to uniquely identify the individual or entity who provided the service. This identifier will be either a 6 digit value (AHCCCS Provider ID) or 10 Character value (National Provider ID), depending on the provider being identified.
- The **Form/Bill Type** identifies the type (CMS 1500. UB-04, Universal Pharmacy or ADA Dental) of the claim that was submitted.

AHCCCS Online Provider Portal Claim Status

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Service Provider

NPI:	1234567890	Organization Name:	Main Clinic
Type:	MD-PHYSICIAN	Status:	ACTIVE

Recipient

AHCCCS ID:	A12345678	Gender:	M
Name:	Ahcccs, Buddy	DOB:	MM/DD/YYYY

Claim Header

Claim Status:	MIXED	Patient Acct. #:	XXXXXX1	Bill Type:	
Status Date:	10/01/2019	Patient Status:		Service Prov ID:	123456

Price Accounting Summary

Line #	Claim Status	Srv Beg Date	Srv End Date	Srv Code	Billed Amount	Payment Amount
01	APPROVED	09/01/2019	09/01/2019	99285	$1,010.00	$153.65
02	APPROVED	09/01/2019	09/01/2019	93042	$75.00	$7.72
03	DENIED	09/01/2019	09/01/2019	94760	$56.00	$0.00

AHCCCS Arizona Health Care Cost Containment System

AHCCCS Online Claim Status Response and Accounting Details

Prior Accounting Summary

- The **Line Number** is a sequential number used to identify a specific service (doctor's visit, x-ray, etc.) related to the claim.
- The **Claim Status** indicates the adjudication status for the line item associated to the claim.
- The **Service Begin Date** indicates the first day the service was rendered.
- The **Service End Date** indicates the last day the service was rendered.
- The **Service Code** indicates the type of service rendered.
- The **Billed Amount** is the amount submitted by the service or billing provider.
- The **Payment Amount** is the amount to be paid after the discounts (other insurance, penalties, share of cost, etc.) have been applied.

AHCCCS Online Provider Portal Claim Status

Claim Status Response

Recipient Search | Claim Search | Help

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

NPI:	1234567890	Organization Name:	Main Clinic
Type:	MD-PHYSICIAN	Status:	ACTIVE

Recipient

AHCCCS ID:	A12345678	Gender:	M
Name:	Ahcccs, Buddy	DOB:	MM/DD/YYYY

Claim Header

Claim Number:	190000000033	Medical Record #:		Rcvd. Recipient ID:	A12345678
Claim Status:	MIXED	Patient Acct. #:	XXXXXX1	Bill Type:	
Status Date:	10/01/2019	Patient Status:		Service Prov ID:	123456

Price Accounting Summary

Line #	Claim Status	Srv Beg Date	Srv End Date	Srv Code	Billed Amount	Payment Amount
01	APPROVED	09/01/2019	09/01/2019	99285	$1,010.00	$153.65
02	APPROVED	09/01/2019	09/01/2019	93042	$75.00	$7.72
03	DENIED	09/01/2019	09/01/2019	94760	$56.00	$0.00

AHCCCS Online Provider Portal Account Details Tab Review

AHCCCS
Arizona Health Care Cost Containment System

AHCCCS Online Provider Portal Accounting Details

Accounting Details

Recipient Search | Claim Search | Help

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

NPI: 1234567890

Organization Name: Main Clinic

Type: MD-PHYSICIAN

Status: ACTIVE

Recipient

AHCCCS ID: 12345678

Gender: M

Name: Ahcccs, Buddy

DOB: MM/DD/YYYY

Price Accounting Summary

Line #	Claim Status	Srv Beg Date	Srv End Date	Srv Code	Billed Amt	Allowed Amt	Payment Amt
03	DENIED	09/01/2019	09/01/2019	94760	$56.00	$0.00	$0.00

Accounting Detail

** No Records Found **

AHCCCS Online Provider Portal Accounting Details

Accounting Details

- The **Sequence Number** identifies a specific payment/discount applied to the claim's line item.
- **Sequence Number 01** indicates the original payment/discount that occurred. Any additional lines indicate adjustments that have been applied.
- The **Payment Status** indicates whether or not a payment was made.
- The **Type** indicates the type of payment/discount that was applied to the claim's line item.
- The **Amount** indicates the amount of the payment/discount.

AHCCCS Online Accounting Details

Accounting Details

Recipient Search | Claim Search | Help

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

NPI:	1234567890	Organization Name:	Main Clinic
Type:	MD-PHYSICIAN	Status:	ACTIVE

Recipient

AHCCCS ID:	A12345678	Gender:	M
Name:	Ahcccs, Buddy	DOB:	MM/DD/YYYY

Price Accounting Summary

Line #	Claim Status	Srv Beg Date	Srv End Date	Srv Code	Billed Amt	Allowed Amt	Payment Amt
02	APPROVED	09/04/2019	09/04/2019	93042	$75.00	$7.72	$7.72

Accounting Detail

Seq #	Pmt Status	Pmt Date	Type	Amount
01	PAID	09/13/2019	AHCCCS ALLOWED	$7.72

Total: $7.72

AHCCCS Online Provider Portal Edit History, Status History and Denial Reasons Review Tabs

AHCCCS Online Claim Status Response and Edit History

Edit History

All claims are extensively edited by the AHCCCS claims processing system.

A “Score Card” is created each time a claim is edited in the AHCCCS processing system. The score card summarizes which edits were passed (successful) and those that failed (caused an action to be performed) and will also indicate the claim actions and status.

- For example Edit H001.1 – Service provider ID Field is Missing.

AHCCCS Online Claim Status Response and Edit History

Edit History

- The **Score Number** is a sequential number used to identify a specific edit result that occurred against the claim header or one of its detail lines.
- The **Line Number** is a sequential number used to identify a specific service (doctor’s visit, x-ray, etc.) related to the claim.
- The **Date** indicates the day the edit was performed.
- The **Edit Failures** list the reason codes why a claim failed an edit.

AHCCCS Online Claim Status Response and Edit History

Edit History

The Edit History tab will list:

AHCCCS Claim Reference Number (CRN) - Is a 12 digit number unique to each claim.
Score Number – Indicates each time a process was initiated.
Clean Claim Date - Show the last date action was taken on the claim.
Adjudication status - Shows the status of the claim (paid, mixed, void, denied)

CLAIM NUMBER: 2000000000000
SCORE NUMBER: 01
CLEAN CLAIM DATE: 01/01/2020
ADJUDICATION STATUS: DENIED

LN NO	ACTION GROUP	FUNCTION DESC	REASON CODE
001	201	DENY CLAIM/LINE	H001.7

AHCCCS Online Provider Portal
Status History Tab

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

Organization Name:	Main Clinic	**Provider ID:**	123456
Type:	MD-PHYSICIAN	**Status:**	ACTIVE

Recipient

AHCCCS ID:	A12345678	**Gender:**	M
Name:	Ahcccs, Buddy	**DOB:**	MM/DD/YYYY

Claim Header

Claim Number:	190000000033	**Admission Type:**		**Accident (Emp):**	N
Claim Status:	MIXED	**Admission Date:**		**Accident (Car):**	N
Status Date:	20190819	**Admission Hour:**		**Accident (Oth):**	N
Medical Record #:		**Admission Source:**		**Discharge Hour:**	
Patient Acct. #:	XXXX22	**Service Prov ID:**	123456	**Form Type:**	HCFA 1500
Patient Status:		**Rcvd. Recipient ID:**	A12345678	**Bill Type:**	

Status History

Score #	Clean Claim Date	Adjudication Status	Status Date
01	20190810	MIXED	

AHCCCS Arizona Health Care Cost Containment System

AHCCCS Online Provider Portal
Status History Tab

Status History

- The **Sequence Number** is a sequential number used to identify a specific adjudication status at a given point in time.
- The **Clean Claim Date** indicates the date all requested information was provided to AHCCCS.
- The **Adjudication Status** indicates the result (Approved, Denied, Not Adjudicated, etc.) of the editing process.
- The **Status Date** indicates the date the claim header or claim line was adjudicated.
- **Mixed Status -** Claims with multiple lines that result in "mixed status" (paid and denied lines) on the same claim reference number.

AHCCCS Online Provider Portal
Denial Reasons Tab

Claim Status | Accounting Details | Edit History | Status History | Denial Reasons |

Service Provider

Organization Name:	Main Clinic	**Provider ID:**	123456
Type:	MD-PHYSICIAN	**Status:**	ACTIVE

Recipient

AHCCCS ID:	A12345678	**Gender:**	M
Name:	Ahcccs, Buddy	**DOB:**	MM/DD/YYYY

Claim Header

Claim Number:	190000000033	**Admission Type:**		**Accident (Emp):**	N
Claim Status:	MIXED	**Admission Date:**		**Accident (Car):**	N
Status Date:	20190819	**Admission Hour:**		**Accident (Oth):**	N
Medical Record #:		**Admission Source:**		**Discharge Hour:**	
Patient Acct. #:	xxxx22	**Service Prov ID:**	123456	**Form Type:**	A
Patient Status:		**Rcvd. Recipient ID:**	A12345678	**Bill Type:**	

Denial Reasons

Line #	Status Date	Denial Code	Description	Reason
01	20190819	L112.1	MODIFIER #1 NOT VALID FOR PROCEDURE;	INVALID COMBINATION OF CODES

Duplicate Reports

Duplicate Report Requests

Paper Remittance advices or notices are not available for viewing on the AHCCCS Online Provider Portal.

If a provider requires a copy of their paper remittance advice, they will have to contact the Division of Business and Finance (DBF) to request a paper copy.

- **Metro Phoenix (602, 480, & 623 area codes):** 602-417-5500
- **Toll Free:** 877-500-7010

The Finance department will impose a fee of $4.00 per page to reproduce the remit.

Duplicate Report Requests

Electronic Remittance advices or notices (also called 835 remit) are sent out to the provider per an electronic file at the end of each financial cycle.

The 835 file remains on the 835 server for 90 days from the payment date to allow the provider time to download the remit to their desktop. At the end of the 90 day period the 835 EDI file is removed from the server.

The Finance department will impose a fee of $25.00 to reload the file again for access.

DFSM Provider Education and Training Unit

Education and Training Questions?

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

Additionally the DFSM education and 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.

Education and Training Questions?

The DFSM Provider Training Team can be outreached at providertrainingffs@azahcccs.gov .

Thank You.